International Labour Organization

Social health protection in Nepal

State of play and recommendations towards universal extension of coverage

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ILO. Social health protection in Nepal. State of play and recommendations towards universal extension of coverage. Kathmandu: International Labour Organization, 2023.

DOI: 0.54394/KRUU7814
URL: https://doi.org/10.54394/KRUU7814

Photos: © ILO
Printed in Nepal

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Acknowledgments

This report was developed by the ILO in the framework of development cooperation projects, including the Social Protection and Public Finance Management funded by the European Union.

This report was coordinated by the ILO Office for Nepal and benefited from the technical inputs provided by the relevant agencies responsible for social health protection in Nepal, in particular the Ministry of Health and Population, the Health Insurance Board, the Social Security Fund, as well as development partners working in this field, and finally the Social Protection Department of the ILO. The report was consolidated by a team including (in alphabetical order): Suravi Bhandary (ILO), André Bongestabs (ILO), Aurore Iradukunda (ILO), Jose Francisco Pacheco Jiménez (consultant), Suman Sapkota (consultant), and Lou Tessier (ILO).

Abbreviations

DH	district hospitals
EA	enrolment assistants
EPF	Employee Provident Fund
FHCP	Free Health Care Programme
GDP	gross domestic product
GoN	Government of Nepal
HIB	Health Insurance Board
ILO	International Labour Organization
KOICA	Korea International Cooperation Agency
MoHP	Ministry of Health and Population of Nepal
OOP	out-of-pocket
PHCC	primary health care centre
S2HSP	Support to the Health Sector Programme
SSF	Social Security Fund
WHO	World Health Organization

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Context

1.1. Epidemiological and demographic profile

Despite important progress made with respect to population health outcomes, universal health care coverage in Nepal is yet to be achieved. Like many lower-income countries, Nepal now faces the challenge of responding to the increased burden of non-communicable diseases for which the current social health protection system is ill-equipped. Non-communicable diseases now represent the leading cause of death in Nepal, accounting for 71 per cent of all deaths in 2019 compared to 31 per cent in 1990 (Institute for Health Metrics and Evaluation 2020). While this holds true, communicable diseases such as respiratory infections, including tuberculosis, and other infectious diseases as well as maternal and neonatal disorders remain major threats and accounted for close to 20 per cent of deaths in 2019 (Institute for Health Metrics and Evaluation 2020).

The current health profile of the country calls for additional investments in social protection, notably through the universal provision of income security in times of ill health and pregnancy as well as essential health care services, including primary health care and maternity care.

1.2. Health system financing

Health care services are funded by the general government budget and social health insurance schemes. While the later remain in their infancy, most health care costs remain borne by households. Domestic general government health expenditure represented 24.8 per cent in 2019 (World Health Organization Global Health Expenditure Database 2019a).

Out-of-pocket (OOP) payments are high and represent the largest source of funding as a share of total health expenditure. This is reflected in the share of OOP payments which was reported at 57.8 per cent of the share of health expenditure in 2019 (World Health Organization Global Health Expenditure Database 2019b). This share has

been attributed to the increasing use of privately provided health services (International Labour Organization 2021). In fact, the share of OOP payment flows to private hospitals 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 2019a; Nepal Ministry of Health and Population and Nepal Health Sector Support Programme 2018).

1.3. Access to health care

The financial burden of ill-health remains predominantly carried by households. As mentioned above, OOP expenditure in Nepal is very high, comprising of almost 58 per cent of health expenditure in 2019, with an increasing trend since the year 2000, and a significant jump since 2006 (World Health Organization Global Health Expenditure Database 2019b). OOP payments account for the largest share of health financing and are paid directly to health facilities. Close to 11 per cent of the population has reported catastrophic health spending defined at more than ten per cent of their household income in 2019 (World Health Organization and World Bank 2021). This high share puts people at risk of impoverishment when using health services and can act as a deterrent of health care access.

The health sector in Nepal is characterised by significant urban/rural disparities in geographical access and quality of care which significantly limits the attractiveness of social health insurance (Mehata et al. 2017; Pandey et al. 2013). In 2012, only 34 per cent of Nepalese households had access to medical facilities within 30 minutes of their house (Mehata et al. 2017). Additionally, less than one per cent of public health facilities met minimum standards of quality care at the point of delivery in 2015 (Nepal Ministry of Health and Population et al. 2017). Motivational considerations among clinical staff such as low renumeration and limited investment in health structures, poorly developed jobs and roles, lack of management skills amongst clinical staff, lack of performance metrics and low uptake of technology also severely hamper quality of care (Pacheco-Jiménez, José 2019; Nepal Ministry of Health and Population 2003; Sherchand, JB 2013). This not only significantly limits the attractiveness of social health insurance, but also the feasibility of visiting a doctor, particularly in the public sector where quality of care is perceived to be poor (International Labour Organization 2021).

1.4. Social health protection landscape

1.4.1. Vision for social health protection

Financial access to health care remains a challenge for many households in Nepal. The incidence of catastrophic health spending at more than ten per cent of total income or consumption was experienced by 10.71 per cent of the total population in 2017 (World Health Organization and World Bank 2021). This indicates that accessing healthcare has an impoverishment impact.

Social health protection is one of the key priorities of the Government of Nepal (GoN). The Health Sector Strategy (2015-20) was established with the goal of institutionalising universal health care coverage with an emphasis on the extension of coverage to the most vulnerable. To improve access to social health protection, various initiatives have been undertaken at the national level: a programme of free basic health care (FHCP) has been implemented, alongside two social health insurance schemes, namely the Health Insurance Board (HIB)[1] Scheme and the Social Security Fund (SSF) Medical Treatment, Health and Maternity Protection Scheme. In addition, the Safe Motherhood Programme provides cash incentives in the form of transportation subsidies for four antenatal care visits, to deliver at health facilities, and one postnatal visit (transportation costs ranging from 1,000 Nepalese rupees (NPR) for Terai, 2,000 rupees for Hills, and 3,000 rupees for Mountains). The Employee Provident Fund (EPF), a contributory pension scheme for civil servants, also provides medical treatment reimbursements under some restricted conditions, therefore it is not expanded on in this report.

[1] Contributions paid by the Government to the Medical Treatment of Deprived Citizens Programme (Bipanna Nagarik Kosh) were also available to provide financial relief to financially deprived people ongoing difficult and expensive diseases such as: Cardiovascular diseases, Cancer, Renal failure, Alzheimer's disease, Parkinson's disease, Head and Spinal injuries, Sickle Cell Anaemia and Strokes. As of 2022, this programme has been integrated into the HIB scheme.

1.4.2. Stewardship

Stewardship of social health protection schemes and programmes in Nepal is divided between numerous stakeholders and thus fragmented without an overall coordination mechanism in place.

The main institutions responsible for the oversight of social health protection schemes include:

- **The Ministry of Health and Population (MoHP)** with the oversight of the autonomous Health Insurance Board (HIB) as per the Health Insurance Act, 2017 (Art. 2(h)); the mandate to deliver the Free Basic Health Care Programme (FHCP) as per the New Nepal, Healthy Nepal initiative; the mandate to deliver the Aama Programme (Safe Motherhood Programme), the Medical Treatment of Deprived Citizens Programme (Bipanna Nagarik Kosh) and the Community-based Health Insurance Schemes (CBHI). The MoHP is also the steward of health in the country and the main regulator of public and private providers.
- **The Ministry of Finance** with the oversight of the autonomous Employment Provident Fund **(EPF)** as per the Employee Provident Fund Act, 2019 (1962). While establishing the EPF, the Act however does not make any provision for medical insurance. Medical benefits are defined under standard operating procedures (Medical Benefits Guidelines).
- **The Ministry of Labour, Employment and Social Security** with the oversight of the autonomous Social Security Fund (SSF) as per the Contribution-based Social Security Act, 2074 of 2017.

Though the need for coordination between the HIB and SSF was initially anticipated, as reflected in the initially planned composition of the HIB which would include a representative of the SSF, this has currently not materialised in practice (International Labour Organization 2021).

1.4.3. Pooling

While efforts to expand coverage to the uncovered were made, large discrepancies between legal and effective coverage characterise social health protection schemes in Nepal, leaving many in the informal economy uncovered (ILO 2023a). The existence of various parallel social health protection schemes coupled with issues of availability, acceptability, adaptability and quality of services can create challenges to the efficiency of the system overall (ILO 2021a).

The main public schemes include the following, risks and financial resources are not pooled across those programmes:

- The **FHCP** is directed at all citizens, it is non-contributory in nature and funded by general taxes. Currently the package entails outpatient curative care for sick children, child growth monitoring, child vaccinations, any modern method of family planning, antenatal care, and services for sexually transmitted infections.
- The **National Health Insurance Programme** under the **HIB** is directed at all citizen on a mandatory basis, it is a social health insurance scheme which is contributory for those who are identified as able to contribute and fully subsidized for those who cannot.
- The **Medical Care, Health, and Maternity Protection Scheme** under the SSF provides a contributory social health insurance scheme directed at workers in all forms of employment and their families. However, regulations for the participation of those in the informal sector and the self-employed are yet to be implemented.
- The **Safe Motherhood Programme** includes reimbursement to facilities for institutional delivery; iv) blood transfusions; v) emergency referrals, including air lifting; vi) abortion services; and vii) free sick newborn care. Transportation subsidies for four antenatal care visits, to deliver at health facilities, and one postnatal visit are included (provided in cash).

1.4.4. Coverage

The coexistence of various schemes with partially overlapping target groups and benefit packages in their design has led to some fragmentation while expansion of coverage in practice remains a challenge.

Legal coverage

The legal framework provides overlapping entitlements. The revised National Health Policy of 2014 was formulated with the aim of ensuring the fundamental rights to health and social security to all citizens through providing a policy framework for the provision of free basic health services to all. Enshrined in the Constitution of Nepal of 2015, social health protection is recognised as a right to all citizens. To operationalise this right, the Health Insurance Act of 2017 provides the framework for social health insurance coverage for the entire population, while the Contribution-based Social Security Act of 2017 provides entitlements to social health insurance amongst other social security benefits (eight of the nine measures set out in the ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102)).

Registration

The FHCP is not subject to registration. The National Health Insurance Programme under the HIB had registered over 4.5 million people in 2022 while the SSF had registered 466,918 people in 2023.[2] Though mandatory, affiliation under the HIB and SSF schemes remains the responsibility of households and employers respectively, who must register—either online or in person—with the respective scheme to be enrolled. The Safe Motherhood Programme provided benefits to 336,417 women in 2020, representing 62.1 per cent of women giving birth (ILO 2023b).

Overall, only 17.7 per cent of the population is affiliated to a social health protection scheme, significantly below regional and global averages (respectively 65.1 per cent for Asia and the Pacific and 66 per cent globally) (ILO 2021d).

There may be additional barriers further to registration for people to be effectively protected, such as not being up to date with contributions (when applicable), being geographically far from empanelled facilities (therefore having to seek care in non-empanelled establishments or incur additional transportation and / or time off work), facing informal payments, etc (ILO 2021d). Renewal of registration and continuity of payment of contributions are typically issues for schemes that may be mandatory by design but that in practice rely on voluntary registration (ILO 2021a).

[2] Representing 17 per cent of the population who had access to registration in 2023 (i.e. projected total employment in the formal sector in 2023 was 2,746,592).

2

Overview of Nepal's main schemes and programmes and design features

2.1. Free Basic Health Programme (FHCP)

Scope of population coverage

Between 2006 and 2009, a set of free health care policies were introduced in Nepal. The FHCP was established in 2009 under the "New Nepal, Healthy Nepal" initiative as the cumulation of such efforts a for the citizens of Nepal. Out of the 319 reported health facilities in Nepal, 249 were public and 67 were private. Therefore, by design the FHCP concerns the majority of facilities in the country.

Financing

The FHCP is financed through general tax revenues.

Benefits covered and level of financial protection

The FHCP provides access to basic health care services free of charge at district hospitals (DH) and primary health care centres (PHCC). It includes outpatient curative care for sick children, child growth monitoring, child vaccinations, any modern method of family planning, antenatal care, and services for sexually transmitted infections. In this framework, it encompasses outpatient and in-patient care, emergency services and medicine in public facilities.

While this policy precedes the adoption of the legislation creating the HIB and the SSF, the

benefit package design under those two schemes did not take explicitly into account the existence of the FHCP, creating some overlap in benefit packages offered under the different schemes and programme. The current design therefore holds the potential to undermine the gatekeeping role of primary care provided in PHCCs if various programmes fund overlapping PHC services in an uncoordinated manner (including primary care that may be provided at secondary or tertiary levels under HIB and SSF schemes).

2.2. National Health Insurance Programme under the Health Insurance Board

2.2.1. Scheme design

Governance

Though constituted as an autonomous institution, the HIB is still building its autonomy. As an independent and self-governed institution, the Health Insurance Act, 2017 prescribes the formation of an autonomous Board to oversee the scheme. The Board is headed by a chairperson and holds decision-making autonomy for the governance of the scheme. Despite being an autonomous organization, the Ministry of Finance, General Controller Office and the Ministry of Health and Population conduct general oversight of HIB.

The primary responsibilities of the HIB are to formulate, endorse and implement policies, strategies, plans, programmes and budgets related to social health insurance such as to assess payment mechanisms and rates, manage and invest in the fund, and monitor, regulate and evaluate the performance of service providers.

The macro-governance model of the HIB consists of three levels: Federal, Provincial and Local. Each level has a representative organization. The Central Office of the Board represents the Federal level and oversees formulating policies, defining budgets and coordinating the overall scheme. The Provincial level is tasked with the implementation of the strategic framework of the HIB. Provincial coordinators oversee tasks of District Coordinators and Enrolment Officers. By design, Health Insurance Coordination Committees (HICC) play an oversight role in overseeing tasks at provincial level.[3] Finally, the local level comprises of enrolment officers and assistants who are tasked with the enrolment and affiliation activities directly with families (Pacheco-Jiménez 2019).

Scope of population coverage

The Health Insurance Board Scheme (HIB) was established through the Health Insurance Act, 2017 and its vision is guided by the Health Insurance Policy, 2014, the Constitution of Nepal, 2015 and the Health Insurance Regulation, 2018. As per the Health Insurance Act, 2017, enrolment concerns all citizens, including civil servants, private sector employees and the self-employed.

Affiliation under the HIB is not automated and remains the responsibility of households. To assist with the registration process, enrolment assistants (EA) working as volunteers (with a small remuneration per registration) take part in door-to-door promotional efforts to enrol families into the scheme. During their visits, the poverty status of the household is also verified through the possession or not of a poverty red card by the household. Ultra-poor households identified as thus are exempt from contributions and their enrolment is fully subsidized. In practice, the implementation of this subsidization is still lacking in some districts. Enrolment to the HIB is also facilitated by an Android-based app operated by the open software, openIMIS. Identity cards with photos of each family member are provided upon enrolment and a receipt provided upon payment of contributions.

The scheme design explicitly includes a non-contributory entry point for those without contributory capacity, which is aligned with the objective of contributing to improve health equity. In practice, the subsidization process is not yet uniformly implemented in all districts. Further, exclusion and inclusion errors are common with poverty targeting (Devereux et al. 2015). Therefore, there is a risk of excluding some households who cannot afford to pay contributions from subsidies . The compounded

[3] As per the Bylaws prepared in 2021, HICCs are meant to support promotion activities of Health Insurance in province to increase the NHI coverage, facilitate agreements with provincial governments regarding the enrolment of ultra-poor families, the quality improvement of health service providers and their adequate equipment under the province government, among others.

effect of poverty targeting limitations and a flat rate contribution for the population identified as capable to contribute can create financial barriers to enrolment.

▶ Financing

The main sources of financing under the HIB include beneficiaries' contributions and Government contributions. As per the Health Insurance Act, 2017, revenue sources for the scheme comprise of yearly contributions collected at the family unit and Government contributions for the ultra-poor and targeted groups such as elderly persons above 70 years old, female community health volunteers (50 per cent subsidy for the household) and families with individuals affected by any of the following diseases: severe disabilities, Multi-Drug-Resistant Tuberculosis, Leprosy and/or HIV/AIDS.

Families of up to five members contribute at a rate of 3,500 rupees (US$30) per year and 700 rupees (US$6) per additional member (Nepal Ministry of Health and Population 2019a). While this modality of contribution was chosen for practical reasons, it is important to note that flat rate contributions tend to be regressive.

▶ Benefits covered and level of financial protection

Benefit package

Benefits under the HIB are rather comprehensive in scope with the inclusion of preventative and promotive care. The benefit package as defined under the Health Insurance Act, 2017 is explicit and comprises of:

- Promotive services like yoga, nutrition education, healthy behaviour, psychosocial counselling.
- Preventive services like immunisation, family planning, safe motherhood programmes.
- Curative services including outpatient, inpatient, emergency, surgery, medicines, medical aid equipment.
- Diagnostic and rehabilitative services.
- Ambulance service.
- Other services as prescribed.

Additionally, a negative list excludes coverage for the following services:

- Spectacles, hearing devices and other medical aids above the prescribed price.
- Plastic surgery.
- Artificial insemination.
- Others as prescribed.

Level of financial protection

The scheme covers 100% of the cost of services, without any official co-payment, up to a ceiling of 100,000 rupees (US$854) per year per family unit of five with an additional 20,000 rupees covered for each additional member. The maximum amount of benefits available per year is set to 200,000 rupees (US$1,708). Elderly persons have a spending ceiling of 100,000 rupees plus an additional 100,000 rupees if diagnosed with any of the targeted severe diseases. There is a cashless third party payment system, by which by design services are free at the point of service.

While comprehensive in terms of scope, the level of financial protection under the HIB is severely limited by the presence of spending ceilings(Pacheco-Jiménez, José 2019). Initially set at 50,000 rupees per year, spending limits were increased to 100,000 rupees in 2018 after criticism that the imposed ceiling was not sufficient to cover the treatment of one family member (International Labour Organization 2021; The Kathmandu Post 2018). Despite a recent increase in the ceiling limit, the current ceiling still limits the financial protection provided by the scheme to families.

Network of healthcare providers

HIB contracts public and private healthcare providers in which the protected population can seek care. In practice, this means that the effective coverage of services the scheme can offer reflects the imbalance in the distribution of healthcare facilities in the country. This has a strong impact on both availability of care but also quality of care, since resources available in health care facilities in rural areas tend to be limited, even when a facility exists (Sherchand, JB 2013; Nepal Ministry of Health and Population et al. 2017).

2.2.2. Implementation

▶ Administration

Purchasing

The HIB follows a purchaser-provider separation and contracts with a network of public and private providers. Access to care is rationed following a referral mechanism, with only public facilities eligible as a first point of contact. The first point of contact facility for beneficiaries consists of their nearest public primary healthcare center or hospital. To access specialized services not available at their first point of contact facility, or to access private services, a referral is required. This process does not have to be followed in the case of emergency treatment following a referral mechanism (Social Health Security Development Committee 2017).

Public, private (either for or not-for-profit), community and cooperative providers are allowed to enter into agreements with HIB after the fulfilment of certain conditions. To be enlisted as a service provider, a health care provider can submit an application to the HIB expressing its interest in the format stated in Annex-7 of the HIB Regulations 2018. The HIB verifies the application's integrity and conducts an observational visit to the applicant institution. During the observation, the HIB assesses health infrastructure, human resources, medical equipment, and pharmacy services. If appropriate from the observational visit, a contract in prescribed format is signed and exchanged between the provider and the HIB. There is no independent accreditation process managed by the Ministry of Health like it is the case in other countries, which can incentivize quality of care and serve as a basis for contracting by different SHP schemes.

Provider payment methods

Reimbursement is done using two mechanisms, fee-for-service and case-based payments (Pacheco-Jiménez 2019). Capitation is expected to be implemented in the near future. The HIB also has a list of unit costs per service that would require regular updates (Pacheco-Jiménez, José 2019). Provider payment methods under the HIB are not linked to performance indicators and benchmarks with important ramifications for the quality of care. Fee-for-service for outpatient care also does not incentivize quality but rather quantity.

Claims management

The administrative process is technology-driven and cash-free. Once the beneficiary makes use of the services, the provider submits the invoice to the HIB that proceeds with the review and payment. It is all done as an IT-based process in OpenIMIS. The programme allows for a direct link between beneficiaries, the Board and the providers, and the information on the patient, his/her service utilisation, the cost of the different interventions and the corresponding payment is all recorded in the system.

While OpenIMIS greatly simplifies the reimbursement process, concerns over long claim processing periods were made by providers in 2019. According to interviewed providers, the period between invoice submission and final payment at the time took between two and six months (Pacheco-Jiménez, José 2019). This was in part due to the lack of workforce reviewing claims and inputting them in OpenIMIS, making the claim review process a slow one, with no medical adviser available in case of suspicious cases (Pacheco-Jiménez, 2019). On average, it was reported that the HIB received 9,000 claims per day in 2019 (Pacheco-Jiménez, José 2019). In addition, the final reimbursement was reported to last 15-20 days to be finally paid once the HIB approved the bills (Pacheco-Jiménez, José 2019). After this level went up in 2020, the HIB decided to implement a system based on artificial intelligence to deal with the claim load, which was subsequently reduced.

Financial management and planning

Some information gaps emerged during interviews conducted in 2019, signalling areas of possible institutional strengthening, in particular:

- The absence of actuarial feasibility of the scheme and periodic actuarial valuation to support the regular assessment of the financial sustainability of the scheme and its parametric fine tuning as needed.
- Strategic purchasing plan and methodologies for prices determination.

▶ Effective access and utilization

Levels of financial protection limited by ceilings and negative perceptions around quality of services in public primary care facilities compared to care provided by private providers can play a negative role in the extension and retention of scheme membership (International Labour

Organization 2021; Pacheco-Jiménez, José 2019). In a context where private care is rationed through referral mechanisms under the scheme, poor quality of care at the first point of service risks further driving OOPs and deters the renewal of memberships if services are deemed not to be adequate. This possibly explains the drop-out rate of 30 per cent reported under the HIB in 2019.

Ratios of services utilisation under the HIB per insured population between 2016-20 were low and reported to be 0.93, 0.09 and 0.20 for consultations and hospitalisation, emergencies and referrals respectively (Pacheco-Jiménez, José 2019).

2.3. Medical Care, Health, and Maternity Protection Scheme under SSF

2.3.1. Scheme design

Governance

The SSF is an autonomous institution. A tripartite Administration Board governs the SSF, and executive management is entrusted to an Executive Director. As per the Contribution-based Social Security Act, 2074 (2017), representatives from employer and workers' organizations are designated by the Ministry of Labour, Employment, and Social Security (MoLESS) to be represented on the Board. Representatives from the Ministry of Finance, Ministry of Law, Justice and Parliamentary Affairs, Ministry of Cooperatives and Poverty Alleviation as well as the Nepal Rastra Bank are also represented within the Board.

The main functions and responsibilities of the SSF Board are to: i) formulate policies related to its schemes; ii) operate and manage the Fund by approving social security schemes, budget, and programmes; iii) formulate policies on investment for the approval of the GoN; iv) maintain up-to-date records of enlisted workers; v) carry out financial audits and evaluations of the Fund; and vi) any other necessary tasks to operate the schemes.

Scope of population coverage

The Social Security Fund was established through the Contribution-based Social Security Act, 2074 of 2017. As provisioned under the Social Security Scheme Operating Procedure, 2075 of 2018, the fund comprises of four schemes including a Medical Treatment, Health and Maternity Protection Scheme, hereby referred to as the SSF scheme; and schemes providing financial protection covering the following life

contingencies: accident and disability protection, dependent family protection, and old age protection.

As provisioned by the Contribution-based Social Security Act, 2074 of 2017, the SSF scheme intends to cover workers in all forms of employment, including on a mandatory basis for workers in formal employment, but also giving access to workers in the informal economy and the self-employed and their dependents. In practice, only a limited number of employers and employees from the formal sector have registered and the registration of dependents has only recently been introduced and is limited to the spouse at the time of writing.[4]

Affiliation process

Affiliation under the SSF is not automated and remains the responsibility of employers. As per the Contribution-based Social Security Rule of 2018, employers and workers must submit an application to the Fund to be enrolled. All applications are submitted online by the employers and if such an application is found to be complete, the employers and workers are registered with the Fund and the SSF provides employers with an enrolment certificate and unique enrolment number and the workers are provided with a unique social security identification number.

▶ Financing

Most of the revenue of the SSF scheme comes from contributions from employers and workers. As per the Contribution-based Social Security Act, 2074 (2017), revenue sources for the scheme comprise of: i) monthly income-related contributions paid by both employers and workers; ii) grants received from the GoN; iii) grants and assistance received from foreign governments and international organizations, interests; iv) profits received from investment of the Fund's money; v) loans from the GoN; and vi) amounts received from any other sources.

Employers deduct 11 per cent of employees' basic monthly salary while they themselves contribute 20 per cent of employees' basic salary to be deposited to the Fund (Social Health Security Development Committee 2017). The distribution rate of social contributions under the SSF is as follows: 28.33 per cent to the old age protection scheme, 1.4 per cent to the accident and disability protection scheme, 0.27 per cent to the dependent family protection scheme and only one per cent to the medical and maternity protection scheme. According to a recent actuarial analysis of the scheme supported by the ILO, it is estimated that in the year 2027-28, the contribution rate required to finance this scheme will be 1.86 per cent, which is higher than the current contribution rate of one per cent.

▶ Benefits covered and level of financial protection

Benefit package

Benefits under the SSF are comprehensive in scope with the inclusion of maternity care and benefits encouraging institutional deliveries and providing income support to pregnant women and their families. As per the Social Security Scheme Operating Procedure, 2075 (2018), medical benefits under the SSF scheme and maternity protection scheme include:

- Physician's consultation service.
- Hospitalisation and surgery.
- Pregnancy test for a male contributor's wife or female contributor.
- Surgery related to maternity or treatment following admission in a hospital.
- Expenses related to maternity for up to six weeks of delivery.
- Expenses of treatment of new-borns up to three months old.
- Diagnosis and treatment of diseases.
- Medication.
- Consultation fee for home service in case of non-admission in a hospital due to inability to visit the hospital for treatment.

Additionally, a negative list excludes coverage for the following services:

- Plastic surgery and dental treatment except where they are required as treatment following an accident.
- Bariatric surgery.
- Abortion carried out in conditions other than as per the prevailing law.
- Expenses incurred in the event the scheme has been suspended due to the inability of the Fund to meet the expenses following the outbreak of an epidemic in the country.
- Benefits already received under the Accident and Disability Protection Scheme.

[4] The third amendment to the law implemented in December 2022 extended benefits to the contributor and her/his spouse.

Level of financial protection

Benefits under the SSF scheme are characterised by ceilings and co-payments which limit financial protection available to beneficiaries. The SSF scheme provides benefits with co-payment and capped ceiling amounts for the following services:

- Hospitalisations: 20 per cent co-payment with a capped ceiling of 100,000 rupees annually for contributor and spouse (the latter is recent).
- Other services outside of hospitalisations: 20 per cent co-payment with a capped ceiling of 25,000 rupees annually for contributor and spouse (the latter is recent).
- The total amount of benefits claimed shall not exceed 100,000 rupees per fiscal year.

▶ Network of service providers

The SSF contracts with a network of public and private providers. The SSF has a standard operating procedure Selection of Health Service Providers for Social Security Fund's Health Protection Scheme and Transfer of Funds, 2077 (2021). Those service providers who have met the minimum standards as set out by the Ministry of Health and Population are eligible to become a health service provider for the SSF. Those minimum standards are under definition at the time of writing. In addition to that, health care providers must have: (i) both an in-patient and outpatient department; and (ii) a digital infrastructure for the management of patients' information, billing, etc. The first criteria is restrictive when it comes to contracting primary health care facilities that should be the first point of care, acting as gate keepers, but may not have an in-patient department (typically PHCCs).

2.3.2. Implementation

The scheme implementation is recent. As it came into force after the scheme managed by the HIB, the two institutions have an important potential to cross-fertilize and streamline processes, especially in respect of provider contracting and management.

Enrolment on a family or household basis is the most adequate considering the likely transmission of health conditions within the household as well as the fungibility of income at the household level, rendering financial protection ineffective if it is only for a few family members and excludes children. It has been a core design principle for the HIB scheme and it should be considered by SSF.

SSF is currently considering the implementation of both registration of the family dependents for the medical care scheme, and more broadly the opening of registration to the self-employed as well as business units in the informal economy. If this is implemented, the overlap with the scheme managed by the HIB will materialize in practice.

▶ 2.4. Safe Motherhood Programme

The Safe Motherhood Programme includes reimbursement to facilities for institutional delivery; iv) blood transfusions; v) emergency referrals, including air lifting; vi) abortion services; and vii) free sick newborn care, as well as cash incentives for pregnant mothers in the form of transportation subsidies for four antenatal care visits, to deliver at health facilities, and one postnatal visit (transportation cost ranging from 1,000 rupees for Terai, 2,000 rupees for Hills, and 3,000 rupees for Mountains). Coverage of the programme stands at 62.1 per cent of women giving birth (ILO Forthcoming). The programme has been in implementation since 2005 with a strong institutional presence under the MoHP. Nonetheless, although the programme provides cash support for women to incentivise institutional delivery, and ante-natal and postnatal care, it does not provide income replacement/support during birth and recovery and therefore does not serve as an income replacement mechanism in line with the contingency defined in ILO C102.

3

Key findings and recommendations

The primary focus of this report is to support strategic decision-making by social health protection institutions on the extension of coverage to uncovered populations, including workers in the informal economy. In doing so, it recognises international social security standards as core guiding principles in the establishment and continuous improvement of social health protection systems (ILO 2020b). Key findings arise mostly from the experiences of the HIB and SSF thus far and recommendations are structured along key scheme design features and their alignment with international social security standards. They do not preclude the need for larger reforms aimed at improving health and social protection financing, respectively.

Key findings

- The GoN has been very active in the past decade on the extension of social health protection. The entitlement to social health protection, with a comprehensive benefit package, is enshrined in the law for all citizens. Quickly after the different laws were enacted, the GoN took action, and a number of programmes and schemes were put in place to give reality to those legal entitlements. While efforts and progress have been significant, this is not yet translated into effective coverage for all.
- Laudable efforts to expand coverage were made, notably to the poor and to the informal economy. Yet, social health protection schemes in Nepal continue to leave a large proportion of the Nepalese population without effective protection against the cost of health care. In practice, there are high out-of-pocket expenditure and financial barriers to access care remain (World Health Organization and World Bank 2021).

- The legal framework includes overlapping entitlements in terms of both scope of population coverage and benefit packages. In practice, this further translates into a fragmented institutional set up, with different institutions running social health insurance and other tax-financed social health protection programmes in a parallel and uncoordinated fashion (ILO 2023b).
- The architecture of the system with fragmented pools de facto limits risk pooling across population groups. In practice, there is a certain level of duplication of administrative processes across said institutions. Still, the overlap is only partially visible because thus far each programme has remained relatively small in reach in comparison with the needs of the population. With the SSF looking at expanding coverage to family dependents, the informal economy and the self-employed, the overlap may become more visible for the intended beneficiaries (ILO 2023a).
- While mandatory social health insurance affiliation is enshrined in the legal framework, in practice it is challenging to implement. The HIB scheme, and to some extent the SSF scheme and the Safe Motherhood Programme, rely mostly on voluntary registration, which in the case of SHI can result in adverse selection. Further, most countries with large informal economies where automatic registration was not in place struggled to reach full registration through voluntary processes (ILO 2021c).
- The two main social health insurance schemes are characterized by a relatively comprehensive benefit package, which partially overlaps with the FHCP, while the networks of service providers of SSF and HIB include facilities at secondary and tertiary levels. SOPs for contracting health facilities under the SSF seem to undermine its capacity to contract primary healthcare facilities. Coordination would be needed to reinforce the central role of primary health care facilities in expanding access to services in an equitable fashion.
- The two main social health insurance schemes are also characterized by ceilings, which is not a typical feature of social insurance, but rather a common practice in private health insurance. Ceilings limit the effective protection against catastrophic healthcare costs, while the alleviation of such costs is often one central goal for SHI (Cichon et al. 1999).
- The contracting process with service providers under both HIB and SSF schemes is not integrated or streamlined, each institution acts autonomously in this respect, holding the risk of duplication of administrative procedures. Further, contracting processes and to some extent some of the provider payment methods in use (in particular fee-for-service), do not incentivize quality. There would be room to improve those processes and foster purchasing strategies with greater potential to influence availability and quality of care.
- The HIB has accumulated a wealth of experience on both registration to social health insurance in the informal economy and claims administration, making an innovative use of technology in this respect. Lessons learned could benefit social health protection stakeholders in developing the country's extension strategy.
- Despite overlaps between target groups under HIB, SSF, and other programmes, at the moment coordination mechanisms are lacking, limiting alignment, synergies and complementarities.
- Negative perceptions around the quality of care in public facilities by some population groups as well as inequitable distribution of health care services and resources across rural and urban areas create challenges to the attractiveness of social health protection schemes. It equally threatens their effectiveness in supporting access to healthcare when needed.
- In the context of significant geographical barriers to care, the absence of sickness cash benefit and maternity income replacement coverage for most of the population is an additional constraint to access care as opportunity costs linked to seeking care such as transportation costs and loss of revenue are considerably

higher in such contexts (ILO 2020c). Securing income replacement is important to ensure individuals and households do not forgo needed care when they require it but also to ensure adequate recovery such as to protect oneself and others in the case of communicable diseases as exposed by the COVID-19 pandemic (ILO 2020a).

Recommendations

- Social health protection is at the juncture of health and social protection sectoral policies. To work well, it requires inter-sectoral coordination and investments in both the health sector and the social protection sector. Recent analysis has indicated differences across sectors.
  - While the social protection sector overall receives a relatively high share of the government budget (representing 16.6 per cent of government expenditure for fiscal year 2020-21), it is rather inequitably distributed. Most of the budget goes to the old age pension of public sector workers, which reaches less than 3 per cent of the total population covered by social protection in Nepal (less than 300,000 beneficiaries), leaving little room for investments in other programmes (ILO 2023b). It is important to note that this scheme is under reform and a transition to a contributory scheme should create room for reallocations in the future (ILO 2023b).
  - On the health sector side, public spending on health in Nepal has historically been lower than the recommended thresholds, despite an increasing trend (Nepal Ministry of Health and Population 2019b). It is important to note that the COVID-19 response and the health reform programmes significantly increased public resources for health, though they have been largely reliant on external funding, while Nepal had previously been increasing its domestic funding for health (UNICEF 2021). Overall, the health budget remains largely centralized (which could explain to a certain extent the difficulties encountered by some localities to subsidize HIB beneficiaries) (UNICEF 2021). For fiscal year 2021-22, the social health insurance plan saw a stable allocation of the central government health expenditure, though decreasing in percentages due to the injection of additional resources to the COVID-19 response (UNICEF 2021).
  - More and better domestic investments in the health and social protection sectors are needed to address some of the constraints to social health protection extension outlined in this note. Those include redressing inequities in distribution of health facilities, workforce and equipment across rural and urban areas, improving quality, strengthening primary care and securing levels of subsidies to social health insurance contributions to a wider net of workers in the informal economy and their families. With a view to reach those objectives, it is crucial that the discussions on the extension and improvement of current social health protection programmes does not stay isolated from the formulation, monitoring and evaluation of national health financing and social protection financing strategies.
- In view of the fragmented institutional picture when it comes to social health protection, it would be advisable to have a coordination platform on social health protection. Such platform could support the alignment, coordination and, if opportunity arises, progressive integration of different programmes towards a joint strategy to expand coverage and improve adequacy. Harmonization can also promote allocative efficiency geared towards population needs.
- Linkages between the Safe Motherhood Programme, the SSA Child Grant, the HIB and SSF health insurance and the SSF's maternity protection schemes could expand the avenues to which pregnant women and new mothers can enjoy

access to healthcare and income security to take care of their new-borns.

- Coherent operational strategies and synergies should be developed to give reality to the mandatory social health insurance registration mandated by law. This supposes to take several steps, which all include evidence generation to support decision making:
  - Ensuring a coherent offer with the correct segmentation, leaving no one behind, with due consideration to the current poverty targeting mechanisms and other means of identification and segmentation already in place and their limitations. Avoiding overlaps and competition between schemes in terms of target population and / or benefit package would be key moving forward.
  - Realistically assess willingness and capacity to contribute to social health insurance with a view to: i/ devise strategies to address issues of trust, awareness and communication; and ii) propose contribution levels that are adapted, which may require different levels of subsidization for workers in the informal economy and their families (ILO 2023a).
  - Better understand the reasons behind non-renewals of SHI to improve streamlined or automatic renewal processes.
  - Seek integrated solution with other sectors. For example, some countries have put in place single registration processes and presumptive tax regimes for self-employed workers and small businesses that can facilitate both enrolment and contribution collection (ILO 2021c). Similarly, some countries have made SHI registration part of the steps to register into school or university, while others have made registration points available at the point of care, and others have opted for automatic registration based on central population databases (ILO 2021d; 2021a).
- To align with international social security standards on social health protection, the two main social health insurance schemes should review the application of ceilings and consider alternative solutions for cost containment. Developing in-house competencies on economic and actuarial analysis would support such a process by giving adequate tools to simulate the impact of parametric changes on the schemes' financial sustainability.
- The different social health protection schemes should aim at creating synergies and complementarity including in the areas of contracting and purchasing. Institutional fragmentation and the resulting limited pooling diminishes the negotiation power of respective schemes with health care service providers regarding both tariffs and payment methods. The existence of various payers can also end up being burdensome for providers (ILO 2021b; 2021a). Therefore some countries have made efforts to align benefit packages, provider empanelment procedures and provider payment methods across schemes with a view to improve efficiency and equity (ILO 2021a). Independent accreditation processes have also helped boosting quality and smooth contracting processes in a number of countries in Asia (ILO 2021a).
- In a context where social health insurance is relatively new in the country, strengthening the competencies and skills related to social health insurance management within responsible institutions is key. Strong institutions are needed to run programmes efficiently and to foster trust amongst the population.

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Annex

Social health protection principles dashboard

Extract from (ILO 2021a)

Nepal	
Universality of protection	
Population legally covered for social health protection (%)	
Population effectively covered by a social health protection scheme (protected persons) (%)	21
Percentage of labour force aged 15+ years legally entitled to income security during sickness (%)	
Percentage of the labour force aged 15+ years effectively covered for sickness benefits (12 days sick leave annually) (%)	3.2
Solidarity in financing	
Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)	58
Risk pooling for the whole population	No [5]
Diversity in financing sources (taxes and social security contributions) *Mix = social security contributions + taxes*	Mix
Adequacy and predictability of benefits	
UHC service coverage index: Coverage of essential health services (range 1-100, SDG 3.8.1) [6]	48
Skilled health staff density per 10,000 [7]	26.4
Application of user fees & co-payments (main public schemes)	Yes
Proportion of population spending more than 10 per cent of household consumption of income on out-of-pocket health care expenditure (%) [8]	10.7
Non-discrimination, gender equality and responsiveness to special needs	
Financing of maternity cash benefits *EL = employer liability* *NC = non-contributory scheme* *SI = social insurance*	EL + SI

[5] Fragmented risk pools for different population groups.
[6] Metadata available at: https://www.who.int/data/gho/data/themes/topics/service-coverage.
[7] A component of SDG target 3c, indicator 3.c.1: Health worker density and distribution, reported following thresholds: World Health Report 2006: 22.8; ILO 2010: 41.2; WHO.
[8] Metadata available at: https://unstats.un.org/sdgs/metadata/.

Percentage of women giving birth receiving maternity cash benefits (income replacement) (%) [9]	
Pre- and post-natal care and delivery covered without co-payments	No
Coverage of temporary migrant workers subject to separate mechanisms and/or employer's liability	No
Primary responsibility of the State	
Domestic general government health expenditure (GGHE-D) as a percentage of gross domestic product (GDP) (%)	1.5
Purchasing: Publicly managed & administered schemes act as main purchaser	Multiple
Provision: Predominance of public provision, including for higher levels of care	No
Entitlements to benefits prescribed by national law	
Benefit package guaranteed by law (main public schemes) *Mix = Implicit and explicit depending on scheme*	Explicit
Equity in access and leaving no one behind	
Births attended by skilled health personnel (%) (SDG indicator 3.1.2)	
Measles immunisation coverage among one-year-olds (%)	
Tuberculosis treatment coverage (%)	
Estimated antiretroviral therapy coverage among people living with HIV (%)	
Social inclusion, including of persons in the informal economy	
Workers in all types of employment are legally covered for social health protection	Yes [10]
Tripartite participation with representative organizations of employers and workers	
Tripartite representation in governance body (where applicable)	Yes

Sources: Adapted from the ILO World Social Protection Database, based on the Social Security Inquiry (SSI) and ISSA/SSA; WHO Global Health Observatory; Global Health Expenditure Database; WHO and World Bank 2020.

[9] Part of SDG target indicator 1.3.1, metadata available at: https://unstats.un.org/sdgs/metadata/.
[10] Provisions for the informal sector and self-employed are still under development.

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