Swiss TPH

Swiss Tropical and Public Health Institute
Schweizerisches Tropen- und Public Health-Institut
Institut Tropical et de Santé Publique Suisse

Associated Institute of the University of Basel

Swiss Centre for International Health

Review of Community Based Health Insurance (CBHI) initiatives in Nepal

Swiss Centre for International Health, Switzerland

MEH Consultants, Nepal

Kathmandu, 02 February 2012

MEH Consultants

Consultant's team

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Objectives of the review

- To review selected CBHI programs in Nepal,
- To evaluate their performance and
- To evaluate their current role in the overall health care financing system in the country (complementing / overlapping other health care financing mechanisms)

Methodology of the review

Methods applied

- Desk review
- Consultation with key stakeholders
- Sample selection:

  - 6 government supported schemes,

  - 6 private schemes

Methods applied

Data collection (1):

- Interviews:
  1. CBHI management committee (12)
  2. Healthcare providers contracted/used by CBHI members (9)
  3. Referral centres contracted/used by CBHI members (2)
  4. CBHI members (FGD) (12)
  5. CBHI Dropouts (FGD) (12)
  6. Non CBHI members (FGD) (12)
  7. District Health Officer (1)
  8. Participation in regional review meetings (2)

Methods applied

Data collection (2):

- Record review:
    1. Financial data
    2. Utilisation of health services
    3. Benefit package
    4. Membership renewal
    5. Membership composition

Findings

General description of the schemes: Provider Based Govt. Supported

Name of the CBHI scheme	Date of start of operation	Number of VDCs / Municipalities * covered	Nr of enrolees in FY 2011
Mangalabare PHC	2004	9	3,842
Katari Hospital	2006	1	2298
Chandranigahapur PHC	2006	6	2,636
Dumkauli PHC	2004	9	1676
Lamahi PHC	2006	6	6,259
Tikapur DH	2006	5+1*	5,980

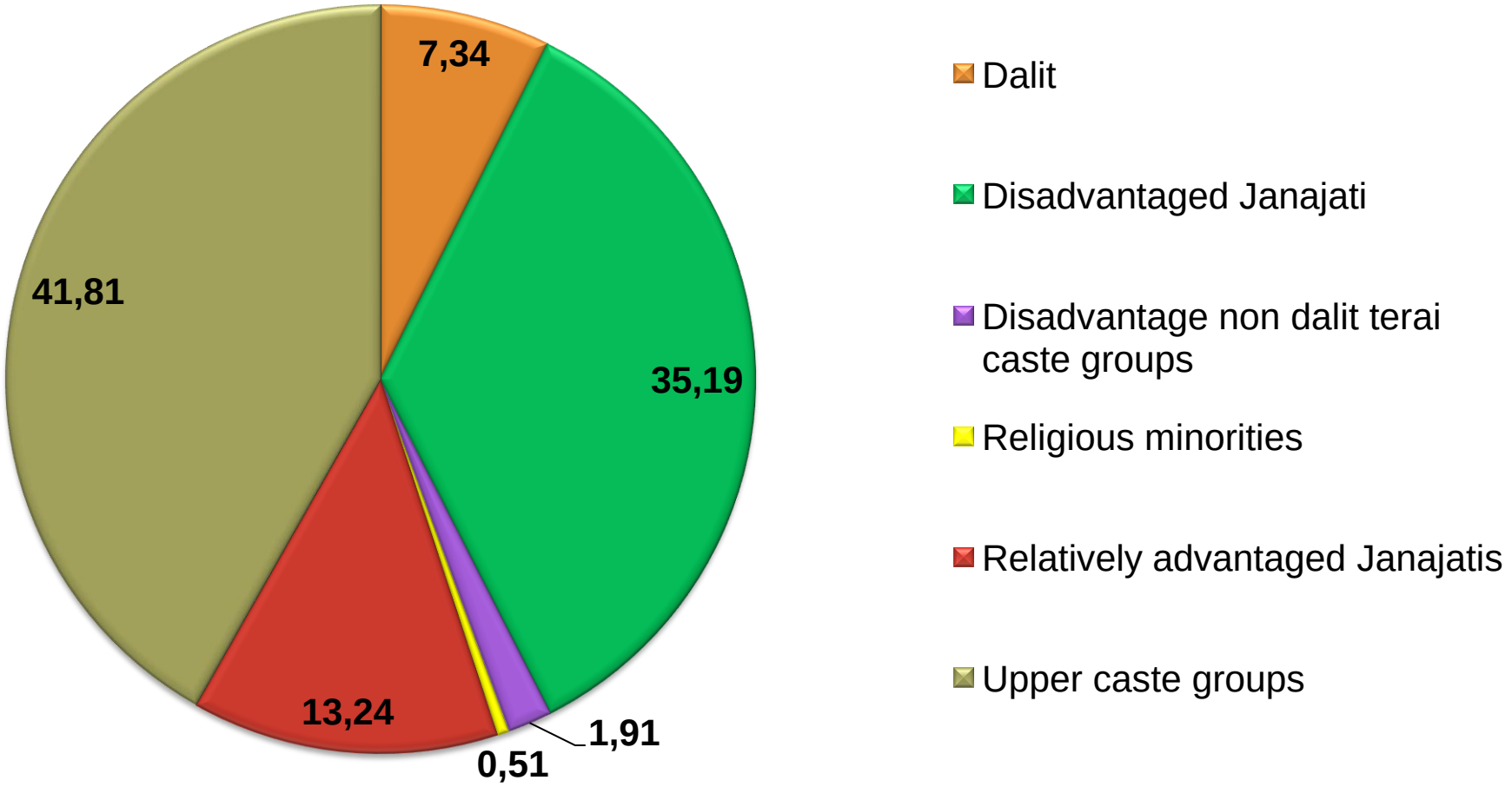
General description of the schemes: Private Organizations / Promoted

Name of the CBHI scheme	Date of start of operation	VDCs/ Mun.	# of Enrollees	Nature of Scheme
Syafru HP	2009	1	831	Provider based, support by **Karuna Foundation.**
Madesha SHP	2009	1	2083	Provider based, Support by **Karuna foundation**
Saubhagya Laghu Swasthya	2011	9	908	Community based supported by Misereror/STC/MIA/DEPROSC
PHCRC, Chapagaon	1972	15	4311	Community based, UMN initiated. Presently supported by KOICA.
Rajmarga Cooperative Society Limited	2003	20	599	Cooperative
Bikalpa Cooperative	2000	2+1*	1,376	Cooperative

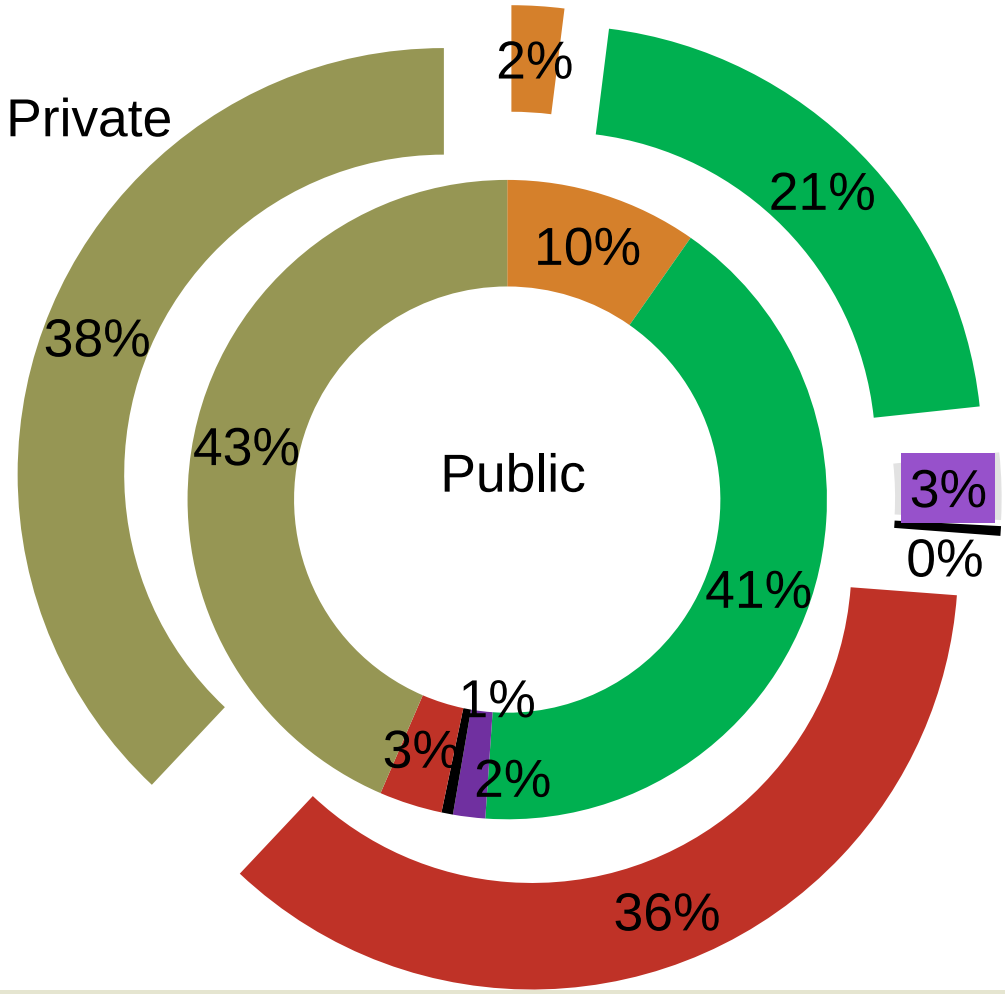
Household Coverage

Scheme name	Demographic Information of Insured Population		% of HHs covered under CBHI
	HHs	Insured Population	
Mangalbare	697	3842	1.60
Katari	392	2298	11.04
Chandranigahapur	493	2636	3.30
Dumkauli	296	1676	1.50
Lamahi	1310	6259	8.92
Tikapur	988	5980	4.26
Madesha	426	2083	28.46
Rajmarga	119	597	0.60
Saubhagya	339	908	1.93
Chapagoun PHCRC	784	4311	4.95
Bikalpa	320	1376	1.83
Saprubesi	164	831	28.42
Grand Total	6328	32797	**3.29**

Total membership composition by ethnicity in %



Composition of membership by ethnicity (Public VS Private)



Membership Cont…

There is provision of subsidy for poor in public schemes (30% HH covered) but negligible number of ultra poor enrolled for free membership. However it ranges from 19% in Mangalbare to 54% in Katari.

Administration and Management

- Separate CBHI Management committees are formed under HFOMC in most of the public CBHI scheme.
- Tikapur, PHCRC, Madesha and Syafru HFOMCs itself manages CBHI schemes.
- Rajmarga and Bikalpa have co-operative management committee.
- Saubhagya has coordination committee formed by insurance clients.

Administration and Management cont…

- All public scheme have appointed one focal person to look after the scheme.
- In both cooperatives, staff of the cooperatives manages CBHI schemes/ no focal person.
- Saubhagya has full time coordinator for CBHI management.

Premium mechanisms

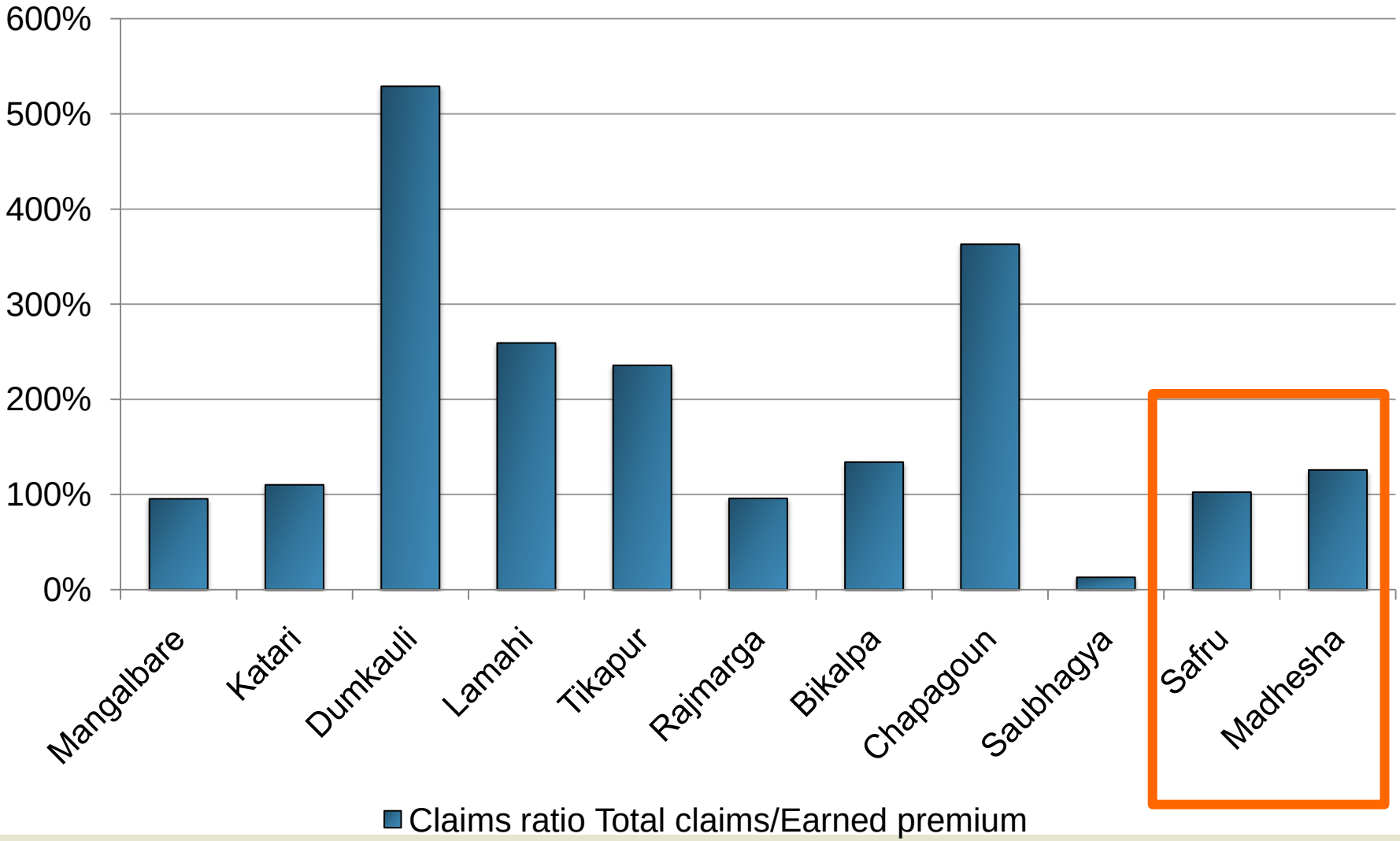
- All schemes have a regulation of one premium payment per year which is accepted.
- Almost all schemes have mobilized facilitators/FCHVs/ committee members themselves to collect premium from HHs.
- Membership enrollment is opened for specific periods except in PHCRC and Syafru; some criticism.
- For most of the schemes premium is set for family of six members with extra amount for additional member.
- Premiums set by CBHI were reported affordable for public in general; except in Bikalpa.
- Premiums were determined based on committee members experience except in Saubhagya, Bikalpa and Rajmarga. Saubhagya has the only actuarial premium calculation.

Benefit package

- In general, benefit package includes consultation, diagnostic services, medicine, transportation and referral services with ceiling in each category.
- The benefit package in public schemes ranges from NRs 3500 (Dumkauli) to NRs. 120000 (Mangalbare) per HH.
- In PHCRC, Rajmarga and Bikalpa there is no ceiling, but they have copayment (30-50%).
- Saubhagya, Rajmarga and Bikalpa have not included medicine in benefit package.
- All schemes have provision of referral services, but only some have written agreement.
- Chronic diseases and conditions are excluded in all schemes except PHCRC.

Viability

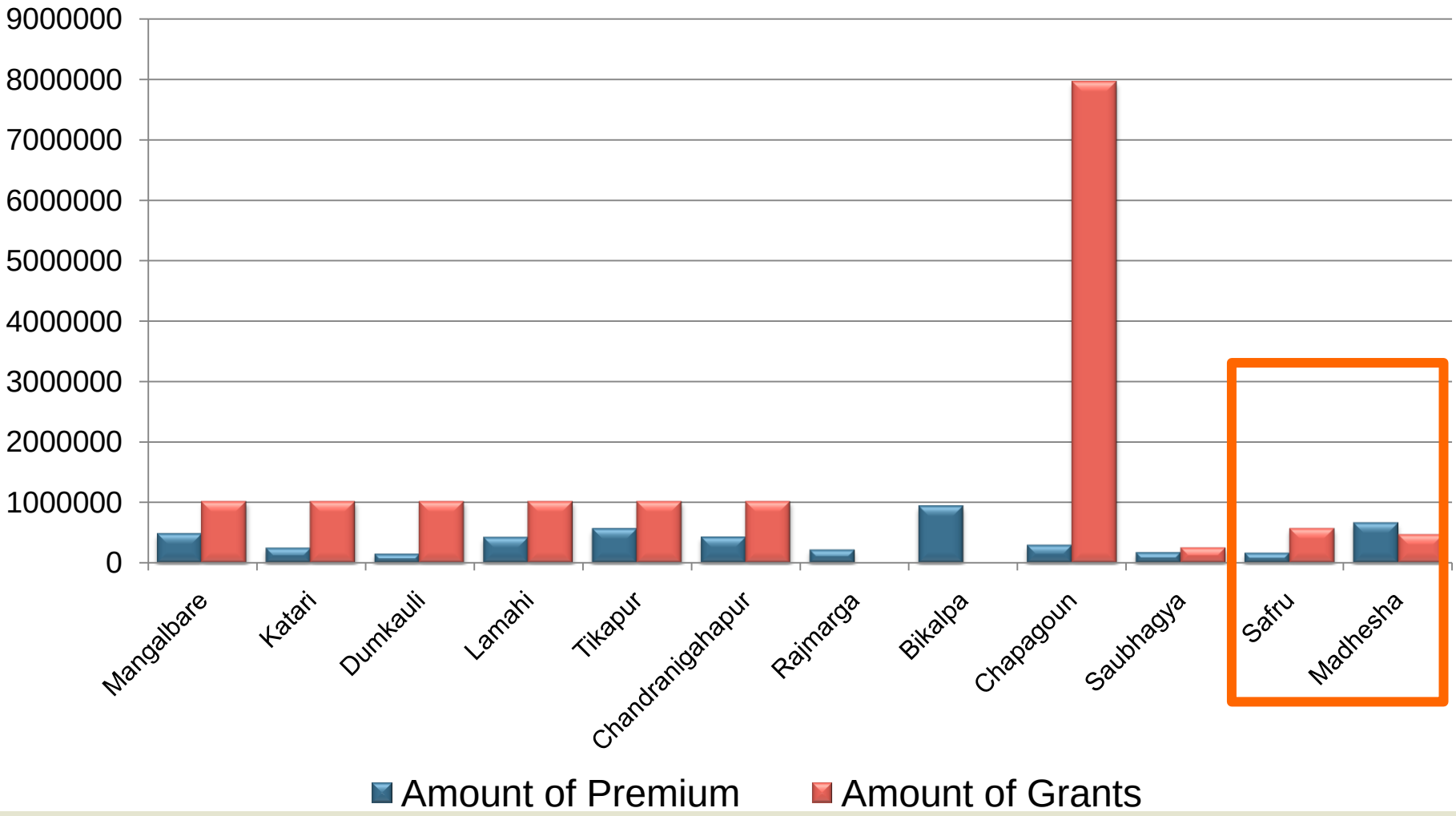
Claims Ratio



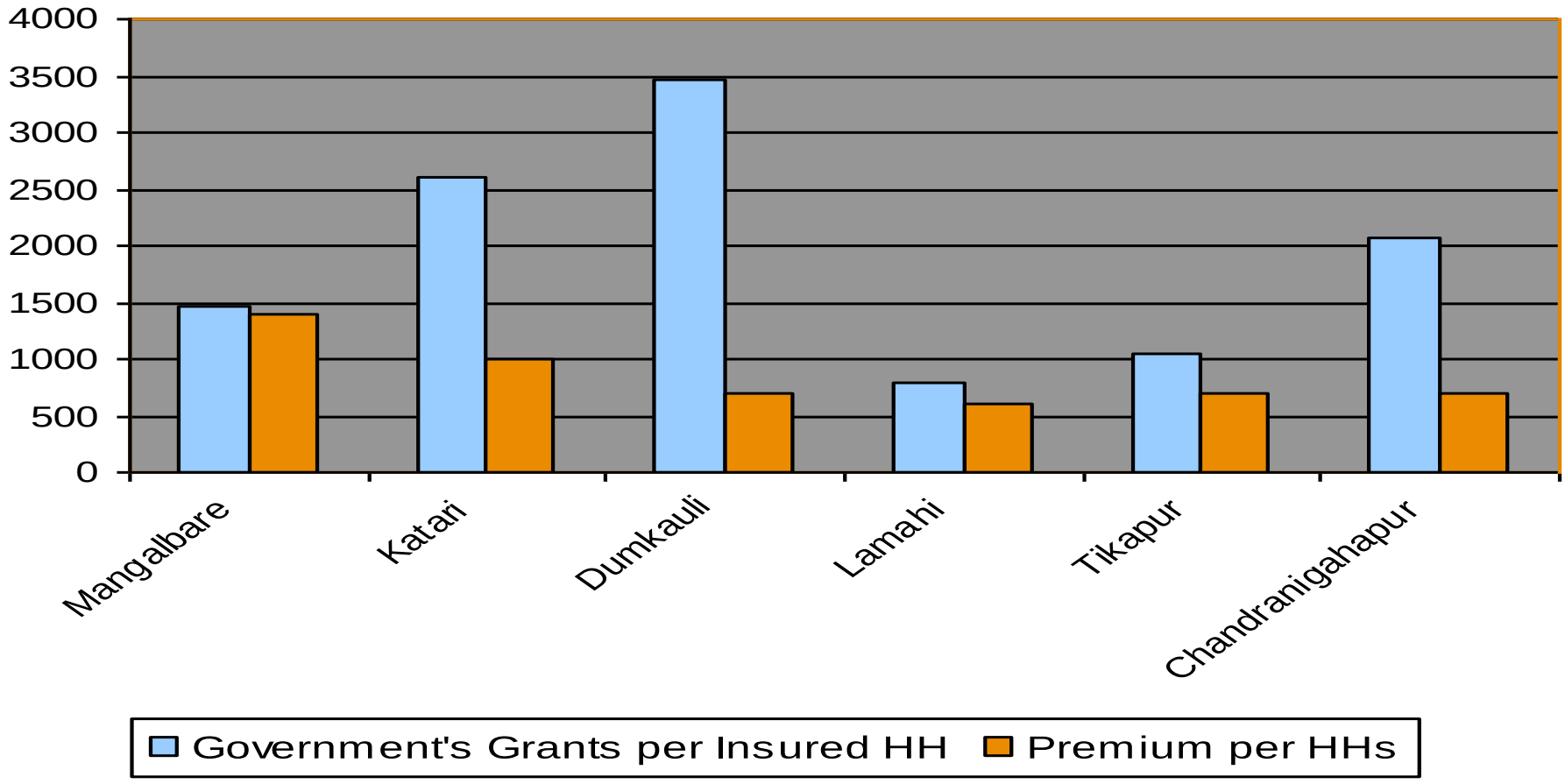
Operating Expense

- For the schemes being aware of their operating expenses: Expense ratio very high (PHCRC- 1452%)
  - Expense Ratio: Total operating expenses/ Earned premiums
- For other schemes no full allocations of expenses (hidden cost in salaries, use of office space etc.) as a consequence the financial viability is not known to full extent.

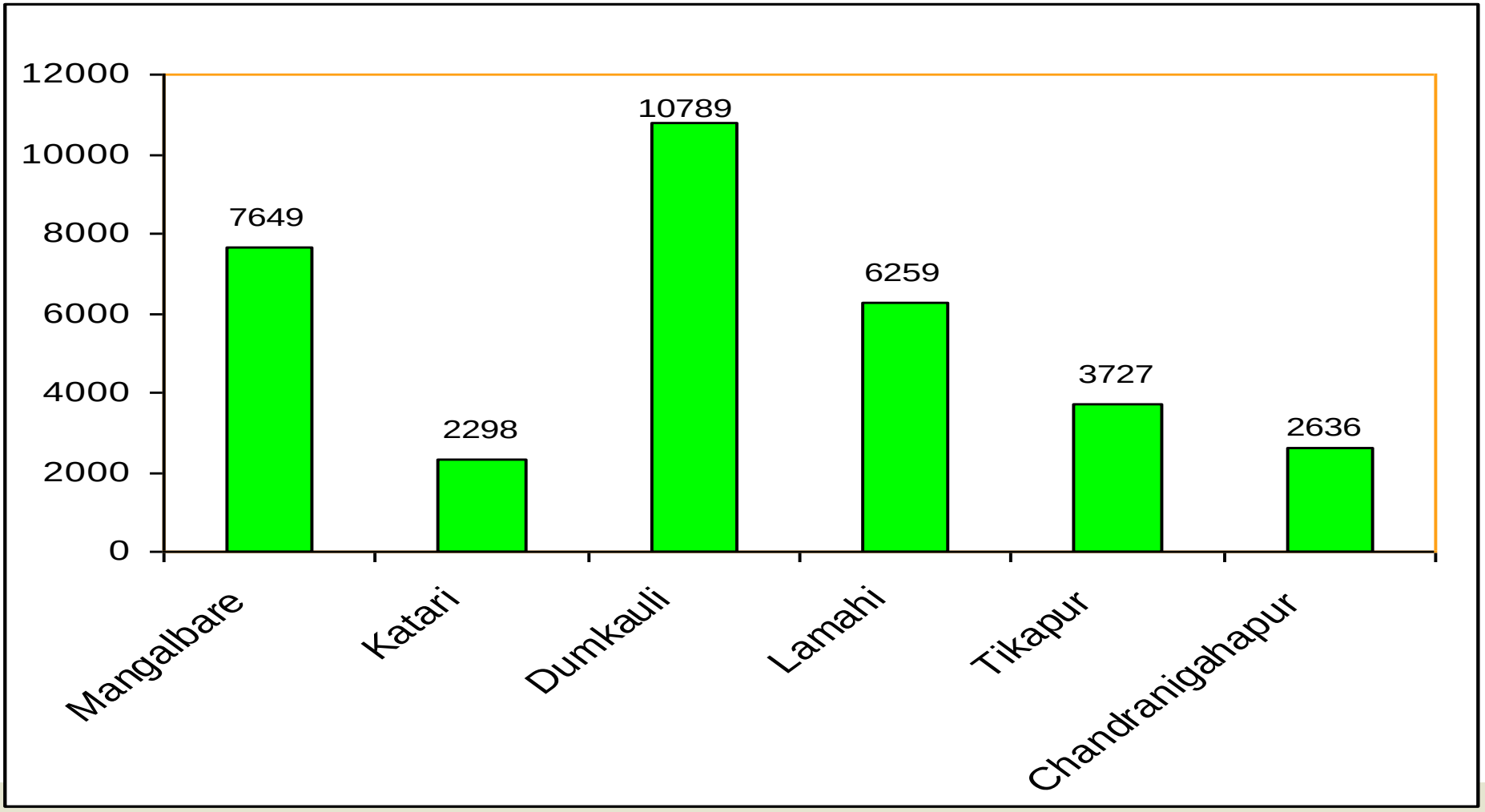
Premiums and Grants



Comparison Between Government's Annual Grants and Premiums at HH Level



Average Government's Annual Grants per Poor Insured HH (Subsidized)



Financial Viability

- Considering the premium income only, the schemes seem financially un-viable.
- The schemes only survive through grants or donation.
- Capacity to handle financial management needs to be enhanced.

Technical Viability

- In order to minimize adverse selection, all schemes have Waiting period, Ceilings, Co-payment, and Family enrolment.
- Management information system: Not in place
- Capacity of management team: very limited; no training is provided, no future human development plan
- Quality monitoring: no monitoring of quality of care
- No mechanism to check the rationality of treatment and prescription (leading to cost escalation).
- No CBHI with few exception has financial, administrative operational guideline other than the one provided by MoHP which is not sufficient to operate the schemes.

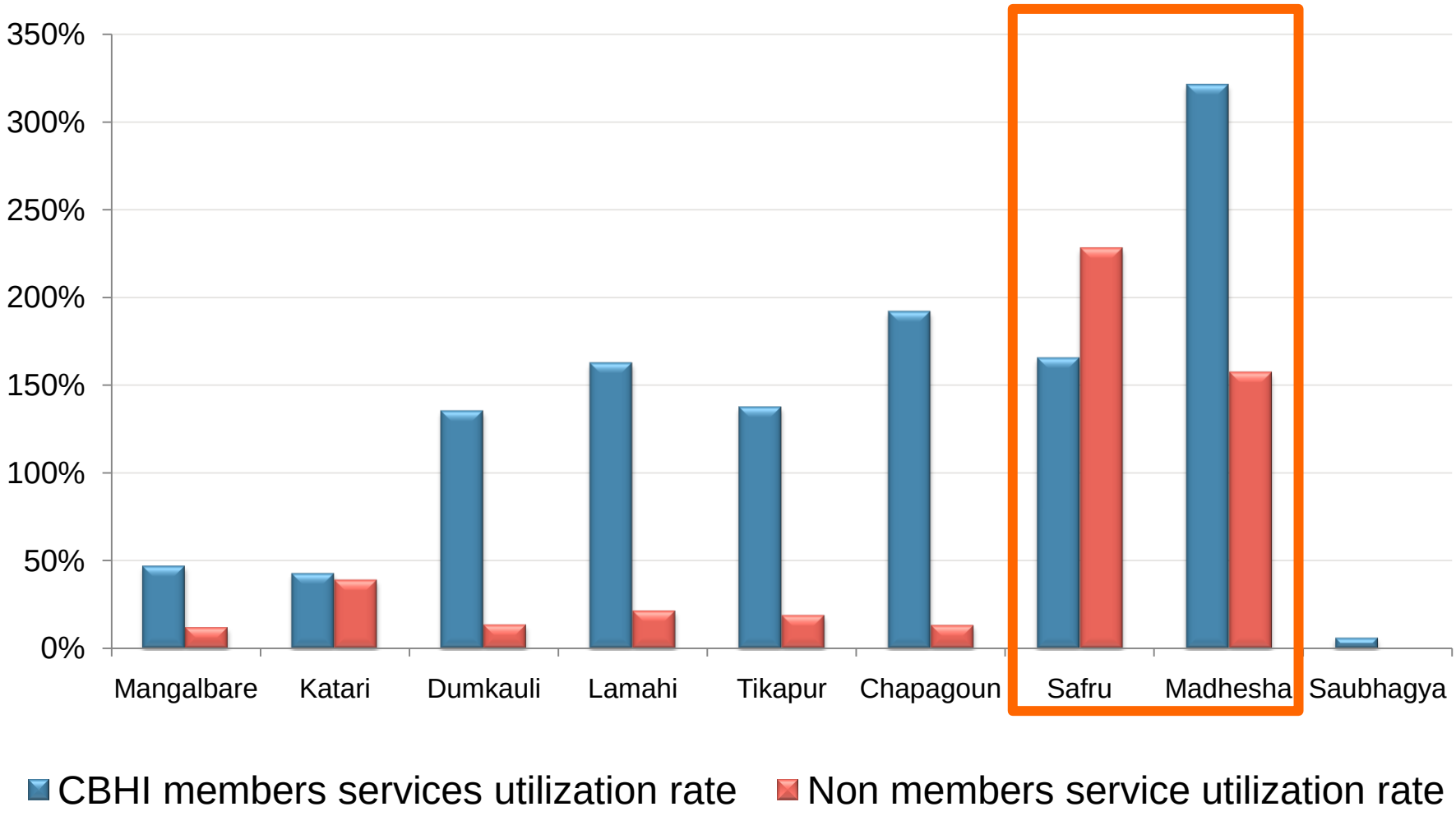
Accessibility

Accessibility

CBHI has improved access of its members to health care services because of

1. improved health seeking behavior.
2. availability of services beyond the Free Health Care Package (including referral).
3. the range of drugs and diagnostic facilities has increased in health institutions.

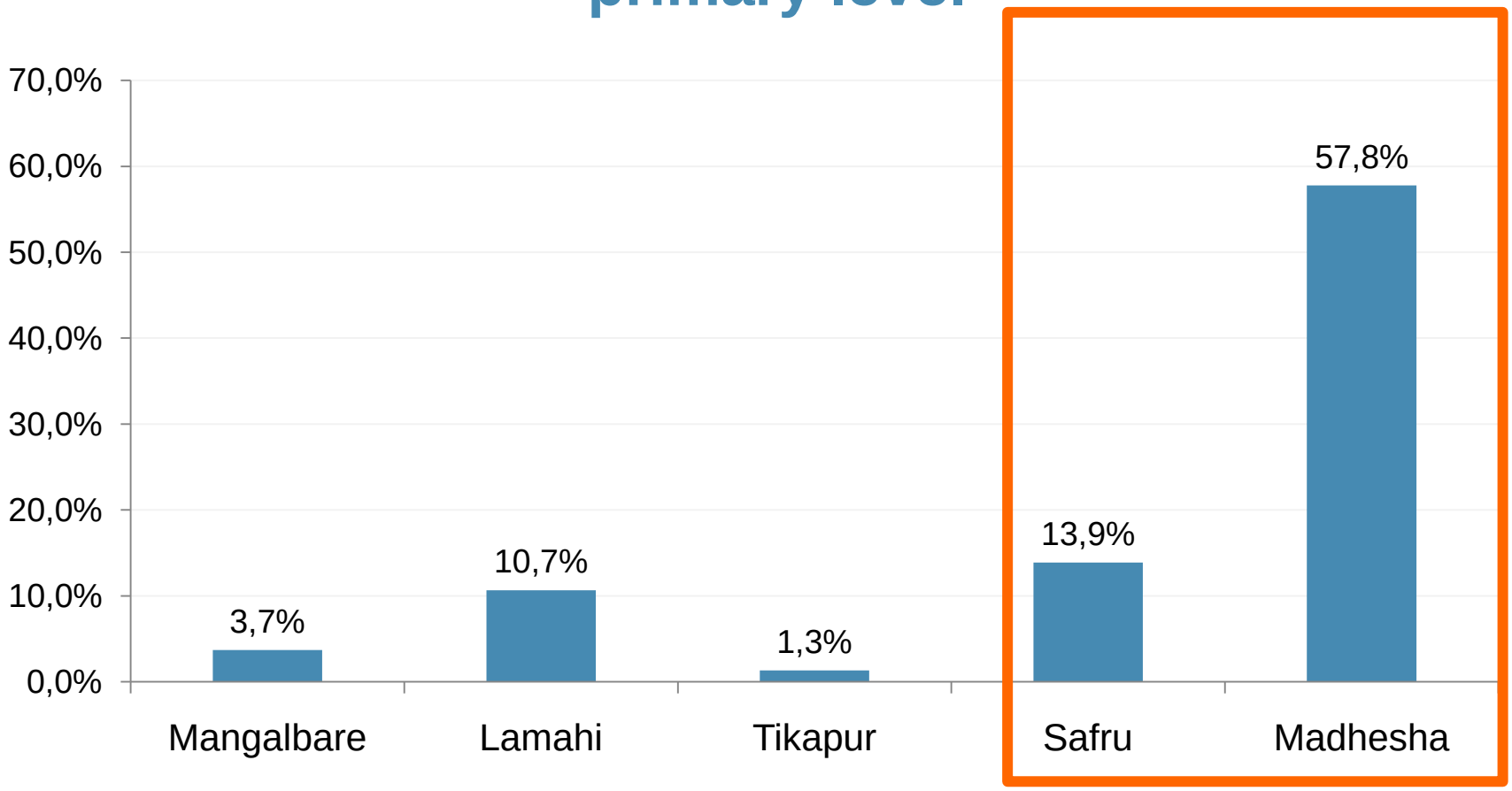
Utilization rate



Quality of health care services

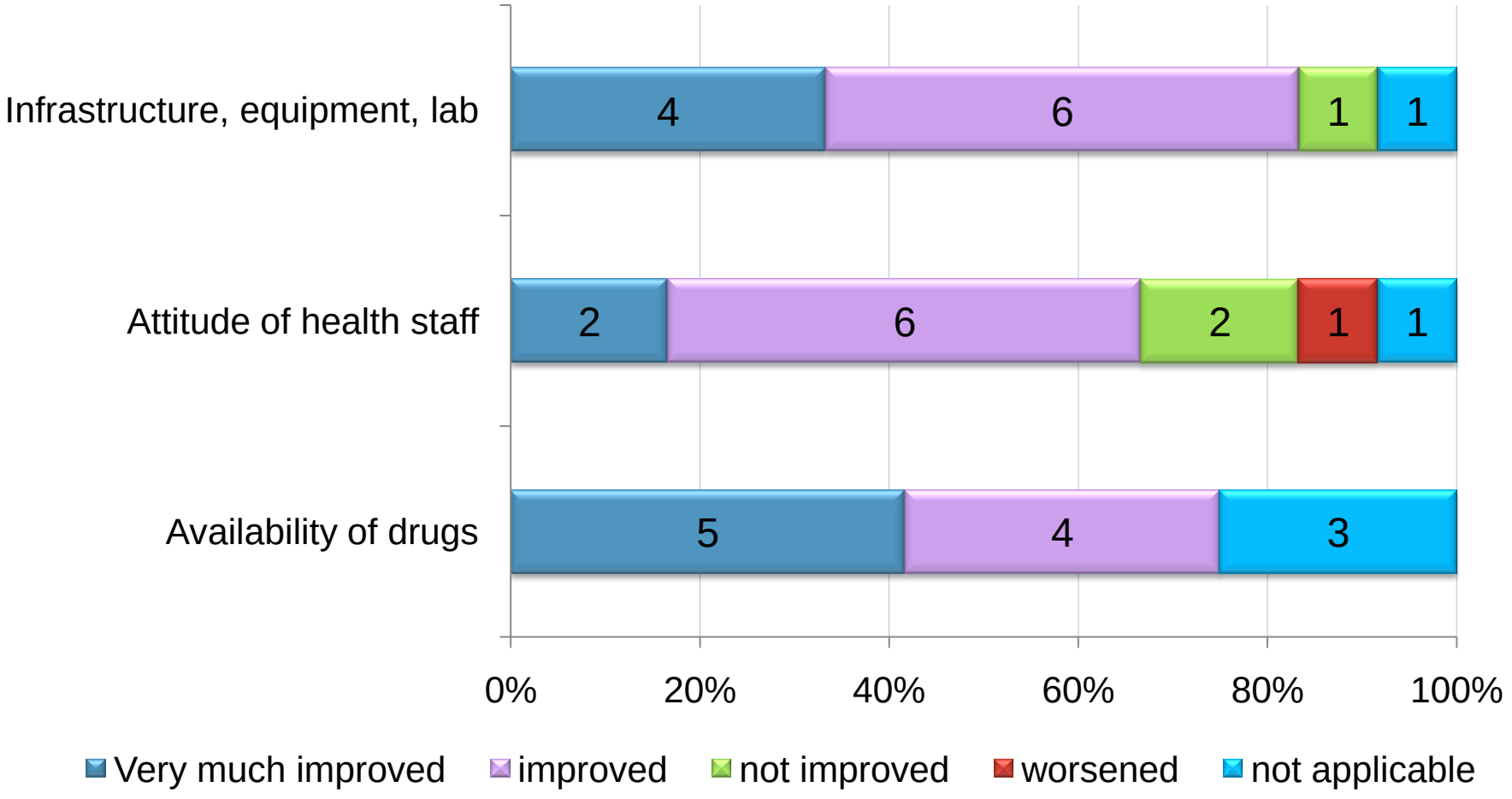
- Stronger voice mechanism for additional health staff, diagnostic services, medicine etc.
- Financial contribution of CBHI to health care providers is low compared to their overall income; therefore potential to quality improvement is low.
- There is low opportunity to collect Patient's satisfaction feedback, except in Saubhagya.

Share of Providers Income accounted by CBHI at primary level



Share of providers income accounted for by CBHI (Total amount of payments made by the CBHI to the providers/ Total income of providers); excludes referral hospital and copayment

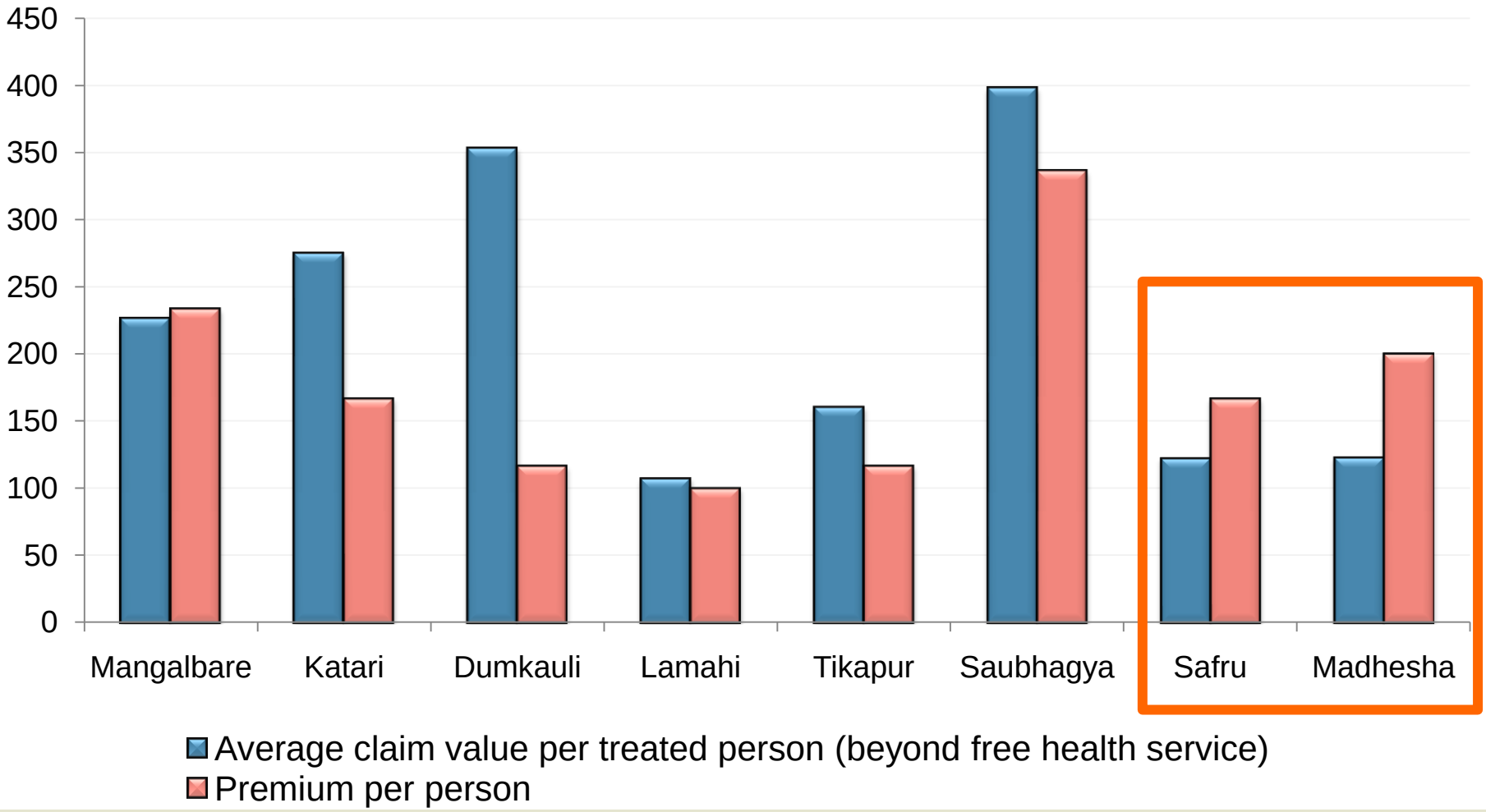
Impact on quality of service perceived by CBHI management



Client value

- Clients perceive CBHI as value for money program
- High client value is also shown in the claims ratio (in 8 out of 11 schemes patients received more than 100% of their premiums; however this is not sustainable)
- At individual level clients in 5 out of 8 schemes have received higher benefit than the premium (graph below).
- Client value is reduced by ceilings (in 9 CBHIs) on benefit categories.

Average claim value per treated person compared to premium cost



Purchaser-provider relations

- Number of service providers is limited in most CBHI schemes.
- Every CBHI has at least one referral centre, except in PHCRC. However, a formal agreement is done only in 5 schemes.
- Referral costs are reimbursed directly to the referral central in 3 schemes, whereas the rest of the schemes directly reimburses to the clients.

Role of the CBHI schemes in the overall health financing system

- CBHI mechanism as such contributes to the overall health financing system by providing better access to health services (beyond free health package limit, referral). However, the schemes so far do not reach significant coverage even of the target populations.
- In the case of social security program, access of ultra poor is limited due to absence of clear entitlement for free treatment.
- CBHI programs are not competing with free health services or with social security program, but rather complement them (additional services in the first case, clear entitlement in the second case).

Role of the CBHI schemes in the overall health financing system

- In conclusion, CBHI schemes are neither technically nor financially viable in their present forms.
- They are not equitable since only a few poor people are receiving protection through subsidy while the majority of the poor are left out.
- The present mechanism is also not geared towards expanding enrollment of the poor.
- However, within their limited scope, and within the grants they receive, they are able to provide a reasonable service to their clients.

Recommendations

All in all it seems that CBHI schemes in current form cannot be scaled up to provide a meaningful contribution to universal coverage. If MoHP decides to pursue the CBHI mechanism further, the following reforms are highly recommended:

1. Establishment of proper financial management structures including financial monitoring (in order to assess and monitor the viability of the scheme),
2. Training and capacity building of CBHI management,
3. Reorientation of subsidy mechanism towards expansion of enrollment of poor (i.e. grants per enrolled HH).

Recommendations

4. Prepare national health insurance policy,

5. Create strong monitoring and reporting mechanism,

6. Expansion of CBHI approach only be feasible if at the same time efficiency is improved and govt. grants also increased, especially to take care of the poor.

Thank You

Namaste from the Team