Review of Community-based Health Insurance Initiatives in Nepal

जर्मन सहयोग
DEUTSCHE ZUSAMMENARBEIT

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

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December 2012

Imprint

Published by:

Deutsche Gesellschaft
für Internationale
Zusammenarbeit (GIZ) GmbH

Health Sector Support Programme
Department of Health Services
Teku, Kathmandu
Nepal
T +977 1 4261404
F +977 1 4261079
E hssp@giz.org.np
I www.giz.de/nepal

Commissioned by:

Federal Ministry
for Economic Cooperation
and Development

Additional technical and financial contribution by:

P4H is a global network for universal health coverage (UHC) and social health protection (SHP).
http://www.who.int/providingforhealth/en

Authors:

Manfred Stoermer
Franziska Fuerst
Kailash Rijal
Ram Bhandari
Cyril Nogier
Ghan Shyam Gautam
Jennifer Hennig
Junu Hada
Shyam Sharma

Edited by:

Susan Sellars-Shrestha

Photographs:

GIZ Archives

Designed and Printed by:

Sigma General Offset Press
Sanepa, lalitpur-2, Nepal
T : 977 1 5554029

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Government of Nepal
Ministry of Health & population
DEPARTMENT OF HEALTH SERVICES
Primary Health Care Revitalization Division

410080,78
Fax: 4100052

Teku, Pachali
Kathmandu, Nepal
Dec. 2012

Acknowledgements

Health insurance has gained momentum among policy makers in Nepal over the last couple of years. At the implementation level, the Ministry of Health and Population has been piloting community-based health insurance schemes since 2003/04. However, these pilots have not been comprehensively reviewed until now and their role is unclear in the present context in which many health services are offered free of cost. The Ministry of Health and Population is also in the process of drafting a health insurance policy and a new health financing strategy. Given these developments, the results of this review are pertinent and timely.

This report is the result of the joint efforts of many individuals from Department of Health Services, GIZ, Swiss Tropical and Public Health Institute and MEH Consultants. I would like to take this opportunity to thank all who contributed to conceptualising this study, collecting and analysing data, and producing the report. I highly appreciate the committed efforts of the study team. I would particularly like to thank Franziska Fuerst, Jennifer Hennig and Ghan Shyam Gautam from GIZ,, Manfred Stoermer and Cyril Nogier from Swiss Tropical and Public Health Institute, Kailash Rijal, Ram Bhandari, Junu Hada, Shyam Sharma and MEH consultants and Susan Sellars-Shrestha, editor who were the main people responsible for producing this report.

I would also like to thank the members of the health facility operation and management committees, representatives of the CBHI schemes, officials at the district health offices and participants in the focus group discussions for providing the information on which this study is based. I also appreciate the ideas and valuable suggestions provided by the officials of the Ministry of Health and Population and my own colleagues in Primary Health Care Revitalization Division.

Thanks are also due to Providing for Health (P4H) for sponsoring this review. My particular thanks goes to Jean-Olivier Schmidt, Vickoria Rabovskaja for technical support and Michaela Gondolph for administrative facilitation of the GIZ sector initiative Providing for Health. Finally, my deep gratitude goes to the whole team for handling the overall process and providing the necessary technical and practical support in accomplishing this review.

Dr. Anand Kumar Shrestha
Director

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Acronyms

ANC	antenatal care
BPKIHS	BP Koirala Institute of Health Sciences
CBHI	community-based health insurance
CBS	Central Bureau of Statistics
CHD	Child Health Division
CT	computed tomography
DDC	district development committee
DEPROSC	Development Project Service Center
FCHV	female community health volunteer
FGD	focus group discussion
FHD	Family Health Division (of the Department of Health Services)
FY	financial/fiscal year
GEFONT	General Federation of Nepalese Trade Unions
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (formerly GTZ)
GTZ	German Technical Cooperation (now GIZ)
HH	household
HIMAL	Health Insurance Models Activation and Levelling-up
HP	health post
HSSP	Health Sector Support Programme
ICU	intensive care unit
INGO	international non-governmental organisation
ILO	International Labour Organization
KOICA	Korea International Cooperation Agency
MBBS	Bachelor of Medicine, Bachelor of Surgery (doctor)
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MRI	magnetic resonance imaging
NGO	non-governmental organisation
NICU	Neonatal Intensive Care Unit
NPR	Nepali rupee
PHC	primary health care
PHCC	primary health care centre
PHCRC	Primary Health Care and Resource Center
PHCRD	Primary Health Care Revitalization Division
PNC	postnatal care
PHECT	Public Health Concern Trust
RTI	Research Triangle Institute
SCIH	Swiss Centre for International Health
SHP	sub health post
STEP	Strategies and Tools against Social Exclusion and Poverty
TB	tuberculosis
TPH	Tropical and Public Health Institute
VDC	village development committee
WHO	World Health Organization

Executive Summary

This study assesses community-based health insurance (CBHI) schemes in Nepal, both government-operated (public) and private. Provider-based health insurance was introduced in Nepal in 2003 as six pilot schemes. In parallel, some privately-operated CBHI schemes have been established and are supported by non-governmental organisations (NGOs) and cooperatives. CBHI schemes in Nepal complement a number of specialised programmes of the Government of Nepal for improving people's access to health care services.

Renewed interest in a contributory insurance mechanism arose in January 2012 when a directive was sent by the Prime Minister's Office to the Ministry of Health and Population (MoHP) directing the Ministry to formulate and implement a "health insurance policy for all Nepalis". However, the only experience the Ministry has in operating health insurance mechanisms is from the six pilot schemes it is running. Against this background, there is a great need to understand Nepal's experience in implementing health insurance and to assess the role that government-supported CBHI schemes play in the current health financing system in Nepal, as well as their possible future role.

In this study, existing CBHI schemes were analysed using a number of common standards and indicators (e.g., coverage, resource generation, pooling and purchasing, quality of delivered health services, patient satisfaction) and by looking at the contribution of CBHI schemes to health care financing in the main areas of universal coverage (financial protection, services covered, population covered). Specific attention was given to determining whether or not CBHI schemes improve their members' access to health services and the quality of health care, and are technically and financially viable.

The study revealed the following about private and public CBHI schemes:

Benefit packages: In general, both private and public CBHI schemes provide members with access to health services beyond those covered by the government's Free Health Care programme. There is no clear difference between private and public schemes in terms of the content of their benefit packages.

Coverage: CBHI schemes have achieved very limited coverage of the population. As all public schemes are facility-based, their geographical coverage is generally limited to the working area of that particular facility. However, even within their catchment area an average of only 3.4 per cent of the population are covered, which demonstrates the low range of influence of these schemes. The coverage rate of the six private schemes sampled is even lower at 2.7 per cent.

Membership composition and poverty orientation: The study found that disadvantaged groups (Dalits, disadvantaged janajatis, disadvantaged non-Dalit Terai caste groups) enrol more in public CHBI schemes (constituting 53 per cent of members) than in private ones (26 per cent of members). This reflects the subsidy inflow into public schemes linked to the number of poor families enrolled.

Enrolment: Enrolment in both public and private CBHI schemes is done through local motivators, female community health volunteers (FCHVs) and management committee members. Targets for enrolment are set in the public schemes, but hardly achieved.

Premiums and subsidies: Premiums in public CBHI schemes are not determined on the basis of actuarial calculations (except for Saubhagya scheme), but rather set by the CBHI management on the basis of experience. The Ministry of Health and Population provides annual block grants to public CBHI schemes to subsidise premiums for people from disadvantaged groups and to cover part of their running costs. The study found that there is no consistency in the proportion of members subsidised in the six public CBHI schemes. The mechanism for providing a lump-sum subsidy in public CBHI schemes does not provide any incentive to increase the number of poor families enrolled beyond the target of 30 per cent. To the contrary, with each additionally enrolled family the subsidy per family is reduced. Private schemes do not have provisions for subsidising premiums based on socioeconomic conditions. Some discounts are granted at the time of renewal of membership for clients who wish to re-enrol, but not for socioeconomic reasons.

Utilisation of health services: The survey found that the overall utilisation rate for health services among members of a CBHI scheme is higher than among non-members, regardless of whether it is a public or private scheme. These findings indicate that CBHI schemes do in fact offer financial protection to their members, which enables them to use health services more often than non-members. How much this higher utilisation constitutes an 'over-utilisation' requires further investigation.

Quality of health care: The survey found that the quality of health care provided to CBHI members, mainly in the public health facilities, is in line with the capacity and infrastructure of the health facility. There is no positive discrimination in facilities towards CBHI members. The same services are available to both insured and non-insured patients. The chances of improving the quality of health care through the negotiation power of health care purchasers is virtually nil as there is no purchaser-provider split in public CBHI schemes. In private schemes, the coverage of CBHI members among the population in the catchment area and their weight in terms of the total number of clients of the facility is low. Therefore, the influence of private CBHI schemes on health care providers is very limited.

Technical efficiency: Accounts and record keeping systems are manual in all public CBHI schemes. Public schemes do not have any financial or administrative guidelines for properly implementing CBHI activities. Only two schemes (Mangalabare and Tikapur) had their accounts audited in the last fiscal year (2010/11). None of the public schemes have supervision and monitoring mechanisms in place, but CBHI management committees were found to be actively involved in CBHI activities.

Public CBHI schemes have not sought any legal identity because they were initiated by the Government of Nepal. CBHI management committees have been formed in four out of the six public CBHI schemes. In Tikapur and Chandranigahapur, facility management committees look after the CBHI scheme. CBHI staff and committee management members have not undergone any specific health insurance or management training, and their capacity is variable and usually limited. In the best case, the CBHI staff had been exposed to other CBHI schemes during field visits. None of the CBHI schemes have a human development plan. Human resources available in public CBHI schemes are limited, and most CBHI activities are undertaken by health facility staff.

In cooperative-initiated schemes, the executive board of the cooperative is responsible for insurance activity; there is no separate insurance management committee. In other private CBHI schemes, the health facility operation and management committee (HFOMC) is in charge of health insurance

management. Both cooperative schemes present the same situation: no specific staff have been appointed to look after the CBHI scheme. The information system is managed in an ad-hoc way. There have not been any annual audits of CBHI activities for quite a long time.

The analysis reveals weaknesses in the management systems of both private and public schemes. All schemes would benefit from rigorous technical support to develop into technically viable organisations.

Financial efficiency: Most CBHI schemes do not have any data to monitor their financial viability. They are, for example, not aware of their operating expenses as expenses are not necessarily allocated to the operation of the scheme (i.e., in most cases expenses such as salaries and office rent are provided by the host health facility and are not specifically allocated to the CBHI schemes). For the ones that know their operating expenses, the incurred expense ratio (incurred expenses/earned premium) is very high.

For public schemes, being by nature embedded within health care facilities, total operating expenses could not be assessed because a significant part of the resources that they use are not disaggregated. Therefore, the study used the claims ratio (claims/earned premium)[1] as a proxy for financial viability. A claims ratio of 100 per cent would indicate that all of the premiums earned are paid out by the CBHI in the settlement of claims. The study found the claims ratio was generally above 100 per cent, ranging from 47 per cent to 386 per cent, with an average of 129 per cent. These figures indicate that these schemes are not financially viable in the mid- and long-term because claims paid exceed premiums earned.

As all public schemes are subsidising some of their members, the premium income used for the calculation of the claims ratio is distorted. Therefore, the claims ratio for all public schemes was analysed ignoring subsidies and assuming that all the members paid the full premium. Even in this case, the claims ratios of three public CBHI schemes were significantly higher than 100 per cent. These schemes are clearly not financially viable. Only Mangalabare and Katari are currently viable from a claims perspective, with claims ratios below 60 per cent. However, the capacity of these schemes to cover their other unallocated running costs is questionable.

The government grant premium ratio (the amount of the annual government grant per enrolled household divided by the annual premium paid by the household) ranges from 1.3 in Mangalabare to 5.2 in Dumkauli. As this ratio is always above one the data shows that CBHI schemes are receiving less from premiums paid by member households than what they receive from the government in annual grants.

For private CBHI schemes, claims ratios vary a lot depending on the scheme, ranging from 13 in Saubhagya to 363 in the Primary Health Care and Resource Center (PHCRC) at Chapagaun; this reflects the different levels of management capacity. The average claims ratio is 189.5 per cent. A

1 However, it must be noted that the study team was not able to use the actual 'earned premium' as the schemes have not set up the change in 'unearned premium reserve'; hence, the written premium was used. The same applies to claims: actual 'incurred claims' could not be used because the schemes have not set up the change in 'incurred but not reported claims' (IBNR –the estimated change in claims that have happened during the accounting period but are not reported yet), nor the 'claims in course of settlement' (CICS – the estimated change in claims that are reported but still in process); hence, the study used paid claims for the calculation of this ratio.

claims ratio (incurred claims/earned premium) of more than 1 (or above 100 per cent) means that a higher amount is spent on paying claims than is earned as premiums. In this case an average of 189 per cent of the premium income is spent on claims, which is not financially viable in the mid- to long-term.

In conclusion, the analysis of community-based health insurance schemes in Nepal shows that their scope and impact is very limited. In the view of the evaluation team, community-based health insurance, the way it is currently being implemented, does not look promising in terms of building a comprehensive, equitable, empowering and sustainable social health insurance system in Nepal, particularly as CBHI schemes do not have a strong support structure at a higher level (such as at the district level). This conclusion is based on the observations that the CBHI schemes in their present structure:

- have an extremely low coverage of the population
- are not able to provide equitable protection for the poor against health-related costs
- do not provide an efficient 'voice' mechanism for articulating the interests of the insured population to health care providers
- are not financially viable or their financial viability is not known

Achieving high coverage of the population: The coverage achieved by the CBHI schemes assessed in this study is extremely low, with an enrolment of 3.4 per cent of their catchment area population for public schemes and 2.7 per cent for private schemes. The reasons for such a low enrolment rate must be sought in the limited capacity of schemes that are based on only one health facility (public schemes) or on a small group of motivated individuals (private schemes). Such isolated local CBHI schemes are unable to provide sufficient management and human resource capacities to achieve a significant impact on the population. A stronger organisational backbone is required to ensure the fulfilment of the basic functions of health insurance, including sufficient capacity for awareness creation, membership enrolment, membership administration and claims administration. A more promising approach than isolated local CBHI schemes would be to build up a scheme based on at least a whole district (and maybe even integrated at a provincial or national level) or to provide decisive central support functions to local CBHI schemes from the district level.

Ensuring equitable protection of the poor: The available data points to some success in enrolling members of disadvantaged groups in CBHI schemes, especially in public schemes. While in public schemes, 54 per cent of the members belong to marginalised groups, in private schemes this proportion is considerably less at 26 per cent of total members. However, existing CBHI schemes fail to provide solutions that would enable equitable access by the poor due to lack of a fair identification mechanism for enrolling the poor into the scheme and lack of a fair funding mechanism for paying insurance premiums for those who cannot afford.

Public schemes do provide subsidies for enrolling poor families into the schemes, as opposed to private schemes. While this is certainly an advantage and an achievement to a limited degree, the identification and enrolment of the poor is completely arbitrary and does not follow any established criteria. In addition, the present system provides no incentive for increasing the enrolment of poor

families; to the contrary, the enrolment of poor families past a minimum level can leave schemes with less funds per family as the overall amount of funds provided by the government is independent of pro-poor enrolment. The mechanisms applied are insufficient to achieve social protection for the very poor. Hence, the survey team recommends the further allocation of government funds for targeted premium subsidies for the poor, and to create incentives for increasing the enrolment of the poor by linking fund transfers to the number of poor households enrolled.

Building up an efficient 'voice' mechanism: An advantage of a health insurance system is the creation of a 'voice' mechanism whereby the health insurance represents the interests of the insured towards the health care providers. In the schemes assessed, only the private CBHI schemes fulfil the criterion of a purchaser-provider split. The public schemes do not have this split, as public health insurance schemes are hosted and operated by the health care provider. In such a constellation, an independent articulation of the interests of members of the scheme is hardly possible. However, to a limited extent, some 'voice' mechanisms have been established in these schemes. Membership assemblies may fulfil such a role to a very limited degree. In order to build up an efficient 'voice' mechanism in a future social health insurance system a purchase-provider split is recommended. Separate institutional entities should represent the interests of the clients (insured persons) and those of the providers of health care.

Ensuring financial viability: The study found that the existing CBHI schemes are either not financially viable or their financial viability is not known, as there are no suitable monitoring instruments in place to measure financial viability. An evaluation of the claims ratio shows that the medical-related expenses of the majority of both public and private schemes are much higher than the premium income collected by the schemes.

In public schemes, the use of government resources by the insurance schemes (personnel from other bodies fulfilling insurance management functions, use of government premises, electricity, transport, etc.) is not clearly recorded and, therefore, does not allow a precise inclusion of such costs in the calculation of the incurred expense ratio. The data collected on the claims ratio indicate low financial viability. The mere fact that the schemes have no overview of their incurred expenses and are not able to monitor their own performance is a problem in itself.

Any future social health insurance system would have to ensure financial viability. As already mentioned above, a health insurance system does not have to rely on premium income alone. Government contributions (in effect premium income funded by government budgets) may complement members' premium payments. This, however, needs a transparent and long-term orientation, ideally linked with the funding of membership for poor and needy population groups.

To sum up, considering the weak results achieved by the CBHI schemes assessed for this study in terms of population coverage and financial viability, the CBHI approach does not seem to be the most promising for realising equitable access to health services towards universal coverage. Isolated, localised CBHI schemes, as presently implemented in Nepal, do not constitute a model on which national health insurance could be successfully built in Nepal. In the view of the evaluation team, CBHI schemes should be considered a transitional solution while the government develops a stronger and more comprehensive national health insurance system.

Viable national health insurance should aim to achieve a wide coverage of the population, ensure the equitable protection of the poor, build up an efficient 'voice' mechanism, and ensure financial viability. All these characteristics could be achieved through a national social health insurance scheme. Such an insurance scheme could be operated at the district level or, alternatively, could provide strong support functions – and possibly a pooling mechanism – at the district level for local CBHI schemes.

Chapter 1
Introduction

Background and policy environment

In recent years, the Government of Nepal has prioritised improving people's access to health care services. The government's commitment to health is reflected in the increased health sector budget. The expenditure of the Ministry of Health and Population (MoHP) has increased in relation to total government expenditure from 4.5 per cent (32.9 billion) in 2004/05 to 6.1 per cent (52.5 billion) in 2009/10 (MoHP 2011b; MoF 2012b). In additional, various programmes have been introduced that provide health services free of costs to all (e.g., the Safe Motherhood Programme, which was introduced in 2005, and the Free Health Care programme, which was introduced in 2007).

Despite this, private sector spending on health remains high. According to the latest National Health Accounts estimate, private households bear more than half of the expenditure on health in the form of out-of-pocket payments (55 per cent in 2008/09) (MoHP 2012). This represents a worrisome gap in financial protection as direct payments for health services can lead to impoverishment and be a barrier to access for those in need of medical attention.

Moreover, direct payments for health services in Nepal are unregulated and often high-priced or for unnecessary care. How to protect people from catastrophic health care spending and tap into the large amount of unregulated out-of-pocket payments being made by private individuals have been topics of intense discussion in Nepal in recent times. The Second Long Term Health Plan 1997–2017 proposes alternative health sector financing mechanisms including "community financing schemes and income generation at public facilities" to complement funding from the public sector and assistance from development partners (MoHP 1997). Accordingly, in 2003/04, the MoHP introduced provider-based health insurance schemes in two districts (Nawalparasi and Morang) as a pilot programme for community-based health insurance (CBHI). Four more districts were added in 2005/06 (Udayapur, Rautahad, Dang, Kailali), bringing the total number of pilot districts to six. The benefit packages of these schemes include consultation fees, diagnostics services, inpatient care and the cost of medicines available at the health care facilities involved.

However, only a few years later in 2007, the Government of Nepal introduced the Free Heath Care programme, making all services up to primary health care centre (PHCC) level and 35 medicines free for everybody, as well as covering the cost of services provided by district hospitals for six target groups (poor, ultra poor, female community health volunteers, senior citizens above 60 years old, helpless and disabled). The introduction of the Free Health Care Programme posed a serious challenge to some existing programmes such as the Community Drug programme (which aimed at ensuring the availability of essential drugs at government health facilities up to district hospital level)[2] and government-supported CBHI schemes. Government-supported CBHI schemes adapted by expanding their benefit package beyond what is covered by the Free Health Care programme and by including referral services.

2 The Community Drug Programme, introduced in 1995, was mainly aimed at ensuring the availability of essential drugs at government health facilities up to the district hospital level (sub health posts, health posts, primary health care centres and district hospitals). Under this programme, government facilities maintained a pharmacy within the premises of the health facility for which the government provided an initial revolving fund. While charging a reduced price (compared to market price) to patients, facilities were able to generate revenue to restock the drug revolving fund and maintain a drug sales outlet within the facility.

Despite all the contextual changes, no thorough evaluation of these schemes ever took place. The possibility of scaling up these pilots to improve access to health services in Nepal came up frequently in policy debates, but very little information is available on how these schemes are running. In the end, the pilots were never scaled up or integrated into a broader system – nor were they abolished.

Renewed interest in a contributory insurance mechanism has arisen since January 2012 when a new directive was sent from the Prime Minister's Office to the Ministry of Health and Population directing it to formulate and implement a "health insurance policy for all Nepalis" (MoF 2012a). However, the only experience the Ministry has in health insurance mechanisms is from implementing the six pilot schemes.

Rationale of review

Against this background, there is a need to understand Nepal's experience in implementing health insurance and assess the role that government-supported CBHI schemes play in the current health financing system, as well as what their future role could be. In order to complement the picture and to take into account the growing number of private schemes, for which the Ministry of Health and Population still has to develop a regulatory framework, the review also covers six private schemes. However, these six private schemes only offer a snapshot of the situation of private CBHI schemes in Nepal and are not representative as such.

Reviewing the CBHI schemes in Nepal has become even more relevant in recent years as the role of community-based health insurance (also known as micro-insurance) schemes has been critically reviewed in the international literature (ILO-STEP 2002; Jakob and Krishnan 2012). Overall, there has been a shift to assess CBHI schemes not only on their individual performance (equity, sustainability, efficiency), but also on their role and contribution to the overall health financing system and its objectives. Evidence suggests that the population coverage of these schemes has remained low and that the most vulnerable households are not usually covered. Thus, most CBHI schemes have small risk pools and limited cross-subsidies (McIntyre et al. 2005).

This review, therefore, aims to take a broader system perspective in order to:

- assess the contribution of CBHI schemes to health care financing in the main areas of universal coverage (financial protection, services covered, population covered)
- assess CBHI performance against the common standards (coverage, resource generation, pooling and purchasing, quality of delivered health services, patient satisfaction)
- provide recommendations for the improvement of CBHI schemes within the context of the current health care financing landscape and policy developments

Structure of report

Chapters 1 and 2 of the report set out the objectives and methodology of the study, followed by an overview of the health financing system in Nepal in Chapter 3. Chapter 3 presents the various programmes of the Government of Nepal that provide health services free of charge to target population groups. The background and history of CBHI schemes is then briefly discussed.

The findings of the review of the 12 CBHI schemes (6 public and 6 private) are presented in Chapter 4. Three questions are asked:

- Do the schemes improve the access of the population to health services?
- Is the quality of care is being improved through the schemes?
- Are the schemes operationally, technically and financially viable and, therefore, sustainable?

Access to health services (first question) is analysed using a number of elements. Firstly, the benefit packages offered by the CBHI schemes are discussed to give an overview of the kind of services provided to members. The quantitative relevance of CBHI schemes is assessed by looking at the number of members and households covered by schemes as a proportion of the total population. The membership composition of public and private schemes is compared to determine the poverty orientation of the schemes. The premiums charged and the subsidisation provided by the government are also analysed to give an additional indication of whether or not members access to health care has been improved. Finally, the contribution of the schemes to increasing utilisation of health services is analysed.

The impact of CBHI schemes on the quality of health services (second question) is determined by looking at the negotiating power of the CBHI with the health care provider and any 'voice' mechanisms that have been built up for the insured population to express its interests to the provider.

The technical and financial viability of schemes (third question) is assessed by looking at the management set-up and various standard indicators. Due to the weak availability of financial data, the claims ratio is used to assess financial efficiency.

Chapter 5 presents the conclusions and next steps. It discusses four aspects of building a national health insurance system: achieving high coverage, ensuring equitable protection of the poor, building up an efficient voice mechanisms and ensuring financial viability. Finally, some principal considerations are pointed out to guide the way forward.

Chapter 2
Methodology

Desk study and field study

The review of CBHI schemes in Nepal was conducted mainly by way of a field study, which was supported by a desk study. The desk study was conducted to analyse policy documents and implementation guidelines (such as the national Free Health Care programme operational guidelines, MoHP 2009, and the CBHI operational booklet, HEFU 2007), as well as project and programme reports and papers published in international reviews. In order to understand the role of government-supported and private CBHI schemes in the overall health financing system in Nepal. The results of this desk study are set out in Chapter 3.

The field study of the 12 CBHI schemes was conducted between 23 October 2011 and 19 January 2012. In preparation for the field study, a list of schemes to be reviewed was made and data collection tools selected. Both were shared with the relevant partners – including the Primary Health Care Revitalization Division (PHCRD) of the MoHP, Health Sector Support Programme (HSSP) of MoHP-GIZ, World Bank, World Health Organization (WHO), and concerned NGOs such as the Health Insurance Models Activation and Levelling-up (HIMAL) project (a collaboration between the MoHP and the Korea International Cooperation Agency – KOICA), Public Health Concern Trust Nepal, Karuna Foundation Nepal and Save the Children – and agreed upon before commencement of field work. A list of partners involved in the preparation meetings held in September and October is attached in Annex 2. The data collection tools were revised after the first field visit. Twelve schemes were then selected for review (six public and six private). The results of the field study are set out in Chapter 4.

Selection of schemes

All of the existing six government-supported CBHI schemes were included in the review (Table 1).

Table 1: Public CBHI schemes reviewed

	Name (in operation since)	Development region	District
1	Lamahi Primary Health Care Centre (2006)	Mid Western	Dang (semi urban)
2	Tikapur Hospital (2006)	Far Western	Kailali (urban)
3	Mangalabare Primary Health Care Centre (2004)	Eastern	Morang (rural)
4	Dumkauli Primary Health Care Centre (2004)	Western	Nawalparasi (rural)
5	Chandranigahapur Primary Health Care Centre (2006)	Central	Rautahat (rural)
6	Katari Hospital (2006)	Eastern	Udayapur (urban)

The selection of private schemes for review was done in a consultative way with MoHP officials and other agencies involved in the implementation of CBHI schemes, such as the Public Health Concern Trust and the Karuna Foundation Nepal (see Annex 2). After a preliminary stock take of existing and known CBHI initiatives, selection of private schemes was done using the criteria presented in Table 2.

Table 2: Selection criteria for private CBHI schemes

Criteria	Specification
Geographic location	Representation from each of the ecological belts (Terai, hills, mountains), as well as from both urban and rural settings
Implementation modality	Representation of independently running, cooperative-based schemes and schemes supported by external development partners
Number of years of operation	At least two-years operation (except Saubhagya, which has only been operating for one year but was selected because the community involvement in overall design of the scheme was considerable higher than in any of the other schemes)

As a result, the following private schemes were selected:

Table 3: Private CBHI schemes reviewed

	Name (in operation since)	Development region	District	Type of scheme
1	Madhesa Sub Health Post (2010)	Eastern	Sunsari (rural)	NGO supported, financial and technical support from Karuna Foundation Nepal, provider-based
2	Syaphru (2009)	Central	Rasuwa (rural)	NGO supported, financial and technical support from Karuna Foundation Nepal, provider-based
3	Rajmarga (2003)	Central	Dhading (rural)	Cooperative-based, with support from Public Health Concern Trust
4	Bikalpa (2001)	Central	Kathmandu (urban)	Cooperative-based (Bikalpa Cooperative), with technical support from Public Health Concern Trust Nepal and financial support from HIMAL project
5	Primary Health Care and Resource Center, Chapagaun (1972)	Central	Lalitpur (semi-rural)	Community-based, with financial support from HIMAL project
6	Saubhagya (2011)	Central	Dhading (rural)	NGO-supported (Micro Insurance Academy, DEPROSC, Save the Children), community-based

Survey tools

Several tools were developed to collect qualitative and quantitative data to assess the role of CBHIs within the health system and their performance. These tools were shared with the study partners before the first field visit and revised and adapted after initial field testing in Morang district.

The following tools were used in this review:

- questionnaire for health provider management
- questionnaire for CBHI management committee
- interview guides for three focus group discussions (FGDs): CBHI members (2 sub-groups: subsidised members and non-subsidised members), CBHI drop-outs and non- members
- the 'factsheet' developed by the Micro Insurance Network was used to collect financial data

These tools aimed at capturing information in six main areas:

- institutional/legal arrangements of the schemes
- relationships between the schemes and health providers
- management tools and control systems used by the CBHI
- contents of benefit package
- membership and premium mechanisms
- financial data (income/expenses) of the scheme

Participants of the FGDs were selected randomly using the CBHI schemes' member registries.

Based on the data collected, wherever data availability and quality allowed, performance indicators were calculated to compare the 12 schemes. The indicators applied are standard indicators for assessing the technical, financial and administrative viability of CBHI schemes as defined by ILO Strategies and Tools against Social Exclusion and Poverty (STEP) (ILO 2007) and the Micro Insurance Network (Performance Working Group) (Garand and Wipf 2010).

The role of CBHI schemes in the health system was assessed using indicators covering the three dimensions of universal coverage: population covered, services covered and financial protection (Table 4).

Table 4: CBHI indicators used

Area of performance	Indicator	Detail
Impact	(Population) coverage ratio	Number of beneficiary HHs (and population) in the catchment area/total HHs (population) in the area
Equity	Proportion of members who are from vulnerable groups	Share of the various vulnerable groups (including women and ethnic groups as per MoHP definition) enrolled in scheme
Equity	Proportion of members who are subsidised	Share of subsidised members in the total number of members
Equity	MoHP contribution per insured HH in public scheme	Total government subsidy (NPR 1,025,000)/total number of insured HHs
Equity	MoHP added contribution per insured individual	Total government subsidy (NPR 1,025,000)/total number of insured persons
Equity	MoHP added contribution per insured poor HH (subsidised)	Total government subsidy (NPR 1,025,000)/total number of insured poor HHs (subsidised)
Effectiveness	Rate of utilisation of services by members and non-members of the CBHI	Total number of benefits covered (excluding referral services) used by CBHI members/average number of CBHI members in one year Total number of benefits covered (excluding referral services) used by non-CBHI members/average number of non-CBHI members in one year
Effectiveness	Comparative health service utilisation rate	Number of benefits (visits) covered for CBHI members/ number of CBHI members Number of benefits (visits) covered for non-CBHI members/ number of non-CBHI members
Impact	Share of providers health services accounted for by CBHI	Number of benefits (visits) by CBHI members/number of benefits (visits) provided by provider*100
Impact	Share of providers income accounted for by CBHI	Total amount of payments made by the CBHI to providers + income received by the provider in the form of co-payment made by CBHI beneficiaries/total income of providers for relevant period
Financial viability	Expense ratio 1	Operating expenses/earned premium
Financial viability	Expense ratio 2	Total expenses/earned premium
Financial viability	Claims ratio (in public schemes: assuming no one is subsidised)	Total claims/earned premium
Financial viability	Net income ratio	Net income/earned premium
Technical viability	Average claim value per insured person (beyond free health service)	Total claim amount/total number of insured person
Technical viability	Average claim value per treated person (beyond free health service)	Total claim amount/total number of insured patients visited outpatient department

Limitations

This review of the 12 CBHI schemes is based on observations and interviews with key informants at the district level in health facilities, CBHI schemes and supporting organisations in 11 districts in the Eastern, Western and Central development regions of Nepal (Sunsari, Rasuwa, Dhading, Kathmandu, Lalitpur, Dang, Kailali, Morang, Nawalparasi, Rautahat and Udayapur). While the study reviewed all existing government-supported CBHI schemes, only a small proportion of private schemes were included in this study and this sample does not necessarily reflect the large variation of situations in Nepal.

Primary data collection at facilities and schemes or supporting NGOs was constrained by the availability and quality of information from their information systems. This in turn limited the number of indicators for which data could be collected and explains why the same indicators are not used for all schemes.

Government-operated schemes are, by nature, embedded within the health care facilities that host them. Total operating expenses for these schemes could not be assessed because a significant part of their resources are provided by their host facility and are not recorded or disaggregated. Costs such as the salary and benefits of health care facility staff partly involved in the CBHI, office expenses (the host health care facility makes one room available to the CBHI) and equipment costs (the use of vehicles, office materials and furniture of the health care facility) are borne by the host facility and not allocated to the CBHI scheme. Other expenses of running the CBHI are paid directly by the health facility and consist of costs related to communication activities (social mobilisation, radio broadcasts), the enrolment of members, premium collection, annual auditing of CBHI accounts, and incentives paid to the facility in-charge and other facility health staff for the daily management of the schemes. Medicines and other items provided by the MoHP under the Free Health Care programme are also not accounted for. The calculation of the operating expense ratio was, therefore, not possible, and the study used the claims ratio (incurred claims/earned premium) as a proxy for the financial viability of CBHI schemes.

Chapter 3
Health Financing System in Nepal

Introduction

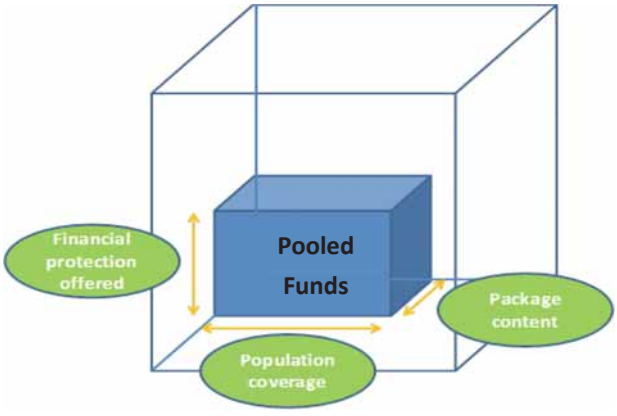
In order to understand the role of government-supported and private CBHI schemes in the overall health financing system in Nepal, this chapter briefly assesses where Nepal stands in terms of universal coverage. WHO defines universal health coverage as:

> *…access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe.* (WHO 2005)

WHO's conceptual framework defines universal coverage in terms of a three-dimensional cube (Figure 1) with the following three axes: i) percentage of population covered/entitled; ii) benefits that they may avail; iii) and share of costs that will be covered. While there is consensus on the concept of universal health coverage, it is not clear at what point universal coverage is fully achieved (or not achieved) as the outer lines of the cube are always changing (e.g., as a result of new medical services and technology). Every country fills the cube in a different way. It is up to the individual country to set targets for these dimensions and to choose among the trade-offs between services provided, people reached and cost.

This chapter attempts to determine Nepal's position according to these three dimensions in order to understand the gaps and shortcomings of the current health financing system and the role that CBHI schemes play in filling these gaps.

Figure 1: Nepal's approximate position on WHO's universal coverage framework



Source: WHO 2010

Who and what is covered?

Apart from a few government and NGO-supported insurance schemes, a small number of cooperatives and 16 private insurance companies, no mechanism is in place at the national or sub-national level in Nepal to provide health insurance to the public. However, unlike in many other developing countries, numerous government-financed health services are offered free of charge to all in public facilities and, to a limited extent, in private facilities. For example, the Safe Motherhood Programme (Aama) is implemented in 54 private facilities, profit and not-for profit, including medical colleges. This is in line with the Interim Constitution 2007, which states that "Every citizen shall have the right to basic health services free of cost from the State as provided for in the law". While over the past few years there has been increased interest in a contributory insurance scheme, there has also been a trend to introduce government-financed programmes providing services free of cost to all citizens or to target groups, the main one being the Free Health Care programme.

The Free Health Care programme was adopted in 2006 and provides basic health care services (inpatient and outpatient) free of cost to everyone (poor or not) at primary health care centres (PHCCs), health posts (HPs) and sub health posts (SHPs) nationwide. This programme also provides 22 listed medicines in SHPs, 32 in HPs, and 40 in PHCCs as well as district hospitals free of cost to all. As an extension of the Free Health Care programme, at district hospitals all available services (outpatient, inpatient and emergency services) are provided free to target groups (poor, ultra poor, helpless, disabled, senior citizens above 60 years of age and female community health volunteers). These services include consultations and treatment, minor surgery, emergency obstetric care (either comprehensive or basic), x-rays and laboratory services.

Figure 2 : Health services provided free of cost

In addition to the Free Health Care programme, a number of treatment and disease specific programmes provide free services to the whole population. Some of these programmes strengthen the demand for health services by providing cash transfers to beneficiaries and incentives to health care providers through specific payment methods. The following are some examples:

- The Safe Motherhood Programme, which has been implemented in its full form since 2009, provides delivery services free of cost from the public and 54 not-for-profit facilities. In addition, cash incentives, ranging from NPR 500 in the Terai to NPR 1,500 in mountain areas, are provided to mothers who receive delivery services under the programme.

- The Antenatal Care Programme, which started in 2009, provides NPR 400 to women upon completion of four antenatal care (ANC) visits and one postnatal care (PNC) visit at a district or sub-district level health facility (district hospital, PHCC, HP, SHP).

- Since 2009, the Uterine Prolapses Treatment Programme has been providing universal free treatment services to women requiring surgery for uterine prolapse, as well as cash incentives, which range from between NPR 1,000 in the Terai to NPR 3,000 in mountain areas.

Besides these universally available programmes, there are a number of programmes targeting certain population groups.

- The Referral Support Programme provides cash incentives of up to NPR 8,000 for deprived, helpless, disabled, underprivileged, pregnant women, and patients with tuberculosis, AIDS and psychiatric illnesses.

- Underprivileged patients (to be defined by the district level committee) can also receive a once-off payment of NPR 50,000 for the treatment of cancer or for heart, kidney, Alzheimer's and Parkinson's diseases.

- People above 75 or below 15 years of age are also eligible for free health care services from specified facilities (e.g., Manamohan Cardiovascular Centre and National Kidney Centre) for the treatment of heart and kidney diseases. The government provides conditional grants to these facilities for this purpose.

- Similarly, victims of the peoples' movement and conflict can obtain treatment from public facilities (mainly regional and central hospitals) free of cost, for which the MoHP reimburses the facility.

Through vertical programmes, a number of free services including medicines and devices are also provided free of cost for family planning, immunisation and selected diseases such as TB, HIV/AIDS and leprosy. A list of all government-financed programmes is set out in Table 5.

Table 5: Government-financed health programmes providing free of cost services

Programme	Target population	Services, medicine and devices provided	Level of facility providing services	Cash transfer to patient	Cash incentive to provider	Cash incentive to health worker	Targeting method	Responsible division/unit
Expanded Programme for Immunisation	Infants and women of reproductive age	Vaccines and accessories	Immunisation services in all hospitals and camps	NA	NA	NA	NA	CHD
Free Health Care programme	Universal	Outpatient and inpatient services	SHP, HP, PHCC	NA	Capitation based budget	NA	NA	PHCRD
		Listed essential drugs	SHP, HP, PHCC, district hospital	NA	NA	NA	NA	PHCRD
Free Health Care programme	FCHVs, senior citizens (>60), ultra poor, poor, helpless, disabled	Outpatient, inpatient and emergency services available in hospital	District hospital	NA	Capitation based budget (NPR 15 for outpatient and NPR 100 for inpatient)	NA	FCHV card, citizenship card, judgment of health worker	PHCRD
Family planning services and incentive	Universal	Family planning services including sterilisation	Government facilities (if service available), family planning camps	NPR 125 for surgical intervention	NA	NPR 170 and 230 for male and female sterilisation	NA	FHD
	Universal	Family planning devices	Government facilities	NA	NA	NPR 40 and 55 for implant and Intra uterine contraceptive devices	NA	FHD
Safe Motherhood (Aama) Programme	Universal	Delivery services including c-sections	Public health facilities (exceptions: BPKIHS, Tribhuvan University Teaching Hospital) and some private facilities)	NPR 500–1,500 as transportation incentives per case	NPR 1,000–7,000, depending on level of facility and cases of delivery	NA	NA	FHD
ANC and PNC incentive service	Universal		SHP, HP, PHCC, district hospitals	NPR 400 upon completion of 4 ANC and 1 PNC visits	NA	NA	NA	FHD

Programme	Target population	Services, medicine and devices provided	Level of facility providing services	Cash transfer to patient	Cash incentive to provider	Cash incentive to health worker	Targeting method	Responsible division/unit
Screening and operation of uterine prolapse problems		Screening and surgical intervention	Publicly contracted public/private facilities	NPR 1,000–3,000 as transportation allowances for those having a surgical intervention	NPR 15,000 per surgical case (additional NPR 3,000–7,000 per case for services through camps)	NA	NA	FHD
Community-based neonatal programme	Pilot districts	Neonatal care and monitoring	FCHV	NA	NA	Up to NPR 400 per case based on performance	NA	CHD
Relief for medical treatment	Underprivileged	Services as needed	Hospitals specified by MoHP	NA	Reimbursement to facilities	NA	District level committee	MoHP
Referral Programme	Deprived, helpless, disabled, underprivileged, pregnant, and patients with TB, HIV/AIDs or mental illness	Referral services within district	Government referral hospitals	Up to NPR 200–500 for referral within district	NA	NA	To be defined by referring health facilities	PHCRD
		Referral services outside district for emergency cases		Up to NPR 2,000–8,000 for referral outside the district				
Referral for complicated pregnancy/ delivery	Poor, Dalits, deprived groups, those having complicated cases in 14 remote districts	Government facilities	Public referral hospitals	District level committee to decide the amount	NA	NA	Health facility to define	FHD
Treatment heart, lungs and valve transplant	Poor		Manamohan Cardiovascular Centre	NA	Conditional grant	NA	Health facility to define	MoHP

Programme	Target population	Services, medicine and devices provided	Level of facility providing services	Cash transfer to patient	Cash incentive to provider	Cash incentive to health worker	Targeting method	Responsible division/unit
Medical treatment services	Victims of conflict and martyrs' families	As necessary	Government facilities	NA	Reimbursement to facilities	NA	Identification card	MoHP
Poor patients treatment programme	Poor	Free eye care services	Nepal Eye Hospital	NA	Conditional grant	NA	Health facility to define	MoHP
Treatment for cardiovascular problems	Below 15 and above 75 years of age, disabled	Treatment of heart, lungs and transplant	Manamohan Cardiovascular Centre	NA	Conditional grant	NA	Citizenship card	MoHP
Treatment for heart disease	Poor	Percutaneous transvenous mitral commissurotomy services	Galgalal Heart Centre		Conditional grant		Health facility to define	
	Poor and vulnerable	Valve distribution	Galgalal Heart Centre		Conditional grant		Health facility to define	
	Below 15 and above 75 years of age	Treatment of heart disease	Galgalal Heart Centre		Conditional grant		Citizenship card	
	Heart patients	Diagnostic services	Galgalal Heart Centre		Conditional grant			
Transportation incentives for kala-azar patients	Those using specialised (referral) services	Health services as needed	Government facilities	NPR 1,500 per case	NA	NA	NA	Epidemiological and disease control division
Transportation incentives for leprosy patients	Those using specialised (referral) services	Health services as needed	Government facilities	NPR 1,000 per case	NA	NA	NA	Leprosy control division
HIV prevention and treatment programme	Needy people living with HIV	HIV testing and counselling Anti-retroviral therapy	Anti-retroviral therapy sites					National Centre for AIDs and Sexually Transmitted Disease Control

Programme	Target population	Services, medicine and devices provided	Level of facility providing services	Cash transfer to patient	Cash incentive to provider	Cash incentive to health worker	Targeting method	Responsible division/unit
	Children affected by AIDs		VDCs	NPR 1,500/ month	Conditional grant			
Medical treatment for specific diseases	Underprivileged citizens	Treatment for kidney, cancer, heart, Alzheimer's, Parkinson's (up to NPR 50,000)	Specified public and private hospitals	NA	Conditional grant	NA	NA	MoHP
Free treatment for poor and disabled patients	Poor and disabled	Treatment of eyes	Nepal Eye Hospital		Conditional grant			MoHP
Community eye camps	Above 50 years of age	Presbyopia screening and distribution of spectacles	Netra Jyoti Sangha	NA	Conditional grant	NA	NA	MoHP
Kidney dialysis	Above 75 years of age		National Kidney Centre	NA	Conditional grant (reimbursement of NPR 2,500 per dialysis)	NA	NA	MoHP
	Patients with hepatitis B or C, or HIV	Kidney dialysis	National Kidney Centre	NA	Conditional grant (reimbursement of NPR 2,500 per dialysis)	NA	NA	MoHP
Care and support for TB patients	All TB patients	Health services as needed	Government facilities	NA		NA	NA	TB Centre
	Multidrug-resistant TB patients			NPR 1,500/ month	Conditional grant			

While a comprehensive set of health services are provided free of cost under the current system, including cash incentives to health services users (Table 5), the programmes and activities under which these services are provided are administered by different divisions and units of the MoHP and Department of Health Services, without any effective linkage between them. This fragmented approach is administratively cumbersome. It also leads to a low capacity to negotiate with providers on fees for health services and weak monitoring of health service quality.

Who is paying and what for?

Given that so many services are provided free by the government, it is astonishing that out-of-pocket expenditure is so high in Nepal. According to estimates by the National Health Accounts 2008/09, 55 per cent of total health expenditure is made directly by private individuals/households in the form of out-of-pocket payments (MoHP 2012). While little is known about the composition of these out-of-pocket payments (e.g., what it is exactly spent on, where and by whom), data from the recent National Health Accounts 2008/09 provides some indication. The largest proportion of out-of-pocket payments is spent on medical goods dispensed to outpatients (48.6 per cent) and curative care services (29.2 per cent). Most of this is spent in the private sector, with 47.6 per cent spent at retail sales outlets and other medical goods suppliers and 29.5 per cent in private hospitals, clinics and labs. In contrast, government facilities only received 4 per cent of total out-of-pocket payments.

These findings are supported by the Nepal Living Standard Survey 2010/11 (CBS 2011) which states that about 63 per cent of people with an acute illness go to the private sector – regardless of their economic status. Poorer people tend to go to private pharmacies (32.5 per cent), and wealthier people seek medical care in private clinics (37.3 per cent). While in rural areas the utilisation rate of public facilities is higher than in urban areas (39.1 per cent and 26.8 per cent respectively), the majority of the rural (60.9 per cent) and urban population (73.2 per cent) opt for private health care providers. Until now, no comprehensive study on health seeking behaviour has been undertaken to understand the reasons for this trend. However, quality in the public sector is perceived as inferior to the private sector. Anecdotal evidence suggests that a high proportion of public doctors operate private practices and may be luring patients into private facilities. The higher utilisation rate of public facilities by populations in urban areas may be because more than 4,000 public facilities (SHPs, HPs and PHCCs) are located in rural settings where private providers are rarely available, except for pharmacies.

Interestingly, the mean expenditure for last consultation is higher in government facilities than in private ones (NPR 1,167 for public and NPR 1,010 for private facilities). The highest share of costs is spent on medicine (NPR 722 in public and NPR 748 in private facilities). The substantial difference lies in higher spending on diagnostic and other services (NPR 312 in public and NPR 191 in private facilities). These numbers might suggest that people use public facilities when they have severe medical conditions that are costly to treat, but consult private clinics or pharmacists on a more frequent basis for needs that are associated with lower costs.

There are also substantial differences in spending among different income groups. The richest quintile spends more than double the poorest quintile, and the same holds true for the amount of health care spending by the urban population in comparison to people from rural areas (CBS 2011).

Table 6: Percentage of health consultations for acute illness by type of institution

	Government institution						Private institution				
	SHP	HP	PHCC	Hospital	Other	Subtotal	Pharmacy	Clinic	Private hospital	Other	Subtotal
Urban	1.1	1.8	1.0	21.3	1.7	26.8	20.9	38.8	10.3	3.1	73.2
Rural	15.5	9.1	2.8	9.3	2.4	39.1	26.2	25.1	4.2	5.5	60.9
Consumption quintile											
Poorest	19.7	8.7	2.9	5.4	1.3	38.0	32.5	19.7	2.3	7.5	62.0
Second	16.6	9.1	2.7	10.1	2.3	40.9	28.8	21.9	2.6	5.8	59.1
Third	13.5	10.6	3.3	10.7	2.7	40.8	22.5	28.0	4.4	4.4	59.2
Fourth	10.9	7.0	1.7	13.8	2.2	35.6	24.7	30.0	6.0	3.7	64.4
Richest	4.8	3.4	2.1	16.0	2.7	29.0	18.6	37.3	11.3	3.9	71.0
Nepal (total)	13.0	7.9	2.5	11.3	2.3	37.0	25.3	27.5	5.3	5.0	63.0

Source: Nepal Living Standard Survey 2010/11 (CBS 2011)

Despite the provision of free services in government facilities, people tend to use private facilities more often than government facilities – leading to high out-of-pocket spending and low levels of financial protection. In the private sector, people mostly visit clinics (43.7 per cent) followed by pharmacies (40.2 per cent), hospitals (8.4 per cent) and other facilities (7.9) for a consultation during acute illness (CBS 2011). The prevalence of large out-of-pocket payments in the private sector is particularly worrisome as there are no legal provisions regulating private health institutions, including pharmacies, which can lead to suboptimal or unnecessary care and unfair pricing. The MoHP is currently drafting a 'Health Institution Operation Act' to rectify this situation.

Challenges in achieving universal health coverage

There are a number of factors contributing to incomplete universal coverage in Nepal, despite a rather comprehensive, but fragmented, mix of universal and targeted programmes. Other reports on the health system in Nepal have dealt in more depth with utilisation patterns, access barriers and the inadequacies of public services (e.g., RTI International 2010a and 2010b), inefficiencies in the way health services are financed (Vinyals et al. 2011; World Bank 2011) and health expenditure by functions, sources and providers (MoHP 2012).

In order to reach universal coverage, services have to be accessible, available and of an acceptable quality; provisions for exemptions or benefits should have a clear entitlement criteria and procedures; and the benefit package should offer sufficient financial protection and be sensible from a health care point of view. These three factors (availability and accessibility; clear entitlement; and sufficient financial protection) are discussed briefly here to find out why the government's attempts to ensure universal health coverage have fallen short of their objective. The unregulated nature of the private sector is also discussed as it contributes to high out-of-pocket expenditure.

Availability and accessibility

Nepal's topography makes it difficult to achieve high levels of access to health services in some areas, such as in the Mid Western and Far Western development regions. Without improvements in transport and infrastructure, these difficulties are unlikely to be overcome in the near future. In terms of access to health facilities, 61.8 per cent of households are located within 30 minutes of health posts or sub health posts (disaggregated as 85.9 per cent for urban households and 59 per cent for rural households). Similarly, the Nepal Living Standard Survey 2010/2011 (CBS 2011) states that only 43.2 per cent of rural households are within 30 minutes of a private clinic or private hospital, in contrast to urban households at 92 per cent. However, it must be noted that proximity to a health facility means nothing if there are no health workers to provide care or no drugs for them to dispense; around 24 per cent of health facilities in Nepal are reported to be understaffed due to absenteeism.

Location and terrain are not the only impediments to the accessibility and availability of health care. A household survey carried out by Research Triangle Institute found that 33.6 per cent of households faced barriers in accessing health services – despite the introduction of free health services at lower level facilities. The reasons vary, but the most commonly reported barriers were "high fee at facility" (42.8 per cent) and "facility too far" (41.2 per cent), followed by unavailability of drugs/equipment (25.5 per cent), high transportation cost (23.8) and long waiting time (19.9) (RTI International 2010a).

A rapid assessment of the Free Health Care programme conducted by RTI International found that up to 89.9 per cent of HPs and SHPs had stock-outs of drugs lasting more than a week. However, stock-outs of listed drugs varied by type of health facility and in different trimesters. Regarding human resources, around 90 per cent of health worker positions were filled at SHPs and HPs and 80 per cent at PHCCs and district hospitals during the two-year survey period. These findings reflect gaps in the implementation of the Free Health Care programme. However, there are signs that the introduction of the Free Health Care programme has led to increased service utilisation by the poor and other vulnerable groups, but numbers remain worryingly low (RTI 2010b).

Lack of clear entitlement and procedures

One of the main challenges facing the various programmes offering free or subsidised health services is how to reach intended beneficiaries. Many of the targeted programmes are difficult to access, and require patients and health workers to navigate complex bureaucratic procedures. This may deter poor people from utilising these services.

In the absence of a national targeting mechanism, there is no objective or effective tool for identifying the poor. For instance, the (extended) Free Health Care programme identifies the poor and ultra-poor on the basis of their 'economic condition'. The Guidelines for the programme define ultra-poor as patients who are able to feed their family for less than six months in a year. While conceptually this approach might seem reasonable, verification can be difficult and time consuming, or even impossible, jeopardizing the whole process. In practice, this may mean that classification is done on an ad hoc basis or not at all (MoHP 2009).

In the case of programmes for Medical Treatment for the Poor and Medical Treatment for the Victims of Conflict and Martyrs' Families, applications are processed by a district-level committee set up for this purpose. There is no information on how and when these committees meet, but anecdotal evidence suggests that these committees do not meet regularly and applications are usually handled by the District Public Health Office.

Most government, and some private, hospitals can cover the cost of additional treatment for selected patients from a conditional grant provided by the government. However, it is at the discretion of the facility to decide when and how much is given to an individual patient. In the case of the National Kidney Centre, for example, people above 75 years of age receive additional treatment, while younger patients are not entitled to benefits from this scheme.

Insufficient financial protection

While the benefit packages under the various programmes and interventions seem broad, there is no scheme in place to provide protection in the case of catastrophic illness. The provision of benefits up to NPR 50,000 in case of cancer and kidney, heart and other chronic diseases neither covers the expenses involved in treating these illnesses, nor does it make sense from a medical point of view. For example, in many instances the National Kidney Centre has to discharge a patient after providing only a few dialysis services free-of-charge, because the patient cannot bear the cost of further lifesaving treatment. Others are left heavily indebted if they chose to continue under their own means. So, while theoretically social health protection is provided by the government, certain shortcomings are apparent in the design and application, including in the targeting methods and benefit package.

Unregulated private sector

Another factor contributing to the high out-of-pocket expenditure is the tendency to use the growing private sector, which is only weakly regulated. The Nepal Health Sector Programme II reports that the for-profit private sector has over two-thirds of the hospital beds and trains 90 per cent of doctors (MoHP 2011b). As there is no central registration procedure in place, no exact number can be given. According to a recent health facility mapping survey by the Department of Health Services and WHO, out of a total 147 hospitals in 27 districts, 33 were government hospitals and the remaining 114 were non-government (DoHS and WHO 2010).

The private sector is also heavily involved in the provision of laboratory services, with 1,284 laboratories compared to the government's 295 (DoHS 2012). This raises questions about who is operating these laboratories and whether or not public funds are being unjustifiably diverted to the private sector, for example, by public-sector doctors referring patients to privately-owned laboratories for spurious or unnecessary tests. There are no exact figures available, but anecdotal evidence suggests that most of the public health workforce is engaged in private practice.

Community-based health insurance in Nepal

Community-based, but government operated

Most health insurance schemes in Nepal (apart from the few private for-profit schemes) can be characterised as community-based or cooperative schemes. However, within this category, the schemes are quite diverse in nature and in terms of the role and involvement of the community. At the same time, what qualifies as a 'community-based' health insurance scheme is still being widely and inconclusively discussed by academics and practitioners. The foremost feature is certainly a predominant role played by the community in mobilising, pooling, allocating, managing and supervising health care resources – even if these schemes still rely substantially on support from the government, donors or other external actors (Jakob and Krishnan 2012).

In many countries, government-initiated and government-operated schemes are labelled 'community-based'; for example, the Community Health Fund in Tanzania (Stoermer et al. 2011, in Stoermer and Leschhorn 2011) and the Health Card Scheme in Thailand. In Nepal, some of the private schemes are actually located and operated within a public facility and managed by the health facility operation and management committee (i.e., schemes supported by the Karuna Foundation Nepal).

In general, many mixed models are in place and the boundaries between a CBHI, micro-insurance and provider-based insurance scheme are often blurred. It is not the aim of this review to debate the categorisation of the different schemes operating in Nepal. It is enough to recognise that a variety of schemes with different features and models exist and are included in the review. Broadly speaking, the existing CBHI schemes in Nepal can be categorised as government (or public) schemes, encompassing those that are initiated and financially and technically supported by the government (through the MoHP), and private schemes, which are usually supported by NGOs or based within cooperatives.

Private CBHI schemes

Nepal has a long history of private, non-profit health insurance schemes initiated with the support of external development partners. The very first, the Lalitpur Medical Insurance Scheme in Ashrang, was initiated by the United Mission to Nepal in 1976 and later expanded to other facilities. The scheme mostly covered the cost of essential drugs and registration and, therefore, was treated as an insurance scheme for essential drugs. After the handing over of the scheme to the relevant facility management committees in the 1980s, some of the schemes failed due to politically divided committees and lack of commitment. Additionally, after the Free Health Care programme was initiated membership gradually decreased. The only surviving scheme is run by the Public Health Care and Resource Center, Chapagaun and is reviewed in this report.

Another prominent example is the BP Koirala Institute of Health Science (BPKIHS) in Dharan district, which started in 2000 and covered urban and rural populations, offering the same benefit package at different premium rates. The scheme covered the organised sector (cooperatives, business groups) and unorganised groups (such as farmers and self-employed groups), but was unable to expand because of high costs and low premium collection, which created a deficit. The scheme

covered less than 10 per cent of the target population and was weighed down by a high proportion of sick members (adverse selection). In addition, insured members visited secondary hospitals for minor illnesses (moral hazard), which proved costly. The scheme shut down after only 4–5 years of operation (NHEA 2012).

Regardless of these failures, community-based and micro-insurance schemes have been mushrooming in Nepal, even though there is no legal framework in place for their operation. The Insurance Act of 1992 does not cover the non-profit insurance market. This gap in the law was brought up by the Insurance Board (Beema Samiti) – the regulatory body of government – in discussions on the revision of this Act. While cooperatives do register with the Ministry of Agriculture and Cooperatives and NGOs with District Administration Office under the Ministry of Home, they do not have to indicate whether or not they are running an insurance scheme. Consequently, it is difficult to assess how many non-profit schemes are operating in the Nepal. The inventory (Annex 5) attempts to capture most of the currently operating schemes, but as no central registration for insurance is required and some schemes are very small no exact number can be given.

The nature of private schemes is quite diverse; however, all private schemes receive support from external partners and donors. The selection of the schemes evaluated in this report reflects this. Of the private schemes selected for this report, two are run by a cooperative (Rajmarga Health Cooperative and Bikalpa Cooperative). Apart from collecting premiums and sending their members to contracted health care facilities for treatment, cooperatives do not carry out other health-related activities, except for Bikalpa which organises health camps in coordination with other institutions.

Another private scheme selected for review is the Primary Health Care and Resource Center in Chapagaun, Lalitpur district, which is managed by a committee comprised of local community representatives. The scheme is one of the surviving schemes of Lalitpur Medical Insurance Scheme initiated by United Mission to Nepal. The scheme is currently receiving support from the HIMAL project.

Two other schemes chosen for this review, Madhesa and Syaphru (situated in Sunsari and Rasuwa districts), are supported by the Karuna Foundation Nepal, an international non-governmental organisation (INGO) focusing on the prevention of childhood disabilities, community-based rehabilitation of children with disabilities, and improved health care (see http://www.karunafoundation.nl/index_uk.html). The Foundation works for the capacity development of local communities. At the district level, all activities are coordinated by a committee involving district-level line agencies.

Finally, Saubhagya Laghu Swastha Surakshya Kosh (referred to as Saubhagya in the rest of this report) is a micro-insurance scheme implemented by Development Project Service Center (DEPROSC), a national NGO. Technical support is provided by several INGOs, including the Micro Insurance Academy, Save the Children and Misereor.

Government supported CBHI schemes

The Government of Nepal announced its intention to implement a community-based health insurance programme in its budget presentation for 2003/04. Following this announcement, the MoHP implemented CBHI schemes in two primary health care centres, Mangalabare PHCC (in Morang district) and Dumkauli PHCC (in Nawalparasi district), as a pilot programme. Later, in 2005/06, the MoHP decided to expand the programme to four more districts, Udayapur (Katari PHCC), Rautahat (Chandranigahapur PHCC), Dang (Lamahi PHCC) and Kailali (Tikapur PHCC) – Katari and Tikapur PHCC were later upgraded to district hospitals.

In 2007, with the aim of scaling up these pilots, the MoHP carried out a study in Ilam, Sindhupalchok, Syangja, Bardia and Kanchanpur districts to assess the feasibility and desirability of such insurance schemes. The study concluded that community-based health insurance schemes were feasible in some of the districts under review. However, the pilot programme was never expanded beyond the initial six districts. At the same time, the Free Health Care programme was introduced in December 2006 and expanded to cover almost the same package of benefits that the government-supported CBHI schemes offered.

Within the MoHP, until 2009/10, the Health Economics and Financing Unit was supposed to directly monitor and supervise the implementation of the pilot CBHI schemes. Since 2009/10, the Primary Health Care Revitalization Division of the Department of Health Services is responsible for allocating budget, providing implementation guidelines and monitoring the performance of CBHI schemes. In the annual guidelines, the Primary Health Care Revitalization Division also makes some provision for how the allocated budget should be used by CBHI schemes. For example, in the fiscal year 2011/12, 50 per cent of the allocated budget was used as a subsidy for targeted enrolees and 50 per cent for administrative expenses including social awareness activities, review and interactions. Apart from occasional monitoring, the MoHP's main involvement is in the provision of a fixed annual grant that is identical for all public schemes, which is to be used to subsidise poor and marginalised groups and to cover some operational expenses.

The main objective of the CBHI programme, according to the 'Community Health Insurance Operational Guidelines, 2006', is to increase access to basic health services for poor and disadvantaged groups (HEFU 2007). The programme also aims to enhance community participation and contribution by providing an alternative health care financing mechanism. By sharing financial risk within the community, regardless of socioeconomic and health status, the programme also aims to develop solidarity among community members. However, the set-up of these schemes has not always been community driven; instead, the MoHP has taken a rather top-down approach. All government-supported schemes are provider based, meaning that the public health facility in which the scheme is housed administers the scheme. Apart from issuing the guidelines, little technical support has been provided by the MoHP in the setting up or operation of these schemes.

While the guidelines set standards in relation to setup, they are vague on other areas. In accordance with the guidelines, all schemes are managed by a subcommittee under the health facility operation and management committee. The subcommittee is in charge of defining and collecting premiums, decides the content of the benefit package, manages routine CBHI activities and negotiates with the

health care providers. In addition, the subcommittee identifies poor and marginalised groups and determines the geographic area to be covered. All schemes are obliged to subsidise the contribution rate (premium) of members for up to 30 per cent of all enrolees from the target groups (marginalised, poor, helpless and disabled). This results in a partial payment of premiums for members of such subsidised groups.

However, the guidelines do not provide information on what kind of benefit package these schemes should offer. They only provide a broad set of services that could be included in the benefit package, such as interventions for child health, safe motherhood, family planning, communicable diseases, diagnostic services, and emergency and referral services. Hence, what is offered by the six different schemes is quite diverse and will be discussed more in Chapter 4.

Chapter 4
Findings: Analysis of CBHI Schemes in Nepal

This chapter presents the findings of the review of 12 CBHI schemes in Nepal. The underlying question of this analysis is whether or not the schemes provide a feasible and sustainable solution for improving the access of the population to health services, and, thus, fill the gaps in risk protection identified in Chapter 3. The analysis is framed around three questions:

- Do the schemes improve the access of the population to health services?
- Is the quality of health care is being improved through the schemes?
- Are the schemes operationally, technically and financially viable and, therefore, sustainable?

Do the schemes improve access to health services?

In order to analyse the contribution of CBHI schemes to improving access to health services in Nepal, this section examines the benefit packages offered by such schemes; the number of members and households covered as a proportion of the total population; and the membership composition of schemes (using ethnicity as a proxy indicator for the poverty orientation of the schemes). In addition, the premiums charged and the subsidisation provided by the government for the poor are analysed to give an indication of whether or not access to health care services for members is improved by the schemes. Finally, the contribution of the schemes to increased utilisation of health services is assessed.

Benefit package: What is covered?

Public schemes

In order to assess whether or not CBHI schemes improve accessibility to health care in a meaningful way, we must first look at the benefit packages they offer to their members. The main question to be answered is whether or not the benefit packages provide meaningful access to services beyond those provided under the Free Health Care programme.

In general, the benefit packages in public and private CBHI schemes cover medicines, diagnostic services, hospitalisation and transportation. The CBHI schemes do not have to pay for services that are already provided free by the government, such as delivery services and associated cash incentives, family planning, treatment for uterine prolapses and treatment for specific diseases such as HIV/AIDS, cancer and TB. CBHI members have access to these services, while preserving the resources of the CBHI schemes for other services.

Non-communicable diseases requiring long-term treatment, plastic surgery and major surgery are not part of the benefit packages of CBHIs. The same is true for organ transplantation, major dental care, major eye care, heart and neurosurgery, MRI/CT scans, and the diagnosis and treatment of chronic diseases such as diabetes, hypertension, neurological disorders and coronary heart disease.

All of the public CBHI schemes include referral services in their benefit packages, but only Mangalabare and Dumkauli have set ceilings for categories of referral and non-referral services. In all public CBHI schemes, referrals are usually to the district or zonal public hospital. Mangalabare switched from a private referral centre (BPKIHS) to a public one after suffering huge financial losses in 2005/06. The reason for these losses was adverse client selection. The scheme had a written contract with the referral hospital and would reimburse the hospital for services provided to its

members. The number of clients who received the maximum benefits was too high to be sustainable. The transportation benefit included the use of ambulance for referral purposes with no ceiling.

In order to control cost escalation and reduce moral hazard, all of the schemes have introduced co-payments for services in their benefit packages, ranging from 10 to 80 per cent of the price of the service. The most comprehensive benefit package offered has a ceiling of NPR 120,000 per family per year in Mangalabare (including referrals) and smallest benefit package has a ceiling of NPR 3,500 per family per year in Dumkauli (without referral).

Over the years, public schemes have adapted their benefit packages and premiums. Lamahi increased its benefit package and reduced the premium to counteract a sharp decrease in enrolment after the introduction of the Free Health Care programme. Tikapur and Chandranigahapur introduced different ceilings for different service categories (e.g., medicines, diagnosis and hospital transportation). Katari and Dumkauli reduced their co-payment fees. Tikapur, Dumkauli, Mangalabare and Katari introduced discount rates for members renewing their enrolment. These changes were possible because public schemes do not have to fully finance their benefit packages from premiums. Because the government provides funds and resources (human and other) to public schemes, the management of these schemes did not have an overview of the degree of cost-recovery for their benefit packages. Details of the benefit packages provided by public CBHI schemes are presented in Table 7.

Table 7: Benefit packages and ceilings in public CBHI schemes

Scheme	Medicine	Diagnosis	Hospitalisation	Transportation	Referral	Total
Mangalabare (with referral)	In-patient: NPR 3,000; outpatient: NPR 1,000	Diagnosis: NPR 5,000; (50% co-payment for CT scan and endoscope)	Bed charge: NPR 1,000; operation: NPR 4,000; operation materials: NPR 1,000; ICU: NPR 4,000	NPR 1,000 for transport to facility only	Koshi Zonal Hospital	NPR 20,000 for individual and NPR 120,000 for family
Mangalabare (without referral)	NPR 3,000	Diagnosis: NPR 3,000; (80% co-payment for CT scan and endoscope)		NPR 500 one way for specific VDC depending upon case	No referral	NPR 6,000 per person
Katari	NPR 3,500	NPR 2,500	Minor surgery: NPR 2,000; bed charge: NPR 2,500 (60% co-payment); ICU; NPR 5,000 (60% co-payment)	NPR 7,000 (50% co-payment for ambulance cost when referred to Janakpur or Rajbiraj hospitals and 60% co-payment when referred to Dharan or Biratnagar)	8 hospitals (Janakpur, Sagarmatha-Raj, BPKIHS, Nobel-Biratnagar, Bir, Bharatpur, Tribhuvan University Teaching Hospital, Koshi-Biratnagar)	NPR 22,500 for family
Chandranigahapur	NPR 2,400 (15% co-payment)	NPR 1,100 (15% co-payment)	0	0	(Any higher facility) NPR 1,000 (20% co-payment); special: additional NPR 10,000 (50% co-payment)	General: NPR 4,500 and referral; NPR 14,500
Dumkauli	NPR 2,000 (10% co-payment)	NPR 1,000 (10% co-payment)	NPR 500 (50% co-payment)		(Bharatpur Hospital) medicine: NPR 2,000 (10% co-payment); diagnostic services: NPR 1,000 (10% co-payment); admission and ambulance: NPR 500 (50% co-payment); surgery: NPR 2,000	Non-referral: NPR 3,500; referral: NPR 9,000
Lamahi*	NPR 5,000		General: NPR 5,000 (75% co-payment); free: NPR 5,000 (75% co-payment); single NPR 2,000 (75% co-payment)		(Only government hospitals) general: NPR 4,000 (90% co-payment); free: NPR 4,000 (90% co-payment); single: NPR 1,000 (90% co-payment)	General: NPR 14,000 (co-payment applies to referral and ambulance only)
Tikapur	NPR 3,500 (10% co-payment)		NPR 1,500 (10% co-payment) NPR 1,000 (10% co-payment)		(Seti Zonal Hospital; Bheri Zonal Hospital) 25% co-payment	NPR 6,000

** Lamahi PHC has seperate provision for single enrolees with ceiling of NPR 5,500 on benefit package.*

Source: Field Survey, October 2011 to January 2012

Private schemes

The benefit packages of private schemes ranged from services available at the health care providers (e.g., PHCRC Chapagaun) to referral services at a tertiary level hospital (e.g., Madhesa). Madhesa and Syaphru (operated by the Karuna Foundation Nepal) are operated by the local SHP and members can obtain additional drugs at the SHP as well as referral services at designated hospitals. In these two schemes, additional services are available at the health facility including laboratory services, delivery services and medicines. Members of these schemes also have access to additional medicines (about 80 in each facility) and laboratory services. In addition, the Karuna Foundation Nepal is involved in disability prevention and strengthening health services in general through their Share and Care Programme, which benefits members and non-members.

Saubhagya reimburses the cost of treatment (excluding medicine) to members. Members of the cooperative-based schemes (Rajmarga and Bikalpa) are entitled to a discount on services, excluding medicines, available at the Kathmandu Model Hospital. Saubhagya also has a list of health facilities from the PHC level to referral level (from the adjoining private hospital to hospitals in Kathmandu and Chitwan). For cost reimbursement, members have to obtain services from the hospitals listed. Details of the benefit packages provided in private schemes are presented in Table 8.

Table 8: Benefit packages in private CBHI schemes

Scheme	Medicine	Diagnosis	Hospitalisation	Transport	Total
Madhesa	SHP: NPR 1,000; District Hospital: NPR 500; BPKIHS Dharan: NPR 3,500	SHP: NPR 1,000; District Hospital: NPR 500; BPKIHS Dharan: NPR 3,000	Bed charge: NPR1,000; operation: NPR 6,000; ICU/ NICU: NPR 7,000; death claim: NPR 5,000	NPR 1,000	NPR 29,500 per family
Saubhagya	Only in hospitalisation cases	Laboratory NPR 250; imaging: NPR 500	NPR 4,000	NPR 400	NPR 5,150 per person
Rajmarga	0	50% discount on consultation, diagnostics and admission, only in Kathmandu Model Hospital (does not cover MRI)			No ceiling
Bikalpa	0	70% discount on consultation, diagnostics and admission, only in Kathmandu Model Hospital (does not cover MRI)			No ceiling
PHCRC, Chapagaun	50% co-payment (medicine cost about 50% less than retail price)	50% discount on consultation, diagnostics, admission		0	No ceiling
Syaphru	NPR 20,000, not segregated into different headings + 10,000 death claim				

Source: Field Survey, October 2011 to January 2012

The PHCRC, Chapagaun does not offer referral services. The facility has set charges for all categories of services, such as registration, consultations, laboratory services and medicine. The cost of medicine in this facility is nearly 50 per cent less than the retail price. In order to assess client satisfaction, occasional interviews are conducted by the PHCRC with users. An in-house quality control mechanism is applied and the best performing department is honoured annually. User charges are

the main source of income for the facility. As in the case of Madhesa and Syaphru, the District Development Committee (DDC) provides an additional financial grant to the facility annually. For the last few years, the facility has also received external support from the HIMAL project.

Saubhagya is the only CBHI among the 12 surveyed in which the premium amount and content of the benefit package are defined in collaboration with the community. It is also the only scheme where the premium amount is based on actuarial calculations.

Some of the benefit packages in private schemes have ceilings for services (Madhesa, Saubhagya and Syaphru) and some do not (Rajmarga, Bikalpa and PHCRC, Chapagaun). The schemes not applying ceilings offer discounted rates on services at listed facilities. Table 9 gives an overview of the ceilings applied by private CBHI schemes

The survey found that for all public schemes and two of the private ones (Syaphru and Madhesa) the benefit packages are complementary to the services covered by the Free Health Care programme. The provision of free medicines by other programmes has contributed significantly to the sustainability of CBHI schemes: none of the schemes studied would have been able to survive if they had to pay for all of the required drugs with their own means. However, there has also been dissatisfaction among CBHI members who consider the quality of medicines provided under the Free Health Care programme as being generally low and, thus, would prefer to obtain medicines off the list of free medicines. Comparing public and private schemes, there is no clear difference in terms of the content of their benefit packages; neither is more or less generous than the other.

Table 9: Ceilings in private CBHI schemes

Scheme	Benefits and ceiling
Madhesa	Ceiling NPR 29,500; different ceilings apply to different service categories Benefits include medicine, laboratory services, ambulance services and services at referral hospital, as well as death compensation to family members.
Syaphru	No ceiling Benefits include medicine, laboratory services, ambulance services and services at referral hospital, as well as death compensation to family members.
PHCRC, Chapagaun	No ceiling All services available at the health care centre can be obtained with 50% co-payment
Saubhagya	Ceiling NPR 5,150 per person per year Benefits include consultations, diagnostics services and transportation only (medicine is not included in the benefit package).
Rajmarga	No ceiling Benefits include 30% discount on consultations, diagnostic services, surgery and bed charges (medicine is not included in the benefit package).
Bikalpa	No ceiling Benefits include 70% discount on consultations, diagnostics services, surgery and bed charges (medicine is not included in the benefit package).

Source: Field Survey, October 2011 to January 2012

How many people are covered?

Public schemes

The review found that CBHI schemes in Nepal have achieved only very limited coverage of the population. As all public schemes are facility-based, their geographical coverage is basically limited to the working area of the particular facility, with the exception of Katari Hospital. However, even within their catchment area, on average, only 3.4 per cent of the population is covered, which illustrates the low range of influence of the schemes (Table 10).

The population coverage rate in public schemes ranges from as low as 1.6 per cent of the catchment area population for Dumkauli to a more significant value of 12 per cent for Katari. In total, the six schemes presently cover 4,176 households with an average of 5.4 members per household.

The six public CBHI schemes in Nepal are active in 38 village development committees (VDCs) and/or municipalities, representing an average of 6 VDCs/municipalities per scheme. This is less than 1 per cent of the total number of VDCs/municipalities in Nepal.

Compared to the previous fiscal year, only two of the public schemes (Lamahi and Tikapur) succeeded in increasing their membership. The membership of Chandranigahapur remained more or less stable and the membership of Mangalabare, Katari and Dumkauli actually decreased (Table 11). Over the past three years, the number of enrolled members has increased by 39.3 per cent overall; however, this was driven by the large increases in membership of Lamahi (+160 per cent) and Tikapur (+33 per cent) due to the commitment of health workers.

Table 10: Coverage of public CBHI schemes and number of households subsidised

Scheme	Development region/district	Total population in catchment area	HH covered by CBHI (% of total HH)	Insured population	Total number of HH subsidised by CBHI (% of HH covered)	Population in catchment area covered by CBHI schemes (%)
Mangalabare	Eastern/Morang	218,210	697 (1.6)	3,842	134 (19.2)	1.8
Dumkauli	Western/ Nawalparasi	105,075	264 (1.3)	1,676	95 (35.9	1.6
Chandranigahapur	Central/Rautahat	86,312	493 (3.3)	2,636	229 (46.5)	3.1
Katari	Eastern/Udayapur	19,127	392 (11.0)	2,298	211 (53.8)	12.0
Lamahi	Mid Western/Dang	89,315	1,310 (8.9)	6,259	478 (36.5)	7.0
Tikapur	Far Western/Kailali	147,866	988 (4.3)	5,980	275 (27.8)	4.0
Total		**665,905**	**4,176 (3.5)**	**22,691**	**1,422 (34)**	**3.4**

Source: Field Survey, October 2011 to January 2012

Table 11: Change in number of households covered by public CBHI schemes (2008–2011)

Scheme	Period			Change in HH covered
	2008/09	2009/10	2010/11	
Mangalabare	1,176	716	697	- 40.7%
Chandranigahapur	452	685	493	+ 9%
Dumkauli	503	296	264	- 47.5%
Katari	576	223	392	- 31.9%
Lamahi	503	1,076	1,310	+ 160.4%
Tikapur	NA	743	988	+ 33% (between 2009 and 2011)
Total	**2,034**	**2,663**	**2,834**	+ 39.3%

Source: Field Survey, October 2011 to January 2012

The FGDs revealed that the variations in membership are due to the following factors:

- attitude of health workers and CBHI committee towards the CBHI
- whether or not the CBHI scheme was expanded to other health facilities in the district (which did not take place as there is no incentive for health workers to launch CBHIs)
- whether or not the CBHI scheme was streamlined with other health activities of the district (as the programme is directly supervised by Primary Health Care Revitelisation Division, no mechanism for review was established at the district level)

Private schemes

The comparison of the six public schemes with the six private schemes revealed some differences. The coverage rate of the private schemes sampled is slightly lower than the public schemes at 2.7 per cent of the population (compared to 3.4 per cent for public schemes) (Table 12). Public schemes also enrol more members per scheme: public schemes enrol an average of 3,781 people or 696 households (with an average of 5.4 members per family), while private schemes enrol an average of 1,684 people or 359 households (with an average of 4.7 members per household).

Table 12: Coverage of private CBHI schemes

Scheme	Development region/district	Total population in catchment area	HHs covered by CBHI	Insured population	Population in catchment area covered by CBHI scheme (%)
Madhesa	Eastern/Sunsari	7,325	426	2,083	28.4
Rajmarga	Central/Dhading	107,955	119	597	0.6
Saubhagya	Central/Dhading	97,790	339	908	0.9
PHCRC, Chapagaun	Central/Lalitpur	83,840	784	4,311	5.1
Bikalpa	Central/Kathmandu	76,088	320	1,376	1.8
Syaphru	Central/Rasuwa	2,552	164	831	32.6
Total		**375,550**	**2,152**	**10,106**	**2.7**

Source: Field Survey, October 2011 to January 2012

Membership composition and poverty orientation: Who is benefiting?

To answer the question of who is actually accessing services and how many members are being subsidised, the survey looked at the CBHI membership composition. The classification of ethnic groups applied by the MoHP was taken as the basis for the analysis, namely, disadvantaged groups (i.e., Dalits, disadvantaged janajatis and disadvantaged non-Dalit Terai caste groups) and advantaged groups (i.e., upper caste and relatively advantaged janajatis).

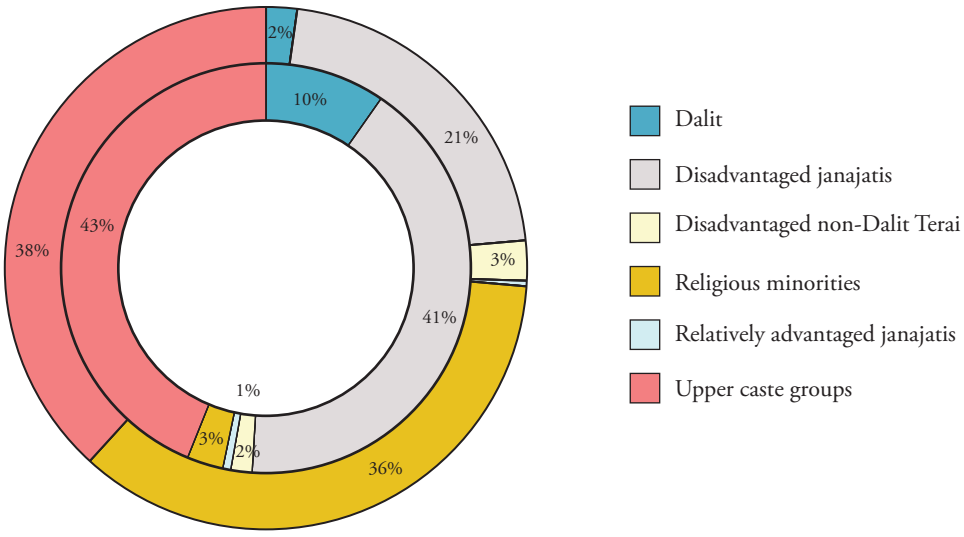
Public schemes

The membership composition shows that disadvantaged groups enrol more in public schemes (totalling 53 per cent of members) than in private ones (totalling 26 per cent of members). Hence, public schemes have achieved a higher poverty orientation than private schemes. This is to be expected given the subsidy inflow into public schemes linked to the criteria of enrolling poor families. It must be noted, however, that ethnicity is only a proxy indicator for socioeconomic status in contemporary Nepal and does not automatically translate into a defined socioeconomic status. However, it is a quite strong proxy indicator, as recent research has shown (DfID and World Bank 2006), and for the purpose of this study was the closest proxy indicator available for an indicative assessment of the poverty orientation of the CBHI schemes.

Private schemes

While upper caste members constitute a similar proportion in both public and private schemes (43 per cent and 38 per cent, respectively) (Figure 3), taking the two categories of relatively advantaged populations together (upper caste and relatively advantaged janajatis), this category is much more represented in private schemes (74 per cent of total members) than in public schemes (46 per cent).

Figure 3: Membership composition by ethnicity in public and private CBHI schemes (FY 2011/12)



Note: The inner circle represents public schemes and the outer circle private schemes.

Enrolment

Public schemes

Usually, enrolment is possible only once a year from May to June, followed by a two to four week waiting period (during which claims cannot be made). However, some schemes take new enrolments at other times: Mangalabare takes new enrolments in November/December and Tikapur from mid February to mid April. During the enrolment period, the CBHI management mobilises volunteers and disseminates messages through radio, newspapers and other means of communication. The Primary Health Care Revitalization Division has given an annual target for the number of enrolees in all public schemes for the last three years; however, none of the schemes have achieved this target.

CBHI schemes enter into a written contract with the enrolled household, which receives a membership card containing the photographs of all enrolled members in the household valid for one year. At the end of the year, the household has to renew the membership if it wishes to continue with the insurance. All public schemes have set the maximum family size as six members. A family with more than six members has to pay an additional premium for each additional member.

All of the public schemes collect premiums in cash a lump sum amount once a year; payment of the premium by instalments is not allowed. All of the public schemes rely on local motivators, female community health volunteers and management committee members to collect premiums. Local motivators and female community health volunteers receive incentives, ranging from NPR 100 to NPR 200 per member enrolled, depending on the scheme. The photographs of the family members are kept at the CBHI as proof of enrolment.

Private schemes

As with public schemes, private schemes mobilise local facilitators and management committee members to collect premiums in cash once a year. The enrolment period is open once a year in Madhesa, Rajmarga and Bikalpa; twice a year in Saubhagya; and all year round in Syaphru and PHCRC, Chapagaun.

In Madhesa and Syaphru the enrolment unit is the family (up to 6 members) and the premium is NPR 1,200 and NPR 1,000, respectively, plus NPR 200 for each additional member. Both schemes cover the death of members from NPR 5,000 to 10,000, as per the choice of members.

PHCRC, Chapagaun offers enrolment anytime of the year for families and other groups such as schools and industry workers. The premium for a family (up to 5 members) is NPR 450 per annum with an additional NPR 100 for each additional family member. Saubhagya collects NPR 336 per person as annual premium. The scheme opens registration twice a year at six-month intervals in order to provide flexibility in registration to the community and to increase coverage.

Premiums and subsidies

Public schemes

In the public CBHI schemes, premiums are not determined on the basis of actuarial calculations, but rather set by the CBHI management based on experience. They range from NPR 700 in Dumkauli and Chandranigahapur PHCs to NPR 1,400 per family of up to six persons in Mangalabare PHC (Table 13).

Table 13: Premiums and subsidies in public CBHI schemes (FY 2010/11)

Scheme	Insurance product	Premium per HH (NPR)	Government subsidy to poor HHs (NPR)	Subsidy to the poor as % of subsidy of full premium	Government subsidy per HH enrolled in the scheme* (NPR)	Government subsidy per subsidised HH in scheme** (NPR)
Mangalabare PHC	Referral	1,400 (up to 6 persons)	1,100	79	1,471	7,649
	Non referral	600 (up to 6 persons)	300 (up to 6 persons)	50		
Katari Hospital	All	1,000 (up to 6 persons) + 100 for each additional member	700 (up to 6 persons) + 50 for each additional member	70	2,615	2,298
Chandranigahapur PHC	General	700 (up to 6 persons) + 50 for each additional member	300 (up to 6 persons) + 25 for each additional member	43	2,079	2,636
	Special	2,000 (up to 6 persons) + 200 for additional member	No subsidy	0		
Dumkauli PHC	General	700 (up to 6 persons) + 50 for each additional member	500 (up to 6 persons)+ 25 for each additional member	71	3,463	10,789
	Referral	1,800 (up to 6 persons) + 200 for each additional member	No subsidy	0		

Scheme	Insurance product	Premium per HH (NPR)	Government subsidy to poor HHs (NPR)	Subsidy to the poor as % of subsidy of full premium	Government subsidy per HH enrolled in the scheme* (NPR)	Government subsidy per subsidised HH in scheme** (NPR)
Lamahi PHC		600 (up to 6 persons) + 100 for each additional member	600 (up to 6 persons) for poor and 500 senior citizens (60 years +), FCHV and disabled	83	782	6,259
Tikapur Hospital	New	700 (up to 6 persons) + 50 for each additional member	450 (up to 6 persons) + 25 for each additional member	64	1,037	3,727
Average					1,473	4,093

* Total government grant to CBHI scheme divided by total number of households enrolled in the scheme, i.e., government subsidy per enrolled household.
** Total government grant to CBHI scheme divided by total number of subsidised households in the scheme, i.e., government subsidy per subsidised household.

Source: Field Survey, October 2011 to January 2012

To make the premium affordable to the poor, CBHI schemes offer subsidised premiums (up to nearly half) for the ultra poor, marginalised, helpless and disabled beneficiaries (as per the MoHP guidelines). However, CBHI management committees do not have specific parameters for how much premiums should be subsidised, but rather make this decisions based on the recommendation of facilitators/motivators in the community, the VDC and members of the management committee. The MoHP provides annual block grants to public schemes to subsidise premiums for disadvantaged populations and to cover part of their running costs. There is no consistency among the six public CBHI schemes in terms of the proportion of members subsidised.

Of the total households enrolled in public CBHI schemes, 34 per cent are subsidised, ranging from 19 per cent of all enrolled families in Mangalabare to 54 per cent in Katari (Table 14). Only one scheme offered a 100 per cent subsidy to a small number (4) of households (Mangalabare). This CBHI management committee does not have any mechanism to check whether or not these households really are 'ultra poor'. The identification of a household as ultra poor is discretionary. However, in every public scheme there are many people involved in this process including female community health volunteers and social mobilisers, VDC secretaries and members of the management committee. Lamahi, according to its management committee, also has a regulation for the provision of free membership to the ultra poor, but this has not been invoked to date.

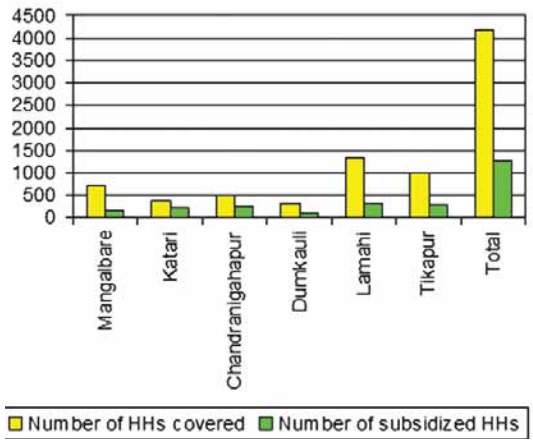
Households that received a subsidised premium one year are not automatically entitled to a subsidy the following year. This may partly explain the dropout rate observed among poor households, particularly in Mangalabare. The case of Mangalabare illustrates the weak effect of CBHI schemes in providing an adequate solution to the poor. Poor families in this scheme are denied a (subsidised) continuation of membership in the following year on the basis that they have already benefited from the subsidy once and that it is now the turn of other families to benefit. As much as this is understandable from the point of view of the CBHI management committee, which has to 'invest' their subsidies in a limited number of families, it leads to severe equity problems, as well as management problems in terms of maintaining a stable client basis.

Table 14: Subsidised households in public CBHI schemes

Scheme	Total number of HH covered by CBHI (% of total HH)	Total number of HH subsidised in CBHI (% of HH covered)
Mangalabare	697 (1.6)	134 (19.2)
Dumkauli	264 (1.34)	95 (36)
Chandranigahapur	493 (3.3)	229 (46.5)
Katari	392 (11.0)	211 (53.8)
Lamahi	1,310 (8.9)	478 (36.5)
Tikapur	988 (4.3)	275 (27.8)
Total	**4,144 (3.5)**	**1,422 (34)**

Source: Field Survey, October 2011 to January 2012

Figure 4: Subsidised households in public CBHI schemes



Source: Field Survey, October 2011 to January 2012

The amount of the subsidy offered to the poor differs according to whether or not the insurance product includes referral services. Dumkauli and Chandranigahapur have insurance products with more benefits and higher premiums, which are not subsidised. The highest subsidy amount in place is in Mangalabare (NPR 1,100 per family). Expressed as a share of the total premiums collected, subsidies represent up to 83 per cent in Lamahi and 79 per cent in Mangalabare.

The MoHP provides the same block grant to subsidise the enrolment of the poor to all public schemes, independent of the number of poor enrolled. In fiscal year 2010/11, the government granted a lump sum of NPR 1,025,000 per scheme. Expressed per beneficiary (enrolled poor with subsidies) the average subsidy per insured household is NPR 1,473, ranging from NPR 782 to 3,463 (Table 13). The government subsidy is on average equal to or higher than the premium in all public schemes.

Private schemes

Private schemes have no such provision for subsidising premiums according to socioeconomic status. Some discounts are granted to members at the time of renewal on the basis of how long they have been a member of the scheme, but not for socioeconomic reasons. The majority of enrolees in private schemes are from upper caste groups (38 per cent) and relatively advantaged janajatis such as Newars, Gurungs and Thakalis (35.8 per cent). Disadvantaged janajatis represent 21.3 per cent of enrolees, Terai caste groups 2.5 per cent, Dalits 2 per cent and religious minorities 0.4 per cent.

Membership in Bikalpa and Rajmarga schemes is limited to the members of the respective cooperatives. Both schemes charge premiums on an individual basis, but all family members of the households are required to enrol. The annual premium per member is NPR 900 in Bikalpa and NPR 365 in Rajmarga.

The premium amounts in half of the private CBHI schemes reviewed for this study are set for a family. An additional individual premium is required for each member above the maximum family number (which ranges from 4 to 6). Three of the schemes, Rajmarga, Bikalpa and Saubhagya, set the premium per person.

Table 15: Premiums in private CBHI schemes

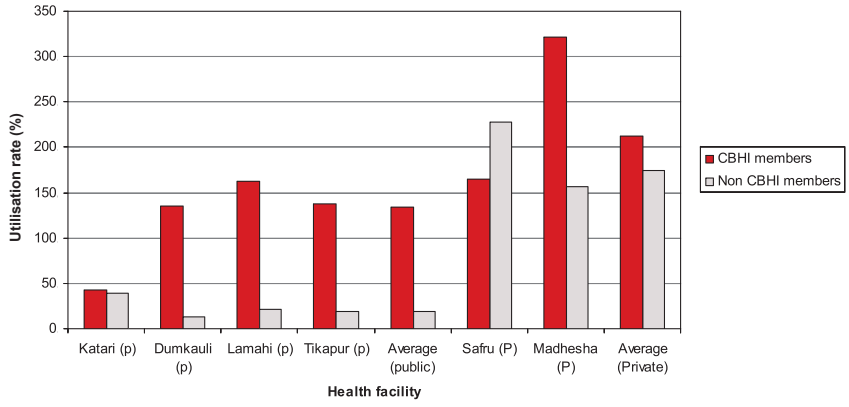
Scheme	Insurance product	Premium
Madhesa SHP	All	NPR 1,200 per family (up to 6 members) + 200 for each additional member
Saubhagya, Dhading	All	NPR 336 per person
Rajmarga Cooperative	All	NPR 365 per person
Bikalpa Cooperative	New	NPR 900 per person
PHCRC, Chapagaun		NPR 450 per family (up to 4 members) + 100 for each additional
Syaphru HP		NPR 1,000 per family (up to 6members) + 200 for each additional member

Source: Field Survey, October 2011 to January 2012

Utilisation of health services

If access to health services is improved through CBHI schemes, this should be indicated through a comparison of the utilisation rate of health services by CBHI members versus non-members. The utilisation rate of health services for CBHI members is calculated as the total number of benefits (consultations, excluding referral services) used by CBHI members in a year, divided by the average number of CBHI members in that year. The utilisation rate of health services for non-CBHI members is calculated in the same way (total number of benefits used by non-CBHI clients in a year, divided by the average number of non-CBHI clients for that year). However, in this review it was not possible to disentangle the services used per service category using the data available for the various schemes. This indicator also does not account for referral services (where they are part of the benefit package) as this data was not able to be collected from the referral service providers. The survey found that the overall utilisation rate of health services among members of a CBHI scheme is higher than among non-members, regardless of whether it is a public or a private scheme (Figure 5).

Figure 5: Service utilisation rate of members and non-members in public and private CBHI schemes



Source: Health facility patient registers during Field Survey, October 2011 to January 2012

Table 16: Comparative health service utilisation rate (excluding referral services) for public CBHI schemes for members and non-members (FY 2010/11)

Scheme	Health service utilisation rate for members (a) (%)	Health service utilisation rate for non-members (b) (%)	Comparative health service utilisation rate (a/b)
Mangalabare*	NA	NA	NA
Katari	42.8	39.1	1.1
Dumkauli	135.3	13.6	9.9
Lamahi	162.9	21.5	7.6
Tikapur	137.6	18.9	7.3
Chandranigahaphur	NA	NA	NA
Average	133.6	18.9	7.1

Source: Field Survey, October 2011 to January 2012

Note:*Data was not available for Mangalabare for FY 2010/11.

Public schemes

The health service utilisation rate for CBHI members in public schemes ranged from 1.1 in Katari to 9.9 in Dumkauli, with an average of 7.1 across the four schemes for which data was available (Table 16). During the FGDs, CBHI members explained that, compared to the previous period when they were not insured, they visited health facilities more often because they wanted to use their entitlement as much as possible (up to the yearly ceiling allowed by the scheme). This fact was confirmed during interviews with the facility in-charge. Schemes try to control the over-utilisation of services by insured people who do not necessarily need them (moral hazard) by introducing ceilings and co-payments.

A health service utilisation rate of 100 per cent means that CBHI members (or non-members) visit their health care facility once a year, more than 100 per cent means that members (or non-members) visit more than once a year and less than 100 per cent, less than once a year. A comparative health service utilisation rate of more than one means that CBHI members use health care services more than the non-members.

Private schemes

The health service utilisation rate in private schemes was not calculated for the two cooperatives, as data were not available on the utilisation of services by their members. The utilisation rate for members of the other schemes ranged from 166 per cent in Syaphru to 617 per cent in Saubhagya for the fiscal year 2010/11 and was 192 per cent in PHCRC, Chapagaun for fiscal year 2009/10. The average utilisation rate for the two schemes was 277 per cent for CBHI members and 175 per cent for non-members in 2010/11.

Table 17: Comparative health service utilisation rate (excluding referral services) for private CBHI schemes for members and non-members (FY 2010/11)

Scheme	Health service utilisation rate (%) for members (a)	Health service utilisation rate (%) for non-members (b)	Comparative health service utilisation rate (a/b)
Madhesa	320.9	157.2	2.04
Syaphru	165.5	227.8	0.73
PHCRC, Chapagaun	NA	NA	NA
Bikalpa	NA	NA	NA
Rajmarga	NA	NA	NA
Saubhagya	6.2	NA	NA
Average*	212.2	174.6	1.22

Notes:*Calculated only for Madhesa and Syaphru.

Data was only available for two private schemes in fiscal year 2010/11. The analysis shows a higher utilisation of health services by CBHI members as compared to non-members. The exception is Syaphru, a private scheme with a reverse pattern of utilisation (the utilisation rate for non-members is higher than for members). A plausible explanation is that the facility, because of its high geographical accessibility (on the main road in the district), attracts clients who are not resident in the catchment area. According to the facility in-charge, almost 25 per cent of the outpatient department visitors in Syaphru are from outside the VDC.

On average, the utilisation rate in public schemes is 67 per cent (in 4 schemes) in fiscal year 2010/11 as compared to 212 per cent in the private ones (average of 2 schemes). The comparative health services utilisation rate is 3.6 for public schemes and 1.2 for private ones.

These findings show that CBHI schemes do indeed offer financial protection to their members, enabling them to use health services more often than non-members. However, how much this higher utilisation constitutes over-utilisation is beyond the scope of this review.

Nevertheless, it is not clear why the utilisation rate of CBHI members is much higher in private than in public schemes while comparative utilisation rate is higher in public schemes. Higher utilisation in private schemes could be linked to the socioeconomic affiliation of members (upper caste groups and relatively advantaged janajatis represent 74 per cent of private schemes' members versus 46 per cent in public schemes and are not constrained by out-of-pocket payments, even after their ceiling is reached). Cultural and health need differences between group members could also explain this fact, as well as supply side characteristics. The difference could also be random as the sample size is so small.

Is the quality of health care improved?

The survey found that the quality of health care provided for CBHI members mainly in the public health facilities is in line with the capacity and infrastructure of the health facility. There is no positive discrimination in the facility towards CBHI members; the same services are available to both insured and non-insured patients.

Furthermore, the CBHI schemes do not monitor or influence the quality of care provided by the health facilities. By virtue of the composition of the CBHI management committee, the facility in-charge is also the member secretary of the CBHI scheme. In the interviews, the facility in-charges indicated that they felt equally accountable to CBHI members and non-members. Most of the CBHI management committee members also sit on the health facility operation and management committee; hence, there is no clear demarcation between purchaser (CBHI) and provider (health facility) roles. Nevertheless, since the introduction of CBHI schemes, some improvements in the quality of care have been perceived by clients and are discussed here.

Negotiation power of CBHI schemes

Public schemes

As already mentioned, all public schemes are provider-based, which means there is no purchaser-provider split. Therefore, the likelihood of an improvement in the quality of health care driven by the negotiating power of the purchaser (CBHI scheme) is virtually nil. However, the lack of a purchaser-provider split is not the only factor leading to the low negotiating power of public CBHI schemes. Overall, the share of providers' income accounted for by CBHI schemes (both public and private) is very low, ranging from 1 to 11 per cent (Figure 6), which does not give schemes sufficient bargaining power.

Figure 6: Share of providers' income (%) accounted for by public (p) and private (P) CBHIs (FY 2010/11)

Source: Field Survey, October 2011 to January 2012

Private schemes

In private schemes, the coverage of CBHI members among the population in the catchment area and their weight as a proportion of the total number of clients serviced by the facility are low. However, the share of health services accounted for by public (Table 18) and private (Table 19) CBHI schemes ranges from 13 per cent (Dumkauli) to 45 per cent (Madhesa), with slightly higher values for the private schemes (Figure 7). Such figures translate to a certain amount of bargaining power.

Table 18: Share of providers' services accounted for by private CBHI schemes (FY 2010/11)

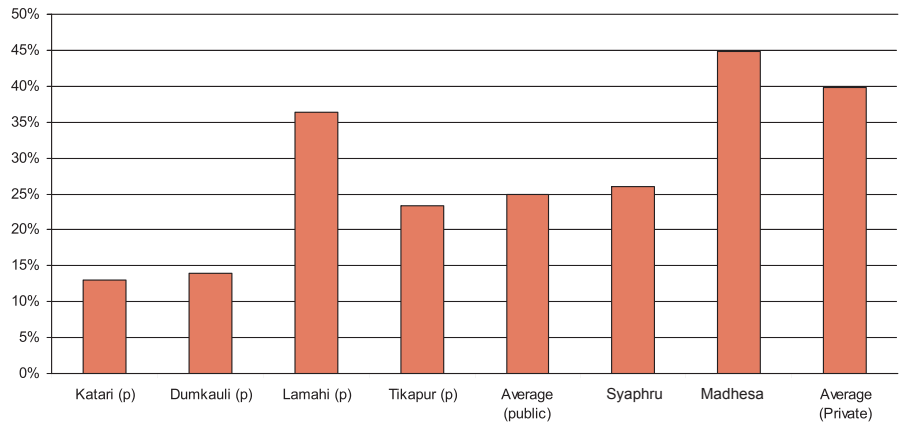
Scheme	Share of providers' services accounted for by CBHI (%)
Madhesa	44.8
Syaphru	25.9
PHCRC, Chapagaun	NA
Saubhagya	NA
Rajmarga	NA
Bikalpa	NA
Average	**39.9**

Table 19: Share of providers' services accounted for by public CBHI schemes (FY 2010/11)

Scheme	Share of providers' services accounted for by CBHI (%)
Mangalabare	7.2*
Dumkauli	13.0
Katari	13.9
Lamahi	36.3
Tikapur	23.4
Chandranigahaphur	NA
Average**	**18.8**

Note:*for 2009–2010, ** for all schemes excluding Mangalabare

Figure 7: Share of health services (%) accounted for by public (p) and private (P) CBHI schemes (FY 2010/11)



Community voice

A potential strength of a health insurance scheme is to represent a large number of clients of the health facility and give them a 'voice', e.g., articulate their demands in terms of the quality of health care. The review included this aspect in the FGDs and key informant interviews.

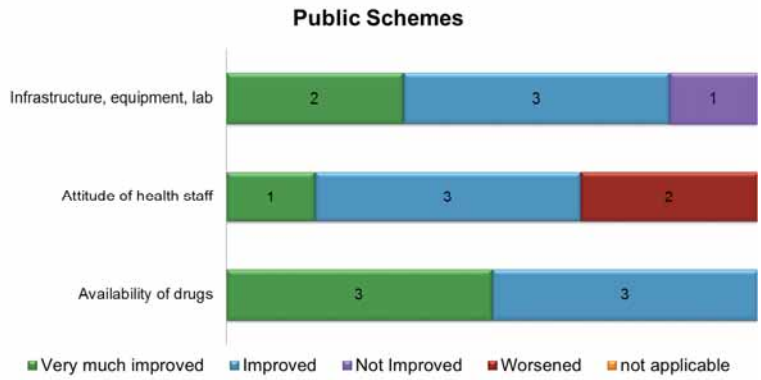
Public schemes

The survey found that public schemes do not have any formal mechanism for collecting members' complaints or assessing member satisfaction with the quality of the health care they receive. However, members' needs and complaints are collected in an informal/unsystematic way during enrolment and premium collection, at community interactions and during household visits. CBHI members expressed their perception that the consoilidation of members' voices through this process has led to an improvement in the quality of services provided by health care providers. CBHI management committee members acknowledge the increased availability of drugs as a major improvement. CBHI schemes procure medicines in addition to those in the Free Health Care programme, which are provided to CBHI clients, contributing to increases in enrolment. This, however, is not reflected in any significant increase in membership numbers, and, accordingly, such perceptions should be taken with caution.

Improvements in infrastructure, the availability of equipment and laboratory services were also mentioned by members during the FGDs. It appears that the health care providers use the resources generated by the CBHI to improve their facilities. According to key informant interviews and FGDs, pressure from CBHI management and members was instrumental in prompting health care facilities to embark on such investments. However, the technical competence of staff recruited by the CBHI scheme to operate additional equipment and laboratory services is questionable.

Three out of twelve health facility operation and management committees (or management committees of the CBHI schemes) negotiated with the MoHP to obtain more qualified human resources in the facility. As a result, Lamahi and Tikapur obtained MBBS doctors in addition to existing medical staff, which has significantly improved the quality of health services provided by these facilities.

Figure 8: Perceived improvement in public health care facilities from the perspective of CBHI management since implementation of the scheme



Source: Field Survey, October 2011 to January 2012

The management committees of the CBHI schemes reported feeling accountable towards CBHI members. They visit the communities, at least during the enrolment period, and provide some feedback to the facility staff. The attitude of health facility staff towards insured patients was perceived as improved in most cases (Figure 8). However, it was also reported that the attitude of health staff had deteriorated in two of the public schemes, although the reason for this was not clear.

The FGDs with CBHI members revealed that they are generally satisfied with the premium amount, benefit package and quality of services provided by the provider. The main reasons given for non-enrolment in schemes were: 1) lack of knowledge about health insurance, enrolment period and benefit package and 2) the limited range of services available at the facility. The main reasons given for dropping out of schemes were: 1) no health care services were needed during the period of enrolment and insurance was seen as a waste of money, 2) the quality of health care and range of services offered was insufficient, and 3) they were not informed of the need to re-enrol in time (during the enrolment period). Another reason cited was ineligibility for a subsidised premium after the first year, which made the premium unaffordable.

Areas suggested by enrolees and non-enrolees for improvement to increase enrolment were:

- upgrade available services provided, including by employing better trained human resources, and make wider diagnostics services and additional medicines available
- ensure upper level referral (access to the tertiary level care if needed)
- expand subsidies to cover the ultra poor

Private schemes

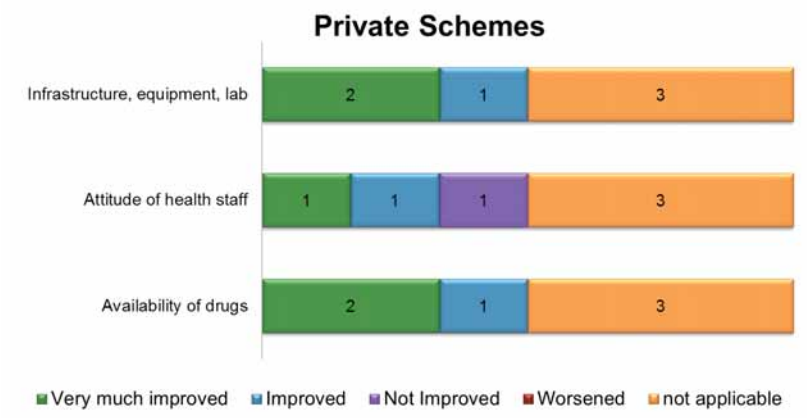
The quality of health care accessed through private schemes varied according to the type and nature of the facility. Madhesa and Syaphru are linked to government health posts, hence, the quality of services is similar to that in public schemes. Both CBHI schemes are facilitated by an external agency, the Karuna Foundation Nepal. They have increased their benefit package over time adding access to a birthing centre and laboratory services.

Rajmarga and Bikalpa CBHI schemes are linked to the Kathmandu Model Hospital. They cannot influence the quality of health care at this hospital. However, the FGD revealed that the quality of health care in Kathmandu Model Hospital is not questioned by the CBHI members.

Saubhagya CBHI has designated local, regional and national hospitals where its members can access services. Local hospitals are designated by the management committee with the technical assistance of the Micro Insurance Academy based in India and Germany. Indicators used for selecting such designated health facilities include the availability of an MBBS doctor, laboratory facility and X-ray facility. The management committee cannot influence the quality of services in these facilities, but the CBHI members are free to choose the facility they prefer and that suits their needs. Therefore, it is expected that members will favour better quality facilities. CBHI members pay directly at the time of obtaining the service and the CBHI reimburses them later.

PHCRC, Chapagaun, Lalitpur district, a provider-based scheme operating in a local PHC, has a better range of health services and is better managed than the public PHCC. It is also using a performance-monitoring tool in the health care facility.

Figure 9: Perceived improvement in private health facilities from the perspective of the CBHI management since implementation of the scheme



Source: Field Survey, October 2011 to January 2012

Management committee members perceive that there has been an increase in the quality of services in half of the private schemes (PHCRC Chapagaun, Madhesa and Syaphru) (Figure 9).

While there is no direct involvement of enrolees in the CBHI management committees, the voice of the community as a whole is raised in the management committees meetings, because the committees are comprised of community representatives selected through political consensus. Decisions taken by the CBHI management committee, such as regarding the content of the benefit package, the premium and ceiling, are taken without consulting enrolees.

The satisfaction of CBHI members with their health care quality and premiums was assessed in FGDs. Members of Bikalpa consider the premium to be high. Both cooperative run schemes have an agreement with only one health care provider, therefore, insured members have no choice of health care provider, which is perceived as a limitation.

In other schemes, members reported being satisfied with the premium amount and how it is collected. Additional expenses incurred by members due to the non-inclusion of medicines in the benefit package was of concern. The drop-out rate in cooperative-based schemes was also a concern. In Madhesa, members perceived that the enrolment rate would increase if ambulance services were offered (which is planned).

The main reasons cited for non-enrolment during the FGDs (in decreasing order of importance) were: 1) households did not receive sufficient information in time to enrol, 2) ignorance of the existence of health insurance scheme in the facility, and 3) dissatisfaction with the level and quality of services at the health care provider. Similar reasons were cited for dropping out as in public schemes, namely: 1) no health care service was needed during the period of enrolment and insurance was seen as a waste of money, 2) the quality of health care services and content of benefit package were insufficient, and 3) ignorance of the enrolment period.

Are schemes operationally, technically and financially viable?

The operational, technical and financial viability of CBHI schemes is crucial for their sustainability. In evaluating the viability of CBHI schemes, this section looks at their legal status, the management of the schemes, human resources, provider-purchaser relationship, role of the MoHP and financial viability.

Legal status

Public schemes

Public CBHI schemes have not looked for any legal identity because they were initiated by the Government of Nepal. Separate CBHI management committees are formed in four out of the six public CBHI schemes. In Tikapur and Chandranigahapur the health facility management and operation committees look after the CBHI.

Private schemes

The legal status of private CBHI schemes, like that of the public schemes, is unclear. Two of the sampled CBHI schemes are registered as cooperatives, Rajmarga and Bikalpa, and, hence, are supposed to be regulated by the Cooperative Act and its Regulations. The cooperatives also have their own by-laws; however, neither cooperative specifically mentions CBHIs in their by-laws.

Madhesa and Syaphru are implemented in association with local health posts and can be considered provider-based, like the public schemes. They don't have a separate legal identity. PHCRC, Chapagaun and Saubhagya are not registered either, but PHCRC, Chapagaun is owned and managed by the VDC. Saubhagya is community-owned and managed as a community-based organisation.

Management

Public schemes

Accounts and record-keeping systems in all of the public CBHI schemes are manual. Lamahi has initiated the development of computer-based software for this purpose, but it is not yet fully functional. In all public schemes, the records of CBHI members are relatively better maintained (in a hand-written register) than the records for claims, health care providers bills and vouchers, which are usually poorly maintained.

As there is no standard to be applied nationally, all records and information are locally managed according to each CBHI scheme's capacity. None of the public CBHI schemes have any financial or administrative guidelines governing how CBHI activities should be implemented. As CBHI schemes receive annual grants from the Government of Nepal, they should, in principle, be audited by a registered auditor (according to the provisions of the MoHP Community Health Insurance Operational Guidelines; HEFU 2007). However, only two schemes (Mangalabare and Tikapur) had their accounts audited in fiscal year 2010/11.

None of the public CBHI schemes have a supervision and monitoring mechanism in place. Only Mangalabare has formed a VDC-level sub-management committee, which is functional to some extent in supervision and monitoring. None of the public CBHI schemes have developed performance monitoring indicators and tools. The number of members enrolled is the only indicator used by the CBHI schemes to measure performance.

CBHI management committees were found actively involved in CBHI activities. The health facility in-charge works as the member secretary of the CBHI management committee. Additional administrative assistants, other than regular health facility staff, have been hired by four schemes to support the scheme. All CBHI schemes maintain separate accounts from those of the health facility. One health facility staff member is usually assigned to work as the CBHI focal person in each health facility.

None of the public schemes are reinsured or hold a guarantee from any other agency. If the CBHI scheme runs into a loss, there is no mechanism for absorbing these losses outside the CBHI.

Regarding risk management, all of the public schemes have set co-payments and ceilings for all benefits to control moral hazard and reduce risk. The risk of adverse selection is also addressed through family enrolment and a waiting period of 15 days to 2 months.

Private schemes

In cooperative-based schemes, the executive board of the cooperative is responsible for the insurance activity; there is no separate insurance management committee. The cooperative board is supposed to present an annual progress report in the annual general meeting of the cooperative.

In schemes supported by the Karuna Foundation Nepal, the health facility operation and management committee of the facility in which the CBHI is based is in charge of the management of the scheme. There is a standard protocol regarding who the members of the health facility operation and management committee should be, i.e., one female community health volunteer, one Dalit, one woman, one head schoolteacher. If the community feels that additional individuals from the same community are active and able to contribute, they may also be included. In schemes supported by the Karuna Foundation Nepal, additional members have been included in the health facility operation and management committees with the consensus of the major political parties. The health facility in-charge works as member secretary of the committee. The bank account of the CBHI scheme is operated jointly by the chair and member secretary of the health facility operation and management committee. The Karuna Foundation Nepal annually audits the accounts of the facility and the CBHI scheme.

In PHCRC, Chapagaun, the management committee of the facility is in charge of health insurance. It includes representatives from the DDC, VDC, schoolteachers, female community health volunteers, social workers and health staff.

The management committee of Saubhagya is formed by representatives of the elected and nominated members from the claims committee. The claims committee consists of CBHI members.

Human resources

Public schemes

The field survey revealed that all of the public schemes participated in an initial simple orientation conducted by the MoHP to address the concerns of CBHI initiators, who were usually the PHC directors. Since then, the CBHI staff or management committee members have not undergone any specific health insurance or management/organisation training and their capacity is variable and usually limited. In some cases, CBHI staff had been exposed to other CBHI schemes during field visits. None of the CBHI schemes have a human resource development plan.

Every CBHI has a management committee, with a secretary (usually the facility in-charge) who is responsible for coordination between the CBHI and the facility. In addition to CBHI tasks, the secretary of the management committee is responsible for providing health care services, as well as other management tasks in the health facility. In all public schemes one facility staff is appointed as the focal person for the CBHI scheme and is involved in the day-to-day activities of the scheme. This focal person dedicates part of their time to CBHI work, while their regular responsibilities at the facility remain unchanged.

Human resources available to public CBHI schemes are limited. In addition to the focal person, Mangalabare has assigned a separate CBHI coordinator. Otherwise, all of the public CBHI schemes have appointed one assistant-level staff, except for Chandranigahapur, which has not assigned anyone to the CBHI. Dumkauli has appointed an additional laboratory assistant. Mangalabare has assigned a second person at the referral level to facilitate the treatment of referred patients. In some cases, CBHI schemes pay incentives to the facility in-charge for taking care of the CBHI (as in Mangalabare and Katari, for instance) and appointed persons receive a salary from the CBHI.

Private schemes

Neither of the two cooperative-based schemes had any specific staff appointed to look after the CBHI scheme. Their information systems are managed in a very ad-hoc way and no proper records are kept. There has been no annual audit of their activities for a long time, only an audit related to their savings and credit programme.

Bikalpa cooperative is better organised than Rajmarga, with its own office, staff and information system – and it conducts an annual audit. However, surprisingly, CBHI-related aspects are not integrated into the regular cooperative system. No proper records are kept for the CBHI portion of the cooperatives' activities. Nevertheless, the awareness level, academic background and commitment of the management committee members in both cooperatives are quite high.

Madhesa and Syaphru, which are embedded in broader programmes of the health facility, the Karuna Foundation Nepal and the community (in cooperation with VDC and District Health Office), have access to an accountant and support staff who also deal with the CBHI scheme. Proper records are kept and annual audits are done. Like other private schemes, Madhesa and Syaphru don't have an operating manual. However, it should be noted that Madhesa has developed a financial manual.

The Saubhagya management committee has appointed a coordinator and five facilitators. The scheme has a software management system, its own operating guidelines and its accounts audited annually. Saubhagya is supported by DEPROSC Nepal, a large development organisation that receives financial and technical support from Misereor and technical support from the Micro Insurance Academy. The scheme management committee members and staff regularly benefit from training and on-site technical assistance.

PHCRC, Chapagaun is better organised than most private schemes, with human resources allocated exclusively to the CBHI scheme. A management system is in place, annual audits conducted and human resources are trained on CBHI relevant issues. However, PHCRC, Chapagaun does not have CBHI operating or financial guidelines.

The analysis revealed weaknesses in the management systems of all of the private schemes including the cooperative-based schemes. The private schemes analysed as part of this review would require rigorous technical assistance and support to develop into operationally and technically viable organisations.

Provider-health insurance relationship

Public schemes

Public CBHI schemes directly reimburse the cost of treatment of the insured patients to the health care provider on the basis of regular invoices. The CBHI pays the facility the same price as non-insured patients; there is no special pricing/discount for CBHI schemes. Insured patients do not have to make an advance payment as long as their total yearly expenses remain under the specified ceiling.

Referral services are included in the benefit packages of all public schemes. Only one scheme (Mangalabare) has a written contract with the referral centre and directly reimburses the facility (the member/patient pays nothing). The other schemes provide members with cash when they are referred.

Private schemes

Saubhagya does not have a contract with any health service provider, but has listed eight hospitals (including private hospitals) in Kathmandu, Chitwan and nearby for the provision of services. Members can visit the designated hospitals for treatment and later claim reimbursement from the CBHI scheme.

Madhesa and Syaphru work with public health facilities and have written contracts with tertiary-level health facilities for referrals. The management committee of Madhesa has signed a contract with the BPKIHS and Syaphru with Kathmandu Model Hospital. In both cases, the scheme pays the provider directly.

The two cooperative-based schemes have written contracts with Kathmandu Model Hospital. After collecting the annual premium, these cooperatives make advance payments to the hospital.

Support from MoHP

Public schemes

In addition to an initial orientation workshop provided to scheme promoters, the MoHP provides technical support to public CBHI schemes in the form of an implementation guideline (Operational Guidelines for Community Health Insurance), which is of limited scope (HEFU 2007). The MoHP also provides financial support in the form of annual grants to the six public schemes, but there is virtually no monitoring of performance. There is also no scientific basis for the calculation of grants; the same grant is given to all public CBHI schemes, irrespective of the number of members enrolled.

Public CBHI schemes are run in isolation, separate from the other activities of the district health office. No indicator related to CBHI schemes is included in the Health Management Information System. As a result, there is no regular reporting on their performance. There is also no regular supervision of the CBHI schemes at the district level and only occasional visits from the central level. The only form of monitoring of CBHI schemes in Nepal consists of an annual review meeting held at the MoHP at which representatives of the CBHI management committees have the opportunity to present and discuss their activities.

Private schemes

Private schemes do not currently receive any support from the MoHP.

Financial viability

Public schemes

Most public CBHI schemes do not have any data available with which to monitor their financial viability. Public schemes are not aware of their operating expenses as not all expenses are allocated to the scheme. The private schemes that do know their operating expenses have a very high incurred expense ratio (incurred expenses/earned premium). The expenses/resources that are not allocated consist of the salaries of staff provided by the host facility for staff who are partly involved in running of the CBHI, the cost of office space provided by the host facility, and equipment costs such as vehicles, office materials and furniture belonging to the host facility. The other expenses of running the CBHI are paid directly by the health care facility and consist of communication activities (social mobilisation in the community, broadcasting of messages on radio), the enrolment of members and premium collection, a yearly audit of CBHI accounts, and some incentives paid to the facility in-charge and other facility health staff for the daily management of schemes. Medicines and other items provided by the MoHP under the Free Health Care programme also remain unaccounted for and would need to be considered if CBHI was to be considered as a possible replacement for other social health programmes.

The calculation of an operating expense ratio was, therefore, not possible within the scope of this review, and the 'claims ratio' (incurred claims/earned premium)[3] was used as a proxy for the financial

3 It must be noted that the study team was not able to calculate the 'earned premium' as the schemes do not set up the change in 'unearned premium reserve'. Therefore, the 'written premium' was used. The same is applicable to claims: The 'incurred claims' could not be used because the schemes do not set up the change in 'incurred but not reported claims' (IBNR – estimated change in claims that have happened during the accounting period but are not reported yet), or the 'claims in course of settlement' (CICS – estimated change in claims that are reported but still in process). Accordingly, for this report, 'paid claims' was used.

Table 20: Financial viability indicators for public CBHI schemes (FY 2010/11)

Scheme	Claims ratio (assuming no members subsidised) (%)	Average claim value per member (NPR)	Share of provider's income accounted for by CBHI (%)
Mangalabare	46.8	119	3.70
Dumkauli	386.1	477	NA
Katari	68.9	118	NA
Lamahi	139.0	175	10.7
Tikapur	190.8	221	1.3
Chandranigahaphur	NA	NA	NA
Average	**129.0**	**196**	**3.75**

Notes: The claims ratio could not be computed for Chandranigahapur as no records were maintained.

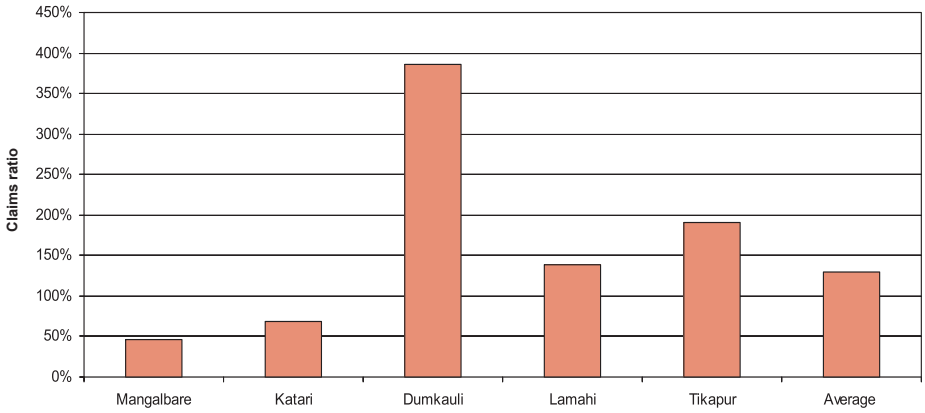
Source: Field Survey, October 2011 to January 2012

viability of the CBHI. The claims ratio (assuming no one is subsidised) is usually above 100 per cent in the CBHI schemes analysed, ranging from 47 per cent to 386 per cent, with an average of 129 per cent (calculated for five out of the six public schemes; Table 20).

A 100 per cent claims ratio means that 100 per cent of the premium earned is used to pay claims. Schemes with 100 per cent (or more) claims ratios are not financially viable in the mid and long term because the claims paid are higher than the premiums earned.

All public schemes subsidise some of their members and, therefore, the premium income used in the calculation of the claims ratio is distorted and the actual ratio without subsidy would be much higher. The claims ratio for all public schemes is analysed assuming that all of the members pay the full premium (Figure 10).

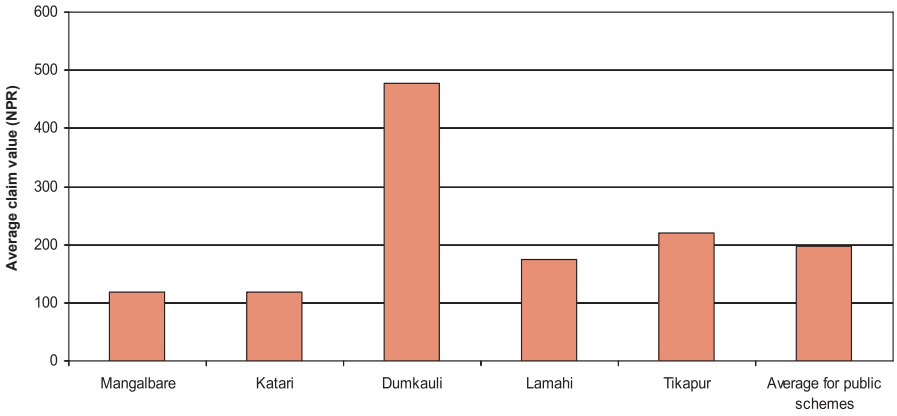
Figure 10: Claims ratio (%) in public schemes (assuming that all members pay full premium) (FY 2010/11)



Source: Field Survey, October 2011 to January 2012

Figure 10 shows that the claims ratio for three of the public CBHI schemes is much higher than 100 per cent. Only Mangalabare and Katari have claims ratios below 100 per cent. Only these two schemes seem viable from a claims perspective. However, the capacity of these schemes to cover unaccounted running costs and the free-of-cost support provided by other the Free Health Care programme is questionable.

Figure 11: Average claim value (NPR) in public schemes (FY 2010/11)



Source: Field Survey, October 2011 to January 2012

In order to compare the income generated from premiums with the income from government grants, a 'government grant/premium ratio' was calculated. This ratio (annual income from government grants per enrolled household/annual premium income per household) ranges from 1.3 in Mangalabare up to 5.2 in Dumkauli (with 1.4 in Lamahi, 1.6 in Tikapur, 2.8 in Katari and 3.1 in Chandranigahaphur). As this ratio is always above one, it appears that CBHI schemes are receiving less from premiums paid by households than what they receive from the government in annual grants.

Private schemes

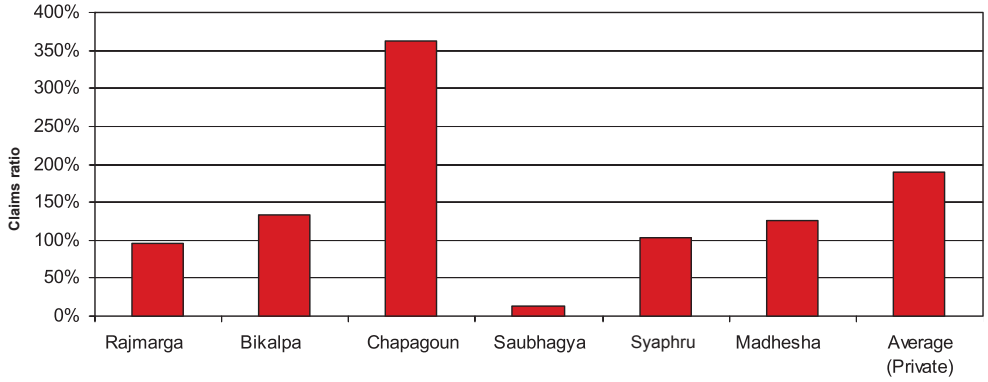
The claims ratio for private schemes varies widely from 13 per cent in Saubhagya to 363 per cent in PHCRC, Chapagaun (Table 21), which is largely a reflection of their different management capacities.

Table 21: Financial viability indicators for private schemes (FY 2010/11)

Scheme	Claims ratio (%)	Average claim value per member (NPR)	Share of provider's income accounted for by CBHI (%)
Madhesa	125.7	394	NA
Syaphru	102.4	202	NA
PHCRC, Chapagaun	363.0	221	NA
Saubhagya	12.9	25	NA
Rajmarga	95.9	350	NA
Bikalpa	134.0	903	1
Average	**189.5**	**338**	**1**

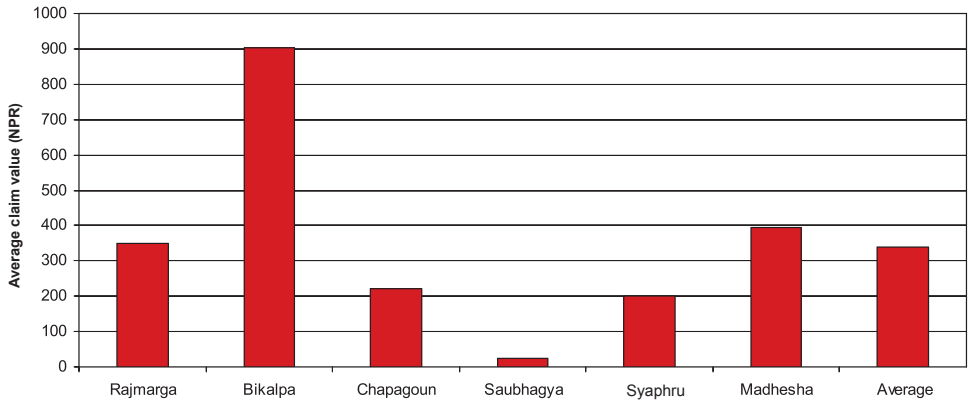
Source: Field Survey, October 2011 to January 2012

Figure 12 Average claims ratio (%) in private schemes in FY 2010/11



Source: Field Survey, October 2011 to January 2012

Figure 13: Average claim value (NPR) in private schemes (FY 2010/11)



Source: Field Survey, October 2011 to January 2012

Saubhagya has a claim committee at every VDC/nodal point, which verifies claims up to NPR 3,000 and then passes it to the coordination committee. Claims above this threshold are verified by the coordination committee.

The average claims ratio for all private schemes is 189.5 per cent. A claim above 100 per cent means that a higher amount is spent in the payment of claims than earned as premiums. In private schemes, on average, 189 per cent of the premium income is spent on claims, which is not financially viable in the mid or long term.

Except for Mangalabare and Saubhagya, all of the CBHI schemes (public and private) paid more for claims and spent more on health services than what they collect as premiums (including government subsidies) in financial year 2010/11. Unfortunately, data from previous years was not available, so could not be used to calculate trends. The claims ratio is exceptionally high in PHCRC, Chapagaun, which has other non-insurance related activities and, therefore, can close the financial gap in its insurance from other financial sources.

In the calculation of premiums, schemes do not account for expenses additional to claims (such as administrative expenses), nor do they make allowance for an accumulated fund to ensure the scheme's financial viability. Hence, their claims ratios do not accurately reflect their financial viability.

Chapter 5
Conclusion

Considering the weak results achieved by the existing CBHI schemes in terms of population coverage and financial viability, the current CBHI approach may not be the most realistic way of achieving equitable access for the population to health services towards universal coverage. Isolated, localised CBHI schemes, as presently implemented in Nepal, do not constitute a model on which a national health insurance should be built. The Government of Nepal can, however, consider using some of the good experience of the existing schemes and define a framework, along with supporting mechanisms, in which current schemes can be used as a transitory mechanism towards a stronger system for universal coverage. Such a system could use a multi-layer risk-sharing mechanism. Some risk would be borne by a local structure – at the district or sub-district level – which would ensure local ownership and the motivation to run the system successfully. A second level risk pool – at the national level – would provide structured financial and technical support to the local structures. Such a system can be seen as a natural development of the current approach, but one that increases stakeholder buy in.

In the absence of a more comprehensive approach to ensuring social health protection, CBHI schemes at least improve access to health care for some. However, the disadvantages of this approach should be taken into account when looking for an alternative. A viable national health insurance should achieve a wide coverage of the population, ensure the equitable protection of the poor, build up an efficient 'voice' mechanism and be financially viable. All of these characteristics can be achieved in a national health insurance scheme, which would probably be best based operationally at the district level.

Such a district-based approach seems to be pursued by the government in the recent decision to pilot 'national health insurance' in five districts (without qualifying it as social or community based). A health insurance policy is currently being drafted by a taskforce consisting of MoHP officials and external development partners. This document will describe the policy's guiding principles and outline its broad features.

Lessons to be learned

The analysis contained in this report clearly shows the limited scope and impact of community-based health insurance schemes in Nepal. Although both public and private schemes have been in existence since 2002 and public schemes are supported by the Government of Nepal, the results achieved so far have been limited.

However, nowhere in the world are CBHI schemes a complete mechanism for achieving universal health coverage. Rather, the question to ask is whether or not they can provide some basis in a transition process to a broader national insurance system, especially regarding their distribution mechanisms, information channels and awareness raising capacities. In Germany, for example, the national health insurance system also started from a multitude of small micro-insurance schemes, which were strengthened once the state gave the sector a firm structure (Bärnighausen and Sauerborn 2002). Similar developments took place in Japan in the 19th Century (Ogawa et al. 2003). Considering these historical experiences, it must be evaluated how Nepal can similarly build on the achievements of CBHIs and improve on these through structured financial and technical support.

In the view of the evaluation team, micro-insurance schemes such as CBHI schemes are only a transitional mechanism for building up a comprehensive, equitable, empowering and sustainable national health insurance system in Nepal, which requires a strong support structure at the sub-district, district or higher level. This conclusion is based on the observations that the CBHI schemes in their present structure:

- have extremely low population coverage
- are not able to provide equitable protection for the poor against health related costs
- do not provide an efficient 'voice' mechanism for articulating the interests of the insured population towards the health care providers
- are not financially viable, or their financial viability is not known

These observations are elaborated on in the following section and conclusions outlined towards developing a national health insurance system.

Achieving high coverage of the population

As the study has shown, the coverage achieved by the CBHI schemes assessed in this study is extremely low. With an average enrolment of 3.4 per cent of their catchment area population for public schemes and 2.7 per cent for private schemes, neither group demonstrates that they would be able to reach a high level of population coverage. The reasons have to be sought in the limited capacities of schemes, which are generally based on one health facility (in the case of public schemes) or on a small group of motivated individuals (private schemes). These approaches seem unable to provide sufficient management and human resource capacities to reach a significant proportion of the population.

Without a stronger organisational support structure to ensure the fulfilment of the basic functions of a health insurance scheme (such as awareness creation, membership enrolment, membership administration, and claims administration), these isolated CBHI schemes are left alone and depend on the personal engagement of members and the support services of donor organisations. The government CBHI schemes are completely detached from government support structures in their health insurance management; for example, the district health officers/public health officers are not involved in supporting public schemes in any way.

In order to achieve a significantly high coverage of the population through a viable health insurance scheme, a considerably stronger organisational support structure has to be developed. Basing part of a national health system on small isolated CBHI schemes with very limited geographical coverage that offer access to limited health care facilities is an inadequate way to fulfil demand for health services (at least not at a reasonable cost and not without expensive external support structures).

A more promising approach would be to build up a scheme based on a higher level, such as a sub-district or a whole district (and maybe even integrated at a provincial or national level), or, alternatively, to provide decisive central support functions to local CBHI schemes from the district level. However, in order to determine which level and structures are appropriate, a thorough analysis of the capacities of government structures at the national and district levels and below is required.

District-based schemes would have two advantages over facility-based or group-based schemes:

- They could mobilise local government structures already in place to support the national health insurance scheme. This does not necessarily mean that the government would have to operate the schemes, but rather that the district government would play a supportive role (e.g., in mobilisation and awareness raising).

- Scarce funds could be used more efficiently in developing a health insurance management information system at the district level (or even higher), instead of within each health facility or small community group. In this way, economies of scale could be realised in the use of funds for the management support of schemes.

A district-based approach does not mean that every district would have to develop a management system of its own. Rather, the central government could invest in the development of an appropriate and functional management structure (by defining standard operating procedures, creating a health insurance management information system, developing manuals, and conducting training and so forth). These management structures could then be applied by each district in a coordinated, countrywide way. A district approach could still have a central structure backing it up, for example, through a risk equalisation fund. Alternatively, a health insurance scheme could be organised at the national level.

To assess the virtues and shortcomings of these two approaches, various factors should be considered. For example, a health insurance scheme addressing a large population with an agricultural base usually faces problems regarding the enrolment and administration of members. In the agricultural and informal urban sectors there is no formal payroll system to serve as the basis for membership enrolment and premium collection. In such a set-up, it is extremely important to use an organisational structure that is able to reach rural and urban populations engaged in informal employment.

Local government structures, reaching down to village councils, do have this outreach into the communities and, therefore, could provide an effective mechanism for awareness creation, mobilisation and enrolment support. The details of such an approach would have to be worked out for the various framework conditions.

A central government-based approach would not be able to substitute the organisational outreach that the local government structures would be able to provide. A central government approach would be likely to base its mobilisation efforts on local government structures. Therefore, irrespective of whether the overall legal responsibility for such a scheme lies at the central, provincial or district government level, a strong role by local government structures should be foreseen. This would have to be accompanied by some degree of independent decision making and flexibility for the local government structures to adjust to local conditions.

Placing the administration on a level below the district creates losses due to inefficiency, as a result of not exploiting all possibilities for economies of scale. However, the same mechanism as suggested for the districts could also be applied at a lower administrative level: a fully-fledged health insurance management system could be developed centrally, but applied at a more local level. An in-depth analysis would need to be conducted to assess the different options for the placement of the health

insurance management system (e.g., at the provincial, district or sub-district level) and to analyse their respective comparative advantages and disadvantages.

Ensuring equitable protection for the poor

The present CBHI structure does not sufficiently ensure the equitable protection of the poor. In the schemes assessed, an analysis of CBHI membership was done using the social classification criteria used by the governmental health information management system. This classification of social groups was used as a proxy indicator for socioeconomic status.

The data available indicates some success in enrolling members from disadvantaged groups in the schemes, especially in public schemes, in which 54 per cent of the members belong to marginalised groups (compared to private schemes with 26 per cent). The problem in the coverage of the poor becomes obvious when we look at the two dimensions essential to an equitable solution:

- a fair identification mechanism for enrolling the poor
- a fair funding mechanism for paying insurance premiums for those who cannot afford

The CBHI schemes assessed for this review fail to satisfy both of these criteria.

In relation to a fair identification mechanism, public schemes do provide subsidies for enrolling poor families into schemes, as opposed to private schemes. This is certainly an advantage and an achievement, to a limited degree. However, the identification and enrolment of the poor is completely arbitrary and does not follow any established criteria. Poor families enrolled in one year that may be interested in re-enrolling the following year can be denied the opportunity due to a 'rotation' of eligibility for the limited subsidies (e.g., as in Mangalabare). Because of the limited availability of subsidised memberships, the determination of who can benefit and who misses out results in a completely non-transparent, arbitrary and inequitable system.

A fair identification and enrolment mechanism for the poor should be based on objective criteria and a transparent selection process. This, of course, is a challenging undertaking. National level criteria for defining the poverty line should be included in such a process. Local communities should be able to participate in the definition and selection process, which may require the inclusion of adequate and locally-defined criteria for poverty. As compared to the procedures presently applied by CBHI schemes, the process should include more than a few arbitrarily-selected families in the programme. There is currently no national mechanism in place for the identification of the poor. The Poverty Alleviation Fund, however, is expected to develop and pilot a new mechanism in early 2013.

Regarding the second criterion, a fair funding mechanism for paying insurance premiums for those who cannot afford, the present procedures of the CBHI schemes are not satisfactory. The private schemes do not provide subsidies for the poor and are, therefore, not accessible to those who cannot pay on their own. The risk protection mechanism is limited to members of social groups that can at least afford to pay the premiums, which excludes the ultra poor.

Public schemes do provide some government budgetary funds to subsidise the premiums of the poor. However, the present system provides no incentive for increasing the number of poor families

enrolled. To the contrary, enlarging the number of poor families enrolled leaves the scheme with comparatively less funds per family as the overall amount of funds is provided by the government as a lump sum, independent of the level of pro-poor enrolment (beyond the minimum level). Hence, the mechanisms applied are insufficient to achieve the goal of social health protection for the ultra poor.

In public schemes, government budgetary funds are used mainly to subsidise premiums for poor families that are able to pay a reduced premium rate. As commendable as this premium subsidy may be, it does not achieve the objective of effectively covering the poorest segment of the population. In effect, a very narrow layer of the social strata of the population is targeted: people who receive the government premium subsidy have to be poor enough to qualify, but not too poor to pay a contribution to the premium. It is obvious that such a system fails to protect the people most in need, and, additionally, creates problems in identifying members from this socioeconomic background. With such a non-transparent criterion, families that may well have afforded the full premium might end up benefiting from a premium subsidy. What is worse, however, is that hardly any families are enrolled from the category of the ultra poor. Although, in principle, such a possibility exists in the schemes assessed, in reality, only a handful of ultra poor families have been enrolled.

To ensure the effective protection of the poor and ultra poor, the problem has to be solved at the grassroots. Obviously, poor people, especially the ultra poor, have difficulties raising sufficient funds to enrol in a health insurance scheme from their own means. The task of ensuring the social protection of poor and ultra poor families must be taken over by the national government. Hence, the transfer of government budget funds to a health insurance scheme to pay the premiums of the poor is an acceptable and effective mechanism for ensuring equitable access by the poor to health care services.

The allocation of government budget funds to targeted premium subsidies for the poor is one of the great advantages of social health insurance systems, as compared to a complete funding of health care providers through government budget funds. In a 'free-for-all' funding approach, the government subsidises the provision of health care to those social groups that can afford to pay as well as those that cannot. In a social health insurance framework, the better-off families would be expected to pay part of the health care costs from their own means, while scarce government funds are concentrated on paying premiums for the poor.

In order to be more effective in a social health insurance framework, as compared to the present CBHI schemes, a mechanism must be established where government budget funds can be used on a large scale to pay the premiums of the poor and ultra poor. Such a mechanism should create incentives for increasing enrolment (i.e., by providing budgetary funds based on the number of enrolled families instead of a pre-determined lump sum). For example, regulations could state that at least 25 per cent of enrolees should be from underprivileged groups and that their premium should be subsidised by a minimum of 60 per cent.

However, the budgetary implications for the government of paying subsidies per poor household enrolled, instead of in a lump sum must be considered. The Ministry of Health and Population/ Department of Health Services may also consider providing an additional budget to CBHI schemes on a lump sum basis for social marketing, campaigns and administrative purposes.

Building up an efficient 'voice' mechanism

Apart from enabling targeted government subsidies for enrolling the poor, a social health insurance scheme has a second big advantage compared to a purely tax-funded system of health care provision. This advantage is the creation of a 'voice' mechanism in which the health insurance scheme represents the interests of the insured towards the health care provider. These interests are structurally different from the interests of the health care provider: while the insured clients of health services have an interest in receiving more and better services for their defined payments, the health care provider has an interest in obtaining more funds for the health care services provided. A health insurance scheme should, therefore, be able to negotiate with the health care provider on behalf of its members for quality improvements and the extension of services.

Obviously, health insurance schemes and health care providers are only in a position to negotiate with each other when they are organisationally distinct. A purchaser-provider split fulfils this criterion, i.e., where the health insurance scheme is organised in a structure separate from the health care provider. In the schemes assessed as part of this review, only the privately-operated schemes have a purchaser-provider split. The public schemes do not have such a split, as the health insurance scheme is operated by the health care provider and hosted in the health care facility. In such a constellation, an independent articulation of the interests of the insurance members is hardly possible. However, some voice mechanisms have been established in these schemes. Membership assemblies play such a role to a very limited extent.

In order to build up an efficient 'voice' mechanism in a future health insurance system a purchase-provider split is recommended. Separate institutional entities should represent the interests of insured members and providers of health care. This, however, does not necessarily mean that the health insurance scheme has to be organised as a private, membership-based programme. The operation of a social health insurance scheme as a governmental body, e.g., under the supervision of the districts, is equally possible. In such a case, it is important to give the health insurance scheme enough autonomy to effectively represent the interests of the insured population towards the health care providers, which may be partly government operated and partly private. In order to establish an effective voice mechanism in such a setting there must be vertical accountability (e.g., to district or higher-level government authorities), as well as mechanisms for 'horizontal' accountability to the members of the scheme and the general public. This public accountability constitutes an important check and balance.

Ensuring financial viability

Finally, an effective health insurance scheme has to ensure financial viability. As shown above, the existing CBHI schemes are either not financially viable or their financial viability is not known as there are no data available and no suitable monitoring instruments in place to measure them. An evaluation of the claims ratio shows that the medical expenses of the schemes (both public and private schemes), in the majority of schemes, are much higher than the premium income of the scheme.

Data from 2010/11 shows that the claims ratio (ratio of total costs for health services to total premium collection including government subsidies for premiums) is more than 100 per cent in

four out of the six public schemes. These CBHI schemes are not sustainable, even if the government fully subsidises the premiums of all enrolees. Therefore, firstly, the benefit package and the premium amounts should be adjusted to match each other. However, while re-adjusting the benefit package and premiums, the payment capacity of both the government and households has to be carefully assessed.

In public schemes, the utilisation of government resources (in terms of government personnel fulfilling insurance management functions and the use of government premises, electricity, transport and office equipment) is not clearly broken down in the records and, therefore, does not allow a precise inclusion of such costs in the calculation of the incurred expense ratio. A full allocation of these costs would require an additional costing exercise in which the working time of government employees would be observed and more precisely allocated to the schemes, and the use of other equipment and resources would be costed and allocated to the schemes. The scope of this study did not allow such an exercise. Despite this limitation, the data collected on the claims ratio indicates a low level of financial viability. The mere fact that the schemes have no overview of their incurred expenses and are not able to monitor their performance is a problem in itself.

A future health insurance system would have to ensure financial viability. As already mentioned, a health insurance system does not have to rely on premium income alone. Government contributions (in effect premium income funded by governmental budgets) may complement premiums collected from members. This, however, needs a transparent and long-term orientation, ideally linked to the funding of the membership of poor and needy segments of the population.

Together with financial viability is the requirement to build up a suitable financial management structure that allows the measurement and monitoring of all relevant financial indicators. A suitable health insurance management information system is needed to fulfil essential functions such as membership administration, claims administration, and financial monitoring.

Next steps

Designing the pilots will require specifying the approach, for which the following questions will have to be addressed:

1. What enrolment mechanism would be appropriate for a rural/agricultural population and urban population working largely in the informal sector (outside formal employment and without pay slips)? How can existing local structures (e.g., wards, VDCs/ municipalities, districts and possibly other structures) be best utilised to play a role in the enrolment of the population?
2. What should core elements of a benefit package look like in order to optimally meet the needs of the population, in a context where several government programmes are already providing free access to selected health services? Such core elements would have to be tailored to the varying availability of health care in Nepal because of its diverse geographic conditions and access.
3. How can a strong insurance management information system be developed that allows the new health insurance system to appropriately handle data management on membership enrolment/ re-enrolment, claims processing and financial management?

4. How can the health insurance system develop a feedback mechanism that allows for the monitoring of the quality of care provided to its members?
5. How should the pooling of funds be optimally organised?
6. What mechanism would allow the identification and inclusion of the poor in health insurance in a fair, transparent and equitable way?

In the wake of the World Health Report 2010 *'Health system financing: A path to universal coverage'* (WHO 2010) a number of countries are presently developing health insurance systems designed to address these questions using various approaches ranging from compulsory health insurance (e.g., Mexico, Rwanda, China) (Savedoff and Gottret 2008) to voluntary health insurance. In Tanzania, for instance, a project funded by the Swiss Government presently supports one region (Dodoma) in transforming the rural Community Health Funds, which were previously operated by the government health service, into viable health insurance organisations (Stoermer et al. 2011). Similar to the public schemes operated in Nepal, these Community Health Funds used to depend on the management capacities of the health facilities and were operated as a 'side business' by health personnel. A provider-purchaser split is now being implemented in which the schemes are provided with their own management and personnel independent from the health facility and backed up by a strong insurance management information system able to manage the data required for enrolment, provider payment, financial management and the collection of user feedback. The re-organised schemes are still fully embedded in the local government structure. Nepal would also require a tailor-made solution for the embedding of health insurance structures based on an analysis of the governance capacities and the specific conditions in the country.

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Annexes

Annex 1: Schedule of study activities

Date	Place	Activity	People
2 Sep 2011	Hotel Everest	Initial presentation of study: objectives, methodology	Study team (MEH Consultants), GIZ, MoHP, supporting agencies (KOICA, PHECT-Nepal and Karuna Foundation Nepal)
20 Oct 2011	GIZ office	Presentation of study objectives and methodology Selection of schemes for review	GIZ, MoHP, PHCRD and supporting agencies (KOICA, PHECT-Nepal and Karuna Foundation Nepal)
21 Oct 2011	MEH Consultants	Refinement of questionnaires and data collection tools	Study team; J Henning (GIZ)
23 Oct 2011	Mangalabare PHCC	Review of Mangalabare CBHI, key informant interview and FGDs	Study team; J Henning (GIZ)
24 Oct 2011	Mangalabare PHCC	Review of Mangalabare CBHI, key informant interview and FGDs	Study team; J Henning (GIZ)
25 Oct 2011	Biratnagar	Meeting with District Public Health Officer Morang, Koshi Zonal Hospital	Study team; J Henning (GIZ)
26 Oct 2011	Kathmandu	Revision of study tools	Study team; J Henning (GIZ)
27 Oct 2011	Kathmandu	Revision of study tools	Study team; J Henning (GIZ)
30 Oct 2011	MEH Consultants	Revision of study tools	Study team, MEH Consultants
31 Oct 2011	MEH Consultants	Revision of study tools, circulated for comments	Study team, MEH Consultants
3 Nov 2011	MEH Consultants	Tools finalization meeting	Study team, MEH Consultants, GIZ
4 Nov 2011	MEH Consultants	Tools finalized and circulated	Study team
8 Nov 2011	Dhading	Review Saubhagya, FGD, key informant interview	Study team, MEH Consultants
9 Nov 2011	Dhading	Review Saubhagya, FGD, key informant interview	Study team, MEH Consultants
10 Nov 2011	Dhading	Review, Rajmarga, FGDs, key informant interview	Study team, MEH Consultants
17 Nov 2011	Chitwan	Review workshop at Chitwan, Bharatpur Hospital	Ram Bhandari, PHCRD, regional stakeholder
24 Nov 2011	Nawalparasi	key informant interview at Dumkauli	Study team, MEH Consultants
25 Nov 2011	Nawalparasi	Review of Dumkauli, FGDs, key informant interview	Study team, MEH Consultants
27 Nov 2011	Dang	Review of Lamahi, key informant interview	Study team, MEH Consultants
28 Nov 2011	Dang	Review of Lamahi, FGDs	Study team, MEH Consultants, PHCRD
29 Nov 2011	Nepalgunj	Review workshop at Nepalgunj, Bheri Zonal Hospital	Study team, MEH Consultants, PHCRD, regional stakeholder
30 Nov 2011	Kailali	Review of Tikapur District Hospital, key informant interview	Study team, MEH Consultants
1 Dec 2011	Kailali	Review of Tikapur District Hospital, FGDs	Study team, MEH Consultants

Date	Place	Activity	People
12 Dec 2011	Sunsari	Review of Madhesa, FGDs, key informant interview	Study team, MEH Consultants
13 Dec 2011	Sunsari	Review of Madhesa, FGDs, key informant interview	Study team, MEH Consultants
14 Dec 2011	Udaypur	Review of Katari, key informant interview	Study team, MEH Consultants
15 Dec 2011	Udaypur	Review of Katari, FGDs, key informant interview	Study team, MEH Consultants
16 Dec 2011	Rautahat	Review of Chandranigahapur, key informant interview	Study team, MEH Consultants
17 Dec 2011	Rautahat	Review of Chandranigahapur, FGDs, key informant interview	Study team, MEH Consultants
26 Dec 2011	Kathmandu	Review of Chapagaun PHCRC, key informant interview	Study team, MEH Consultants
27 Dec 2011	Kathmandu	Review of Chapagaun PHCRC, FGD	Study team, MEH Consultants
28 Dec 2011	Kathmandu	Review of Kirtipur, Bikalpa, FGDs, key informant interview	Study team, MEH Consultants
29 Dec 2011	Kathmandu	Review of Chapagaun PHCRC, FGDs	Study team, MEH Consultants
30 Dec 2011	Kathmandu	Review of Kirtipur, Bikalpa, FGD, key informant interview	Study team, MEH Consultants
8 Jan 2012	Dhading	FGDs Saubhagya, Rajmarga	Study team, MEH Consultants
11 Jan 2012	MEH Consultants	Format prepared for quantitative data analysis	Study team, MEH Consultants
12 Jan 2012	MEH Consultants	Quantitative data analysis (ethnicity, total HHs, insured HHs)	Study team, MEH Consultants
13 Jan 2012	MEH Consultants	Quantitative data analysis (ethnicity, total HHs, insured HHs)	Study team, MEH Consultants
19 Jan 2012	Rasuwa	Review of Syaphru, FGDs	Study team, MEH Consultants
20 Jan 2012	Rasuwa	Review of Syaphru, key informant interview	Study team, MEH Consultants
23 Jan 2012	MEH Consultants	Quantitative data analysis (ethnicity, total HHs, insured HHs)	Study team, MEH Consultants
24 Jan 2012	MEH Consultants	Quantitative data analysis (ethnicity, total HHs, insured HHs)	Study team, MEH Consultants
25 Jan 2012	MEH Consultants	Progress briefing, study team	Study team, MEH Consultants
26 Jan 2012	MEH Consultants	Findings analysis	Study team, MEH Consultants
27 Jan 2012	MEH Consultants, Teku	Findings analysis	Study team, MEH Consultants
29 Jan 2012	MEH Consultants, Teku	Findings analysis	Study team, MEH Consultants
30 Jan 2012	MEH Consultants, Teku	Findings analysis	Study team, MEH Consultants
31 Jan 2012	MEH Consultants, Teku	Preparation for presentation	Study team; J Henning (GIZ)
1 Feb 2012	MEH Consultants, Teku	Preparation for presentation	Study team; J Henning (GIZ)
2 Feb 2012	MEH Consultants, Teku	Summary findings, presentation at MoHP	Study team; GIZ, MoHP, PHCRD

Date	Place	Activity	People
3 Feb 2012	MEH Consultants, Teku	Presentation, feedback incorporated	Study team, MEH Consultants
5 Feb 2012	MEH Consultants, Teku	Presentation, feedback incorporated	Study team, MEH Consultants
13 Feb 2012	Kathmandu	Findings sharing in flagship training, Kathmandu	Study team, MEH Consultants

Annex 2: List of partners in preparation meetings

	Name	Designation and organisation	Meeting(s) attended
1	Dr Anand Shrestha	Director, PHCRD	20 Oct 2011
2	Mr Madan Shrestha	PHCRD	2 Sep 2011; 20 Oct 2011
3	Mr Ramji Ghimire	PHCRD	2 Sep 2011; 20 Oct 2011
4	Mr Chandra Bahadur BC	PHCRD	2 Sep 2011; 20 Oct 2011
5	Mr Dol Raj Sharma	PHCRD	2 Sep 2011
6	Mr Rupnarayan Khatiwada	PHCRD	2 Sep 2011
7	Mr Subodh Lamichhane	PHCRD	2 Sep 2011
8	Mr Shree Ram Thapa	PHCRD	2 Sep 2011
9	Mr Gagan Singh Tinkari	PHCRD	2 Sep 2011
10	Dr Bhim Singh Tinkari	PHCRD	2 Sep 2011
11	Mr Basanti Maharjan	PHCRC Chapagaun	2 Sep 2011
12	Mr Navin Kumar Mishra	PHC Lamahi, Dang	2 Sep 2011
13	Dr Bhawesh Thapa	PHC Mangalbare, Morang	2 Sep 2011
14	Mr Ramsaran Adhikari	PHCRD	2 Sep 2011
15	Mr Yadu Nepal	PHCRD	2 Sep 2011
16	Ms Prabha Baral	Section Officer, MoHP	20 Oct 2011
17	Mr Krishna Bahadur Karki	Under Secretary, MoHP	2 Sep 2011
18	Mr Yogendra Gauchan	Revenue Administration Training Centre, MoF	2 Sep 2011
19	Dr Anil Raj Bhattarai	Director, Insurance Board	2 Sep 2011
20	Mr Shyam Shrestha	Bikalpa Cooperative	2 Sep 2011
21	Mr Prabhat Thapa	Assistant manager; KOICA/HIMAL	2 Sep 2011; 20 Oct 2011
22	Mr Sun Hee Park	KOICA/HIMAL	2 Sep 2011
23	Ms Latika Maskey Pradhan	AusAID	2 Sep 2011
24	Dr Narendra Kumar Khanal	Tikapur Hospital, Kailali	2 Sep 2011
25	Mr Moti Ram Jaisi	Tikapur Hospital, Kailali	2 Sep 2011
26	Dr Ram Kumal Shah	Katari Hospital	2 Sep 2011
27	Mr Mandar Shikhar Benarjee	Programme Coordinator, Karuna Foundation Nepal	2 Sep 2011; 20 Oct 2011
28	Mr Bikash Bajracharya	Programme Coordinator, Karuna Foundation Nepal	20 Oct 2011
29	Mr Deepak Raj Sapkota	Karuna Foundation Nepal	2 Sep 2011
30	Ms Kimat Adhakari	Karuna Foundation Nepal	2 Sep 2011
31	Ms Aradhana Thapa	Karuna Foundation Nepal	2 Sep 2011

	Name	Designation and organisation	Meeting(s) attended
32	Dr Basant Maharjan	PHECT Nepal	2 Sep 2011; 20 Oct 2011
33	Mr Manfred Stormer	Consultant, Swiss TPH	20 Oct 2011
34	Mr Cyril Nogier	Consultant, Swiss TPH	20 Oct 2011
35	Mr Shyam S Sharma	Consultant, MEH Consultants	20 Oct 2011
36	Mr Ram Bhandari	Consultant, MEH Consultants	2 Sep 2011; 20 Oct 2011
37	Mr Kailash Rijal	Consultant, MEH Consultants	2 Sep 2011; 20 Oct 2011
38	Ms Junu Hada	Consultant, MEH Consultants	2 Sep 2011; 20 Oct 2011
39	Ms Franziska Fuerst	GIZ	20 Oct 2011
40	Dr Ghan Shyam Gautam	GIZ	2 Sep 2011; 20 Oct 2011

Annex 3: List of people met

CBHI Scheme	Period	Person	Position
Public CBHI schemes			
Managalabare PHCC, Morang, Eastern Development Region	23 and 24 Oct 2011	Muktinath Neupane	CBHI Chairperson
		Dr Bawesh Thapa	Medical Officer
		Mahesh Chaudhary	CBHI Focal Person
		Nabaraj Subba	District Public Health Officer, Morang
		Dr Umakanta Jha	Medical Superintendent Koshi Zonal Hospital
Katari Hospital, Udaypur, Eastern Development Region	15 Dec 2011	Ram Bahadur Pokhrel	CBHI Management Committee Chairperson
		Dr Ram Kumar Shah	Medical Officer
		Khagendra Prasad Adhikari	CBHI Focal Person
Chandranigahapur PHCC, Rautahat, Central Development Region	17 Dec 2011	Ananta Koirala	CBHI Management Committee Chairperson
		Dr Kundan Chaudhary	Medical Officer
		Guna Raj Ghimire	CBHI Focal Person
Dumkauli PHCC, Nawalparasi, Western Development Region	25 Nov 2011	Hira Lal Kharal	CBHI Management Committee Chairperson
		Jeevan K Shrestha	Acting In-charge
		Jageshwor Bhusal	CBHI Focal Person
Lamahi PHCC, Dang, Western Development Region	27 Nov 2011	Om Prakash Suvedi	Health Facility Operation and Management Committee Chairperson
		Tilak Ram Basnet	CBHI Management Committee
		Tilak Ram Chaudhary	CBHI Management Committee
		Dr Mahesh Gautam	Medical Officer
		Tilak Ram Chaudhary	CBHI Management Committee
		Navin Kumar Mishra	CBHI Focal Person
Tikapur District Hospital, Kailali, Far-West Development Region	1 Dec 2011	Moti Ram Jaisee	CBHI Management Committee Chairperson
		Dr Narendra Kumar Khanal	Medical Officer
		Basudev Bajagain	CBHI Focal Person

CBHI scheme	Period	Person	Position
Private CBHI schemes			
Rajmarga Health Cooperative, Dhading, Central Region	10 Nov 2011	Netra Paudel	Acting Chairperson, Cooperative
Madesha SHP, Karuna Foundation Nepal, Sunsari, Eastern Region	12 Dec 2011	Krishna Kumar Nepal	Health Facility Operation and Management Committee Chairperson
		Hari Bahadur Adhikari	CBHI Coordinator
		Mahesh Pokhrel	Facility In-charge
		Yogendra Giri	Programme Manager, Karuna Foundation Nepal
Saubhagya Laghu Swastha Bittyae Sangstha, Dhading, Central Region	8 Dec 2011	Shanta Khadka	CBHI Coordinator
		Shanta Pandey	CBHI Assistant
PHRC, Chapagaun, Lalitpur, Central Region	27 Dec 2011	Chandra Sundar Maharjan	CBHI Management Committee Member
		Ram Krishna Prajapati	Executive Director, PHCRC
		Basanti Maharjan	CBHI Focal Person
Bikalpa Cooperative Ltd, Kirtipur, Kathmandu, Central Region	28 Dec 2011	Ashok Bhansari	Cooperative Chairperson
		Shyam Shrestha	Advisor
		Narayan Maharjan	Board Member
		Nirmala Bhandari	Secretary
Syaphru HP, Karuna Foundation Nepal, Rasuwa, Central Region	19 Jan 2012	Nurbu Chirring Tamang	CBHI Management Committee
		Enough Syangden	HP In-charge

Annex 4: Questionaries and other survey tools

Questionnaire A: For health provider management

Date: Place:

General

Name of the health facility/organisation:

Address:

Name and positions of the interviewees:

Contact: (email/phone)

Scheme started since:

Discussion themes/questions

1 Socioeconomic context ***(not to be done if data is already collected with the CBHI)***

Population coverage

S.N.	Name of the VDCs/ municipalities	Total HHs	Population		
			Male	Female	Total

What are the common health problems in your community (catchment area)?

List top five diseases (HMIS 32)

1.

2.

3.

4.

5.

Describe the health seeking behaviour among the community people (Do they go to the HP or sub-HP or traditional healer, or do they ignore their illness? Do they go to the pharmacy instead of the HP to get medicine or do they use a traditional method?)

People's priority of health seeking behaviour (health facility)

1. .....

2. .....

3. .....

4. .....

5. .....

What is the level of poverty (% persons below the poverty threshold?)

S.N.	Name of the VDCs/ municipalities	Total HHs	% HH having own food production sufficient for one year	Average household income (NPR)	% of HHs having no land

2 Administrative arrangements with the CBHI *(not to be done if data is already collected with the CBHI)*

How long has your facility been working with CBHI?

What type of arrangements do you have with CBHI? (contract, specify)

What type of services do you provide to the CBHI members? (primary care, preventive, outpatient/inpatient, laboratory/ diagnostic, maternity, drugs, transport, other)

What are the services you are rendering to the CBHI members that are not covered under free health services?

Has there been any change in the benefit package (under CBHI) that you provide over time?

Do you feel any lacking in the benefit package?

Are the members of the CBHI treated differently than non-members (e.g., counselling, waiting time, priority in ambulance service) ?

Is there a differentiation in prices for similar services between CBHI members and non-members?

Does your health facility assign staff specifically for CBHI clients? If so please specify.

Are there any incentives provided to the staff attending to CBHI matters? If so, in what form?

What are the payment modalities for the services provided to the CBHI members? (fee for services, payment per day, payment per case, capitation etc.)

How did you define the payment process and the level of payment?

Are you satisfied with this modality of payment?

Do you keep separate records for CBHI insured?

How is the identification of members done? (membership card, ID card)

How do you verify the entitlement of members? (identify members from insured HH)

3 Utilisation pattern

Utilization Information

	HHs/member coverage by year							
	2060/61 (2003/04)	20061/062 (2004/05)	20062/063 (2005/06)	2063/064 (2006/07)	2064/065 (2007/08)	2065/066 (2008/09)	2066/067 (2009/10)	2067/068 (2010/11)
Total no. patient male								
Total no. patient female								
CBHI members male								
CBHI members female								

What are the reasons behind increasing or decreasing of utilisation by CBHI members?

4 Pattern of expenditure

What are the costs for the health facility and the revenue from the CBHI over the last three years?

SN	Particulars	2065/066 (2008/09)	2066/067 (2009/10)	2067/068 (2010/11)
	Total income (all sources)			
	Total income received in the form of co-payments made by CBHI beneficiaries			
	Revenue from CBHI			

Note: Data on cost to be collected through financial statement.

Do you have managerial freedom to utilise the fund generated through insurance? (Can the fund also be used to incentivise the staff?)

5 Review, monitoring, supervision and Governance

What kind of monitoring tool or mechanism do you have so as to ensure that the health facility keeps its contractual obligations towards the CBHI members?

Do you have any periodic reporting system in place? If yes, to whom do you report?

Do you have any mechanism to get feedback on your reports?

Do you prepare planning and review documents? If yes, can you share them?

Do you have any mechanism for assessing members' complaints and a solution mechanism?

6 Role of the government/DDC/VDC/NGOs

Which kind of financial and administrative support do you get for cooperating with the CBHI scheme? By whom and in what form?

7 Self-assessment and future perspective

Do you think that the CBHI scheme has helped you to improve your services and infrastructure?

What is the impact after the implementation of the insurance scheme on the quality of the services?

Changes	Availability of drugs	Attitude of health staff	Infrastructure, equipment, laboratory facility	Others, specify
Very much improved				
Improved				
Not improved				
Worsened				
I don't know				

Is the relationship/interaction between health facility and CBHI good? If yes, what do you like? If not, what would you like to see changed?

What are the perceptions of local people towards health insurance and what are their expectations of it?

Do you regularly conduct patient satisfaction surveys in general? And for the CBHI members? If so, what are the major findings?

What do you think about the alignment of CBHI scheme with other government programmes?

What changes did you observe in the CBHI since the implementation of the Free Health Care Policy?

Do you see this scheme as suitable for being replicated in other parts of the country? If yes, do you suggest any modification? If no, why not?

How are the needs of the poor and disadvantaged groups (Dalits, Janajatis, etc.) taken into account by the CBHI and by the health facility?

How do you see the future of this scheme? What improvements do you suggest?

Do you have any queries/suggestions?

Note: The factsheet developed by the Micro Insurance Network was used to collect financial data from CBHI schemes.

Questionnaire B: For CBHI management committee (chairperson)

Date: Place:

General

Name of the health facility/organisation:

Address:

Name and positions of the interviewees:

Contact: (email/phone)

Scheme started since:

Discussion themes/questions

1. Socioeconomic context

Population coverage

S.N.	Name of the VDCs/municipalities	Total HHs	Population		
			Male	Female	Total

What are the common health problems in your community?

Describe the health seeking behaviour among the community people (Do they go to the HP or sub-HP or traditional healer, or do they ignore their illness? Do they go to the pharmacy instead of the HP to get medicine or do they use a traditional method?)

People's priority in health seeking behaviour:

1. _____
2. _____
3. _____
4. _____
5. _____

What is the healthcare provision situation in your area

How many public/private healthcare service providers are available in your area and how far are they from this health facility? (Give number or more than 5.)

	Public	Distance/duration (minutes walk/ride/km)	Private	Distance/duration (minutes walk/ride/km)
Hospitals				
Clinics				
Pharmacy				

2. Setting up of the CBHI

What were the motivating factors for the start of the scheme?

Did you do a study before the implementation of the scheme: feasibility study, or study to evaluate the effect of insurance later on? Can you share the results?

Who were the initiator/promoters of the schemes? (e.g., healthcare provider, group, individual members, NGOs)

How long did it take to set up the CBHI?

Did you obtain any kind of support? If yes:

Technical support from MoHP, NGOs, donors:

Financial support:

Administrative/logistical support:

Other (specify)

3. Legal issues

What is the legal status of the CBHI?

Is the CBHI registered? If so, with whom?

Under what guidelines/regulations is the CBHI operating?

Does the CBHI have a written statute?

4. Available insurance products

S.N.	Membership types	Premium (amount paid by members)	Premium (source)	Benefit package (primary care, preventive, outpatient/inpatient, laboratory/diagnostic, maternity, drugs, transport, other); are there ceilings/ other services?

5. Membership pattern

What provisions do CBHI have for membership? (e.g., written contract, receipt, social control by community, policy document)

How is membership constituted? (e.g., voluntary/compulsory, individual/ household/ group membership)

Which family members are included in a household membership?

What are the marketing strategies to attract CBHI members?

What is the premium for different family members? (are dependants included with/without lower premiums)

What is target population and composition? (number by age and gender)

What process do you have in place to reach your target population?

What is the enrolled population?

S.N.	Name of the VDCs/ municipalities	Programme covered HHs	Members		
			Male	Female	Total

Type of membership/ HI product/premium type	HHs /Members coverage and renewal by year							
	2064/065 (2007/08) members	2064/065 (2007/08) renewal	2065/066 (2008/09) members	2065/066 (2008/09) renewal	2066/067 (2009/10) members	2066/067 (2009/10) renewal	2067/068 (2010/11) members	2067/068 (2010/11) renewal

What is the socioeconomic profile (prevailing economic activity) of the enrolees relative to non-enrolees in your community?

S.N.	Name of the VDCs/ municipalities	Total HHs	% HH having own food production sufficient for one year	Average household income (NPR)	% of HHs having no land

Members by caste	< 5 years	6–16 years	17–59 years	60 years and above	Total
Bhramin/Chhetri					
Janajati/ethnic group					
So called lower caste people					
Others, e.g., Muslims					
Total					

What are the reasons behind increasing or decreasing enrolment/dropout rate?

How is the identification of members done? (membership card, ID card)

Is the card issued at household level or individual level?

Can members use health services from several facilities as a package of insurance scheme? If so, what are the differences in services provided? (detail public/private)

6. Benefit package

Who defines the benefit package and what is the basis for defining it?

What changes in the benefit package were made over time?

What are the services covered by this scheme beyond the package of Free Health Care programme? (detail per membership type)

What do you feel is lacking in the benefit package?

7. Premium mechanism

Who pays the premium to whom? (employer, insured person, other)

What is the procedure for collection of premium?

How can premiums be paid? (instalments or one annual payment, cash or kind; detail per type of membership if applicable)

What is the duration for enrolment? Is there a minimum duration for enrolment?

Can people enrol anytime of the year?

Is there any waiting period before being entitled to the benefits?

How are the premiums defined, and by whom? (experience rating, actuarial process, arbitrary)

Are there some exemptions from premium payment? (total, reduced rates; describe these groups, how are they identified and describe problems encountered)

SN	Who is exempt	Exemption amount	Basis of exemptions (proof/ documentations)

8. Administration of the CBHI

CBHI internal management

How was the board/committee constituted? (representation/process/duration of term)

Is there a regular manager?

Which professional background do the top management persons have?

Chairperson

Vice chairperson

Treasurer _____

How are statistics collected? (technical practice, forms, IT)

How is bookkeeping done? (accounting guidelines, IT, bank account, signatories)

Is the CBHI scheme integrated with other programmes or independently administered?

How is the organisational link between the community/community organisations and the health insurance scheme (CBHI)?

How and by whom are the decisions on fund utilisation, human resources and other aspects made? (i.e., how is the scheme governed)

CBHI and members

What is the process of member registration?

How do you verify for entitlement for different types of membership?

In case of ceiling, how do you control these ceilings?

CBHI and providers

Is there any contract with providers? If yes, what are the provisions (e.g., basis for payment)?

How do the health care providers verify the entitlement of members? (identify members from insured HH)

In case of ceilings, how do you control these ceilings?

How is claims processing done, including verification?

What do CBHI members have to pay at the time of getting different services? (co-payment, advance payment, etc. for medicine, transport, laboratory, etc.)

Infrastructure of the CBHI

Offices/branches, _____

Vehicle (for administration purposes), _____

Equipment (IT, etc.) _____

Human resources working in the CBHI

How many staff work for the CBHI? Position; qualifications; time spent (%)

Do they have clear a job description or terms of reference?

Did they receive specific training on micro-health insurance at the start of their work?

Is there mechanism for human resource capacity development? (e.g., training, education)

Main indicators

Please provide data on the following: (by year)

- Total amount of payments made by the CBHI to the providers (detail by provider)
- Total number of services dispensed to CBHI members

Provide details of CBHI expenditure along with financial tables (Excel file)

Financing sources

S.N.	Source of funding	2065/066 (2008/09)	2066/067 (2009/10)	2067/068 (2010/11)
	Premiums			
	Central government contribution			
	DDC contribution			
	VDC contribution			
	Other			
	Total			

If there are contributions from VDC, DDC and central government, then what are they for?

If there are donations in addition to government subsidies (including non-monetary such as equipment, housing, maintenance assistance etc), provide details.

If there are loans, then for which purposes, what is the source of loan?

Other (specify) _____

Do you receive any non-financial external support such as technical or in-kind? If yes, what kind of support do you receive and by whom?

9. Resource pooling and risk management

Financial risk management

Where/by whom is the fund held?

What are the rules for the management of the fund?

Does the CBHI have re-insurance? If so, how does this work?

Who pays the deficit if the CBHI run at a loss?

Administrative risk management

How do you control the problem of over-utilisation? (co-payment, etc.)

How do you make sure that the CBHI does not mainly enrol people with high health risks? (household/group enrolment, waiting period, exclusion, etc.)

How do you control fraud? (provider and members)

10. Purchaser-provider relations

Does the CBHI operate its own healthcare services?

Does the CBHI contract its own providers? Specify the type and number of providers.

What is the modality of payment to the providers? (outpatient, pharmacy, inpatient, primary care): per diem, per case, fee for service)

What is the modality of payment to the referral level? (outpatient, pharmacy, inpatient, primary care, per day, per case, fee for service)

What is the attitude of the healthcare providers? (do they adhere to the contracts/ agreements?)

11. Review, monitoring, supervision and governance

Do you have any indicators/basis to assess the performance of the insurance scheme over years? If yes, can you share them?

What is the practice of auditing?

How do you monitor and supervise the scheme? (internal/external, who are involved, how it works, any plan for capacity enhancement)

What mechanisms do you have to ensure standard quality and efficiency?

Do you have any mechanism for assessing members' complaints and a solution mechanism?

What mechanism do you have for good governance practices (transparency, accountability, participatory)?

12. Role of the government and MoHP

Is there supervision of the CBHI by the government authority? (which one, how often)

What kind of support do you receive from the government to implement this insurance scheme?

13. Self-assessment and future perspective

What is the impact after the implementation of the insurance scheme on the quality of the services?

Changes	Availability of drugs	Attitude of health staff	Infrastructure, equipment, laboratory facility	Others, specify
Very much improved				
Improved				
Not improved				
Worsened				
I don't know				

Details:

Does your CBHI perform well? If yes what do you like? If not, what would you like to see changed?

What are the perceptions of local people towards health insurance and what are their expectations of it?

Do you regularly conduct patient satisfaction surveys and healthcare provider surveys?

What are the strengths associated with this CBHI and factors contributing to its success?

What are the weaknesses associated with this CBHI and factors impeding its success?

What is your plan for the future on the implementation of health insurance? Do you have any plan to change the current organisational structure, implementation modality and rules?

Can the scheme continue without subsidies from the government or other donors?

Is this CBHI properly aligned with other government programmes and how?

What changes did you introduce into the CBHI since the implementation of the Free Health Care Policy?

Do you see this scheme as suitable for being replicated in other parts of the country? If yes, do you suggest any modification? If not, why not?

How are the needs of the poor or disadvantaged groups (Dalits, Janajatis, etc.) taken into account by the CBHI?

How are women's health related issues addressed in the CBHI?

How do you see the future of your scheme?

Do you have any queries/suggestions?

Note: The factsheet developed by the Micro Insurance Network was used to collect financial data from CBHI schemes.

Questionnaire C: For district and central level officers/experts

General:

Name of the CBHI:

Place: Date:

Name of the interviewee: Position:

Address: Contact: (email/phone)

Discussion themes/questions

Background discussion on different CBHI schemes implemented/supported by the government (6 public schemes) and other types of CBHIs (6 private schemes)

1. What is the institutional context for CBHI implementation? (existing legislation, existing legal status of CBHI, institutional support from MoHP, etc.)

2. What is the current role of the government/MoHP in supporting the CBHI in terms of the four following dimensions:
   - promoter and facilitator
   - adviser in the design phase
   - monitoring and evaluation
   - trainer
   - co-funder (subsidies for the poor?)

3. Are the existing CBHI schemes properly aligned with other government programmes (Free Health Care Policy for instance, exemption of the very poor/disabled/single women/elderly people/conflict affected people at district/zonal hospital hospitals)? Do you have suggestions for better aligning CBHI with other programmes?

4. What are the shortcomings and strengths with regard to the implementation of the CBHI in your district and in Nepal in general? How can these shortcomings be reduced and strengths be enhanced?

5. Would you prefer a model where the health care provider is running the insurance scheme or a model where the insurance scheme is independent from the service provider? Why?

6. Do you have a monitoring and reporting mechanism for the CBHI in place, and what do you monitor?

7. What are your views on the performance of CBHI schemes in your district?

	Very good	Satisfactory	Not satisfactory	Comments
Governance (transparency, accountability, participation)				
Oversight mechanism				

Sustainability (financial viability, administrative and management capacity, lifespan of the CBHI)				
Patient satisfaction				
Population covered				
Services covered				
Financial protection				

8. What is the impact of Free Health Care programme on the CBHI?

9. What are the measures implemented by the CBHI to address poor/disadvantaged group enrolment and participation? (performance in terms of equity)

10. Is there any support by the government given to the CBHI for enrolling the poor?

11. What is the impact of the CBHI on the quality of care for non-insured?

12. Is the CBHI a suitable instrument for improving access to quality health care? Why, or why not?

13. What additional benefits does the CBHI bring to improve access to quality health care (when compared to Free Health Care services)?

14. What do you suggest the government to do next regarding the improvement of CBHI schemes?

15. Do you have any queries/other suggestions?

Canvas for the three focus group discussions

A1. For enrolees

Name of the CBHI :

Place :

Date :

Participants of FGD: A separate attendance sheet

Discussion themes/ questions

What was the general health seeking behaviour before enrolling in the CBHI? Why: location (nearest to house), price (cheaper), free treatment, good facilities (bed), availability of drugs, trust (in personnel) etc.

What was the general health seeking behaviour after enrolling in the CBHI? Why: location (nearest to house), price (cheaper), free treatment, good facilities (bed), availability of drugs, trust (in personnel) etc.

What are the motivating factors for joining the CBHI?

Explain the specific value addition of CBHI in the context of free health care package?

What is the involvement of client in premium and benefit package setting process?

What are the benefits of joining CBHI? (benefit package)

Are there different options to choose for benefit package and premium?

Is the benefit package satisfactory in relation to the premium paid**?**

Would you have suggestions for changing the benefit package?

Are you satisfied with the quality of services you are getting?

What are your views on the affordability and utilisation of premiums?

What do you think about the payment modalities of the premium? Are you satisfied, or do you suggest changes?

What are the most important problems in the health facility where the insurance scheme is based?

(e.g., drugs are not available/good, staff are not skilled, staff are not friendly, inadequate facility/equipment, laboratory services not available/good, or other reason)

Do you think the health insurance contributes to overcoming this problem in the health facility?

Are you satisfied with the enrolment procedure in the scheme? Why?

What are the positive and negative aspects of CBHI?

Did you notice any changes after the implementation of health insurance scheme in the following areas (probing tips):

- availability of services and quality
- behaviour of health workers
- opening time of health facilities
- waiting time
- improvement of facility/equipment

Have you heard about the provision of free treatment at the district and zonal hospitals for the very poor, differently-abled people, single women, elderly people and conflict affected people?

Do you have any further comments and suggestions?

A2. For non-enrolees

Name of the CBHI :

Place :

Date :

Participants of FGD: A separate attendance sheet

Discussion themes/ questions

What are the general health seeking behaviour in this area? Why: location (nearest to house), price (cheaper), free treatment, good facilities (bed), availability of drugs, trust (in personnel) etc.

Are you aware of CBHI scheme in this area? If yes, what are the reasons for not joining the CBHI scheme of this area?

How can the situation of non-insured people in this area be compared with the insured ones in terms of receiving health care services?

Is there any difference in the quality of services provided by the health facility to the CBHI enrolled and non-enrolled people?

What are the most important problems in the health facility where the insurance scheme is based? (e.g., drugs are not available/ good, staff is not skilled, staff is not friendly, inadequate facility/equipment, laboratory services not available/good, other reason)

Do you think the health insurance contributes to overcoming this problem in the health facility?

Is the benefit package satisfactory in relation to the premium**?**

In order to cover a larger number of people in CBHI, what sort of changes in the benefit package would you like to make?

What is the enrolment procedure of this CBHI scheme?

What are your views on the affordability and utilisation of premiums?

What do you think about the payment modalities of the premium? Are you satisfied, or do you suggest changes?

Please explain some positive and negative aspects of this CBHI scheme.

Did you notice any changes after the implementation of health insurance scheme in the following areas (probing tips):

- availability of services and quality
- behaviour of health workers
- opening time of health facilities
- waiting time
- improvement of facility/equipment

Have you heard about the provision of free treatment at the district and zonal hospitals for the very poor, differently-abled people, single women, elderly people and conflict affected people?

Do you have any further comments and suggestions?

A3. For dropouts

Name of the CBHI:

Place:

Date:

Participants of FGD: A separate attendance sheet

Discussion themes/ questions

What was the general health seeking behaviour during CBHI enrolment? Why: location (nearest to house), price (cheaper), free treatment, good facilities (bed), availability of drugs, trust (in personnel) etc.

What is the general health seeking behaviour after dropping out of CBHI? Why: location (nearest to house), price (cheaper), free treatment, good facilities (bed), availability of drugs, trust (in personnel) etc.

What were the motivating factors for joining the health insurance (CBHI) at that time?

What were the reasons for not continuing the health insurance (CBHI)?

Do you see a specific additional value to being enrolled in a CBHI when at the same time the Free Health Care programme provides services?

Involvement of client in premium and benefit package setting process.

What were the benefits of joining CBHI? (benefit package)

Were there different options available in terms of benefit package and premium?

Was the benefit package satisfactory in relation to the premium paid**?**

Would you have suggestions to change in the benefit package?

What do you think about the payment modalities of the premium? Are you satisfied, or do you suggest changes?

What are your views on the affordability and utilisation of premiums?

Was the quality of health services satisfactory while you were a member of the CBHI?

What are the most important problems in the health facility where the insurance scheme is based? (e.g., drugs are not available/ good, staff is not skilled, staff is not friendly, inadequate facility/equipment, laboratory services not available/good, other reason)

Do you think the health insurance contributes to overcoming this problem in the health facility?

Were you satisfied with the enrolment procedure in the scheme? Why?

What were the positive and negative aspects of this CBHI scheme?

Was the management of the CBHI scheme satisfactory?

What would have to change in the CBHI for dropouts to rejoin the scheme?

Did you notice any changes after the implementation of health insurance scheme in the following areas (probing tips):

- availability of services and quality
- behaviour of health workers
- opening time of health facilities
- waiting time
- improvement of facility/equipment

Have you heard about the provision of free treatment at the district and zonal hospitals for the very poor, differently-abled people, single women, elderly people and conflict affected people?

Do you have any further comments and suggestions?

Annex 5: Inventory of CBHI schemes in Nepal (as of June 2012)

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
1	Bikalpa Cooperative Ltd, Kirtipur	2000	New CBHI model going to be implemented	CBHI scheme/ cooperative and service provided by the Kathmandu Model Hospital	HIMAL	Total members: 2,000	Registration, general physician's and specialist/consultant fees, inpatient general bed, any kind of surgical operation, any kind of laboratory test and investigation, X-ray, ultrasound and ECG, emergency services, general dental services (excluding tooth extraction and specialised dental services), acupuncture and moxibustion; 10% discount on CT-scan 70% subsidy, with provision of 20: 80 sharing of difference amount (between premium paid and subsidised amount) at end of the fiscal year	Co-payment: 30%
2	Chapagaun PHCRC, Lalitpur	1972	Running	CBHI scheme/PHCRC	HIMAL	Fee: Varies according to type of insurance scheme (HH, school, institutions, and industries) Total members:2,199	At least 50% discount on consultation (OPD, emergency, operation), diagnostics (laboratory tests, X-ray, ECG), admission (enrolment and bed) and medicine; no referral services available; medicine cost about 50% less than retail price; no ceiling on benefit package	Co-payment: 50%
3	Thimi Municipality and Korea Nepal Friendship Hospital, Thimi		Running	CBHI scheme/ Korea Nepal Friendship Hospital	HIMAL	Fee: 1,200 HHs and 500 institutions	All services (33 services) available in Korea Nepal Friendship Hospital	Co-payment: 50%; ambulance charge is free in the case of referral

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
4	Lamjung Community District Hospital, Lamjung		New CBHI model going to be implemented	CBHI scheme/District Hospital	HIMAL	Fee: 1,250 HHs	CT scans, MRIs, colour developer, heart surgery, neurosurgery, teeth replacement, glass, hearing machine, plastic surgery, other machines, artificial organ transplant, cancer, cosmetic eye consultation	Medicine: 20–50% Diagnostics (laboratory, X-ray): 20–50% ECG, USG: 20–50% Surgery: 50% Consultations: Free Inpatient services: 20–50%
5	PHECT-Nepal Community Health Insurance Programme, Kathmandu, Lalitpur and Dhading	1993	Running	Scheme operator: NGO (PHECT-Nepal) Service provider: Kathmandu Model Hospital and Kirtipur Hospital, run by PHECT-NEPAL Counterpart: Community based health/other cooperatives (for beneficiaries)		Membership: Voluntary Beneficiaries: Community based health/ cooperative members and their families Subsidy: 50–70% depending on modality of individual cooperatives (decided by individual cooperative) Total members: about 4,000 from six cooperatives (as at 2058/59 BS)	Doctor's consultation, operation charge, bed charge, investigation (available at Kathmandu Model Hospital and Kirtipur Hospital) No coverage of medicines and consumables	Co-payment: 30 –50% depending on individual cooperatives

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
5.1	Setidevi Health Cooperative, Setidevi, Kathmandu		Running	Cooperative	External assistance PHECT-Nepal		50% subsidy	Co-payment: 50%
5.2	Women's Health Cooperative, Tikathali, Lalitpur		Running	Cooperative	External assistance PHECT-Nepal		50% subsidy	Co-payment: 50%
5.3	Rajmarga Health Cooperation, Dhading	2003	Running	Cooperative based	External assistance PHECT-Nepal	Total members: 599	50% discount on consultation fees, diagnostics and admission (service available only in Kathmandu Model Hospital)	Co-payment: 50%
5.4	Mahila Ekata Cooperative Ltd, Kirtipur, Kathmandu		Running	Cooperative	External assistance: PHECT		50% subsidy	Co-payment: 50%
5.5	Kirtipur Multipurpose Cooperative, Kirtipur, Kathmandu		Running	Cooperative	External assistance: PHECT-Nepal		50% subsidy	Co-payment: 50%
6	CBHI Tikapur, Kailali district	2006/07	Running	Government scheme/ District Hospital	Government funding KOICA/ HIMAL technical support since 2011	Subsidy: 272 families Full payment: 716 families Total members: 988 families	Total benefit package NPR 6,000 (including medicine: NPR 3,500, emergency services, inpatient services, laboratory services, investigation NPR 1,500; ambulance NPR 1,000) Referral services for all above (Bheri Zonal Hospital, Nepalgunj) Contribution: General premium for new subscribers NPR 700; membership renewal NPR 600; subsidised premium rate NPR 250; subsidised renewal NPR 200	Co-payment: 10% on every service

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
7	Mangalabare PHC, Morang	2004	Running	Government scheme/ PHCC		Total members: 3,842	Medicine indoor (NPR 3,000); medicine outdoor (NPR 1,000); diagnosis (NPR 5,000); bed charge (NPR 1,000); operation (NPR 4,000); operation material (NPR 1,000); ICU (NPR 4,000); ambulance (NPR 1,000) one way; referral to Koshi Zonal Hospital	Co-payment: 50% on CT scan and endoscopy
8	Katari Hospital, Udaypur	2006	Running	Government scheme/ Hospital		Total members: 2,298	Medicine (NPR 3,500); diagnosis NPR 2,500); bed charge (NPR 2,500); minor surgery NPR 2,000); ICU (NPR 5,000); ambulance (NPR 7,000) and 50% discount on ambulance cost for referral to Janakpur and Rajbiraj Hospital for snakebite, delivery and poisoning	
9	Chandranigahapur PHC, Rautahat	2006	Running	Government scheme/ PHCC		Total members: 2,636	Medicine 15% co-payment and up to NPR 2,400; diagnosis 15% co-payment and up to NPR 1,100; referral 20% co-payment and up to NPR 1,000	
10	Dumkauli PHC, Nawalparasi	2004	Running	Government scheme/ PHCC		Total members: 1,676	Medicine (NPR 2,000); diagnosis (NPR 1,000); hospitalisation (NPR 500)	
11	Lamahi PHC, Dang	2006	Running	Government scheme/ PHCC		Total members: 6,259	Medicine (general members NPR 5,000, sponsored members NPR 5,000, per individual NPR 2,500); ambulance (general members 75% co-payment up to NPR 5,000, sponsored members 75% co-payment up to NPR 5,000, per individual 75% co-payment up to NPR 2,000); referral to government hospitals (general members 90% co-payment up to NPR 4,000; sponsored members 90% co-payment up to NPR 4,000; per individual 90% co-payment up to NPR 1,000)	

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
12	Saubhagya Laghu Swasthya, Dhading	2011	Running	Community run with community led structure	External donor funding, overall project management: Save the Children Implementing partners: DEPROSC and Nirdhan Technical partner: Micro Insurance Academy	Total members:1,809	Hospitalisation more than 24 hours (NPR 3,000 per person, NRs 20,000 annual cap); laboratory test (NPR 600 per person, NPR 3,000 annual family cap); imaging (NPR 400 per person, NPR 3,000 annual family cap); transportation (NPR 300 per event)	Annual renewal; family floater system; discount of 10% for families size above 4; reimbursement system; subsidies on some health services from providers
13	Sanjeevani Laghu Swastha Surakchhya Kosh, Banke	2011	Running	Community run with community led structure	External donor funding, overall project management: Save the Children Implementing partners: DEPROSC and Nirdhan Technical partner: Micro Insurance Academy	Annual membership fee depends on the benefit package Total members: 4,050	Hospitalisation (NPR 2,000); laboratory test (NPR 250); imaging (NPR 200); transportation (NPR100)	Family floater system; annual renewal; reimbursement system; subsidies on some health services from providers

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
14	Health Welfare Scheme, BPKIHS, Sunsari	2000	Running	Health insurance of staff and students under BPKIHS	No	All staff and their dependents (spouse, mother, father, unmarried children); female staff have option of choosing parents or in-laws Premium: NPR 500–1,500 depending on position held	Free services include consultations, dressing, general bed, critical care bed, surgery and other surgical procedures; 90% subsidy on laboratory and radiology investigations, physiotherapy, semi general bed and basic dental services (extraction, RCT, scaling, filling, dental X-ray); 50% subsidy on paying ward; medicine up to NPR 5,000/year applicable for inpatient only Lens, spectacles and hearing aids are not included	Co-payment: 10-50% on selected services
15	Emergency Welfare Fund (managed by GEFONT), Kathmandu	2005	Running	Trade union managed scheme	Danish Labour Union (only for reproductive health of working women)	GEFONT membership registration fee: NPR 60/year All members of GEFONT can be enrolled in the scheme with registration fee of minimum NPR 25 per person/ year	GEFONT has agreement with Helping Hand Community Hospital whereby its members are entitled to receive discount on: bed charge (50%); medicine (7%); consultations and surgery (30%)	Individual registration, co-payment

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
						Female members of GEFONT can receive benefit package even if they are not registered in the scheme		
16	Micro Health Insurance Programme, Sindupalchowk district	2010	Running (pilot project)	Community based scheme	No	Premium: NPR 50/month Total members: 10 Beneficiaries: 20 (total 10 woman and one children each)	Free registration, consultations, outdoor and indoor services, laboratory facilities, and certain defined medicines at Bahunepati, where Dhulikhel Hospital is managing its outreach clinic Referral services not covered	
17	Share&Care Madesha Eastern / Sunsari	2010	Running	Madesha SHP	Technical and Financial: Karuna Foundation	1st year: 551 2nd year: 421 Households	Premium Rs.1200 per year per household up to 6 members and Rs. 200 per additional member. Benefit: Primary care in the Sub Health and Inaruwa Hospital when SHP is closed and referral service from BPKIHS with a total ceiling of Rs.30,600	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.
18	Share&Care Bhokraha Eastern / Sunsari	2009	Running	Bhokraha SHP	Technical and Financial: Karuna Foundation	1st year: 165 2nd year: 451 3rd year: 564 Households	Premium Rs.500 per year per household up to 6 members and Rs. 100 per additional member. Benefit: Primary care in the Sub Health and referral service from BPKIHS with a total ceiling of Rs. 12,000	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.

SN	Name of the scheme, district	Starting date	Status	Type of scheme and organisational structure	External funding and assistance	Membership and beneficiaries	Short description of benefit package and contributions	Purchasing arrangement
19	Share&Care Aurabani Eastern/ Sunsari	2011	Running	Aurabani SHP	Technical and Financial: Karuna Foundation	1st year: 394 Households	Premium Rs.1000 per year per household up to 6 members and Rs. 200 per additional member. Benefit: Primary care in the Sub Health and Duhabi Hospital when SHP is closed and referral service from BPKIHS with a total ceiling of Rs.16,500	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.
20	Share&Care Bhaluwa Eastern/Sunsari	2011	Running	Bhaluwa SHP	Technical and Financial: Karuna Foundation	1st year: 415 Household	Premium Rs.1200 per year per household up to 6 members and Rs. 200 per additional member. Benefit: Primary care in the Sub Health and Inaruwa Hospital when SHP is closed and referral service from BPKIHS with a total ceiling of Rs,21,800	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.
21	Share&Care Syaphru Central/ Rasuwa	2009	Running	Syafru HP	Technical and Financial: Karuna Foundation	1st Year: 188 2nd Year: 164 Household	Premium Rs.1200 per year per household up to 6 members and Rs. 200 per additional member. Benefit: Primary care in the Health and referral service from Model Hospital with a total ceiling of 20000.	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.
22	Share&Care Mechchhe Central/ Kavre	2008	Running	Mechchhe SHP	Technical and Financial: Karuna Foundation	1st Year 468 2nd Year 295 3rd Year 220 4th Year 191 Household	Household is the unit. Premium Rs.500 per year per household. Benefit: Primary Care with additional drug and HR than Free Health Care provided by GoN.	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.
23	Share&Care Chapakhori Central/ Kavre	2009	Running	Chapakhori SHP	Technical and Financial: Karuna Foundation	1st Year 230 2nd Year 154 3rd Year 191 Household	Household is the unit. Premium Rs.700 per year per household. Benefit: Primary care in the Sub Health Post. For referral Agreement is made with Dhulikhel Hospital. Maximum up to 5000 without categorization.	Drug and reagents are purchased by HFOMC in the SHP and referral cost is paid directly to the hospital. Services are Cashless.

Deutsche Gesellschaft
für Internationale
Zusammenarbeit (GIZ) GmbH

Health Sector Support Programme (HSSP)
Department of Health Services
Teku, Kathmandu, Nepal
T +977 1 4261404
F +977 1 4261079
E hssp@giz.org.np
I www.giz.de/nepal