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*Personal Viewpoint*

# Social health insurance: A knowledge-do gap in eastern Nepal

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**Abstract**
Health care costs, and those for inpatient care in particular, pose a barrier to seeking health care, and cost be a major cause of indebtedness and impoverishment, particularly among the poor. The Ministry of Health in Nepal intends to initiate alternative financing schemes such as community and social health insurance schemes as a means to supplement the government health sector financing source. Social Health Insurance (SHI) is a mechanism for financing and purchasing / delivering health care to workers in the formal sector regulated by the government. Considering all these facts BP Koirala Institute of Health Sciences (BPKIHS) has introduced SHI scheme in 2000 as an alternative health care financing mechanism to the community people of Sunsari and Morang districts. In the beginning small area was elected as a pilot project to launch the scheme. A major objective of SHI is to reduce poverty caused by paying for health care and to prevent already vulnerable families from falling into deeper poverty when facing health problems. A total of 26 organizations with 19799 populations are at present in SHI scheme. Sixteen rural based organizations with 14,047 populations and 10 urban based organizations with 5752 people are the beneficiaries in this scheme. BPKIHS SHI Scheme is the outcome of the visionary thinking on social solidarity and as an alternative health care financing mechanism to the community. BPKIHS is mobilizing people's organizations and is offering health services through its health insurance scheme at subsidized expenses. This has helped people to avail with health facilities who otherwise would have been left vulnerable because of their penetrating health needs. There is huge gap between premium collection and expenditures. The expenditures are more and this may be due to knowledge – do gap in the program. If conditions are unsuitable, SHI can lead to higher costs of care, inefficient allocation of health care resources, inequitable provision and dissatisfied patients. It can also be more difficult to realize the potential advantages of SHI in future. The future challenges confronting the scheme are to give the continuity and sustainability of the program to its catchments areas. This might entail a shift in its program operation mechanism. People's active involvement is required, which will further provide a sense of ownership in the scheme amongst the people.

Health care costs, and those for inpatient care in particular, pose a barrier to seeking health care, and cost be a major cause of indebtedness and impoverishment, particularly among the poor. An individual with a low income may be unable to afford preventive care, or curative care in the event of illness, which may result in the worsening of his or her state of health.

The indicators are developed by Ministry of Health (MOH) for sustainable development of health financing and resource allocations in Nepal are as follows[1]:-

- At least 10% of health expenditure borne by elected local bodies e.g. District Development Committee (DDC), Village Development Committee (VDC), Municipalities in public health facilities by 2006/7;
- At least 5% of health expenditure borne by local community in public health facilities by 2006/7 e.g. Community Drug Program (CDP), Community Health Insurance (CHI).
- Increased financial contribution from private sector.
- Increased target population served under alternative health financing schemes
- 60% of the target population access to affordable and quality care.

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Nepal has made significant progress in the health sector during the period of the 9th Plan (1997 – 2002). The public sector has defined its priorities far more precisely, and has improved the focus on promotive and preventive health services and on a limited package of curative health services. The first half of the 1990s saw the share of public expenditure devoted to these priorities fall sharply, from 77% in 1991 – 92 to 57% in 1997 -98. The 9th plan reversed this decline, with the share of these priority programs increasing to 64% in 2001/2002. The Medium Term Expenditure Framework for 2002/2003 to 2004 – 5 has allocated 72% of the health budget to these expenditures. They are defined as 'Priority 1'. The 9th plan also saw some significant gains in health status: the proportion of children with full vaccination coverage increased from 37% in 1991 to 66% in 2001, and the reduction in child mortality over the plan period exceed the target.[1]

The Ministry of Health intends to initiate alternative financing schemes such as community and social health insurance schemes as a means to supplement the government health sector financing source. SHI is a mechanism for financing and purchasing / delivering health care to workers in the formal sector regulated by the government. Currently there are no such schemes in Nepal, though a small number of agencies provide medical benefit packages, including membership of private insurance schemes, to their employees. MOH will consider implementing pilot SHI schemes and replicating the appropriate schemes based on piloting experience[1].

This is suitable for the informal sector and it covers a variety of schemes with variations in (a) target groups, (b) provider arrangements, (c) benefits of services, (d) exemption arrangements for vulnerable groups, (e) means of contributing, (f) degree and type of cross subsidy and (g) Administrative mechanisms. There are already a small number of community health insurance schemes (including Community Drug Program) within Nepal. CHI schemes are attractive as they provide the opportunity to link the activities into local management processes. MOH is considering working closely with different CHI schemes and using them to provide information for developing an approach for wider replication elsewhere in Nepal[1].

A healthy population contributes to poverty reduction and to long-term economic growth of a country. The Child Mortality Rate (risk of dying by age 5 per 1000 live births) is a highly significant predictor of economic performance[2]. Nepal's high under – 5 mortality rate of 104 per 1000 live births is matched by a low GNP per capita of US$ 220[3]. Under 5 years mortality in 2002 was 81 for males and 87 for females while per capita GDP (PPP US$) was 1310. Per capita total expenditure on health at average exchange rate was persistent at US$ 12 in 1997 – 2001, while per capita expenditure on health at international dollar rate was increasing from $58, to 60, 59, 61 and $63 from 1997 to 2001 respectively[4]. Global data indicates that better health means more rapid economic growth. In turn, economic growth reduces poverty and improves health. The case for investing in health is very strong.

**Composition of Health Expenditures in Nepal**

Relative to its South-Asian neighbours, Nepal spends a higher share of its GDP on health expenditures. According to the UNDP Human Development Report[5], in 2000 Nepal spent 5.6 percent of its GDP on health. For comparison, India, the next highest spender in the region, spent 5.1 percent of its GDP on health over the same period. Despite these expenditures Nepal ranks poorly in the region across key health indicators. The country has one of the highest infant and maternal mortality rates and the lowest life expectancy at birth in the region.

One of the failing of health expenditures in Nepal has been the inability of health spending to reach the poor and disadvantaged thorough affordable access to health service. Unlike its South-Asian neighbours, most of Nepal's expenditures come from private out-of-pocket contributions, which in 2000 accounted for approximately 70 percent of total health expenditures (3.6 percent of GDP). The poor and disadvantaged in Nepal are less capable of accessing health services through private out-of-pocket contributions and are predominantly reliant on public health services that are currently inadequately resourced to fulfil that demand.[1]

Approximately 14 percent of total health expenditures in Nepal are channelled through the Ministry of Health and an additional three percent is spent by other ministries, autonomous bodies (e.g., universities) and local bodies (District Development Committee, Village Development Committee and municipalities). In addition, direct expenditures by external development partners account for another 13 percent of health expenditures.[1]

These estimates of total health expenditure suggest that Nepal spends approximately NRs. 1,200 per capita (US $ 16.8 per-capita) on health expenditures. This statistic on per-capita expenditure, however, must be balanced against the fact that health spending is highly uneven across income groups with the majority of private expenditures coming largely from

the few, relatively well off and spent primarily on curative and tertiary care.[1]

**Social Protection in Health**

Traditional treatment practices are still prevalent in rural Nepal. We frequently hear successful stories of faith healers curing chronic diseases. However, the belief system is gradually changing People have started valuing constitutional and environmental factors as contributing agents to health problems. People preferring faith healers in earlier times to solve their medical needs, have started to rely on hospitals for treatment. The coverage in the health care sector has significantly increased. To improve service delivery through community participation, the handing-over the management of health facilities to the village level is being implemented simultaneously. The health networking of the government health system has further penetrated down to the village level, which has positively contributed in improving the level of health awareness. Even the government of Nepal has tried to train the traditional healers as health workers. Besides these efforts, various programs of other non-governmental and private organizations that are implemented in these districts have equally contributed to enhance the awareness level in the health sector.[6]

Social security is a new concept in Nepalese contest, which is for the first time introduced in 1995, through the pension scheme for the elderly. Later on, this service was extended to widows and physically and mentally disabled people. In this scenario, social health insurance of BPKIHS has been looked upon as a milestone for health security of people in the Eastern region of Nepal.[6]

**Local Situation**

**Demographic Context of the Insurance Scheme's Zone of Operation**

The demographic context deals with the population growth rate, family size and the area of implementation of the insurance scheme. It explains geographical distribution of the target population, average population size and migration patterns of the people in the target area.

Records on population maintained by the insurance scheme are not segregated by age groups. It is maintained according to the institutions. The family size of the population differs by the place of residence, ethnicity and other socio-economic factors. Emphasis is given to the average national household indicator of 5.5 people per household. This very marginalized population are migrated permanently from their place of residence. However, seasonal migration of individuals is a common trend amongst many households. It has been observed that young adults from the family are migrating to urban centres in search of employment. Due to the lack of records and registration, the actual trend and data is not available.

**Economic Aspects**

In rural areas, around 71 percent of the population belongs to lower income groups whereas in urban areas, only 39 percent belongs to this group. The proportion of middle income groups is 20 percent and for higher income groups this is 8 percent in rural areas, whereas this is 33 and 28 percent respectively in urban areas. Two-thirds of the population of Sunsari and Morang districts belong to lower income groups, 12 percent belong to higher income groups and the remaining belong to middle income groups.[7] Agriculture has been practiced as the major occupation for many people in these communities. About 90 percent are involved in informal economy work which includes agricultural labour, factory work and portering. The remaining 10 percent are employed in government organizations, non-governmental and other business sectors. For most of the people, agriculture and livestock products and daily-wage labour are the major source of cash income. The household income of a majority of families fall between NRs 1,000 to 3,000 per month. This is due to the lack of income-generating opportunities at the community level. Further, limited avenues restrict opportunities for formal economy work.[8]

**Social Aspects**

The literacy rate for these districts, Sunsari and Morang is 64 percent which is lower than the national literacy rate 66 percent as a whole.[9] Female literacy rate of 38.4 percent is considerably lower that the male literacy rate of 65.5 percent in these districts. This reveals that there are families who still consider sending girl child to the school as a matter of low priority.[7]

**BPKIHS and SHI**

BP Koirala Institute of Health Sciences (A Health Sciences University) has been established in Dharan Sunsari in eastern development region in 1993. The objective of its establishment is to produce socially accountable, responsible and competent health work forces in different discipline, provide up to tertiary care level health services continuously to meet the growing health needs of the population of eastern region and to carry out necessary research in the field

of health.[11] Since its establishment the institute has been continuously striving very hard to fulfil its set objectives in a coordinated manner with other stake holders and development partners.

While providing health services to the people it has been observed that more than 30% of the patient coming to the hospital are unable to afford the tertiary care service charges. Similarly Sunsari health interview survey (1994) of Sunsari district revealed that 65% of the people of this district belong to lower income group. Low level income has direct effect on people's health. Unless they become healthy they can't work up to the strength. There is direct relationship between income and health status of an individual.

Considering all these facts BP Koirala Institute of Health Sciences (BPKIHS) has introduced Social Health Insurance scheme in 2000 as an alternative health care financing mechanism to the community people of Sunsari and Morang districts. In the beginning small area was elected as a pilot project to lunch the scheme. A major objective of social health insurance is to reduce poverty caused by paying for health care and to prevent already vulnerable families from falling into deeper poverty when facing health problems.[12]

A total of 26 organizations with 19799 populations are at present in SHI scheme. Sixteen rural based organizations with 14,047 populations and 10 urban based organizations with 5752 people are the beneficiaries in this scheme.

During the five years period many reforms had been made to make the scheme financially viable by learning the lesson, sharing experiences. Larger pulling of resources is better. But in spite of increased number of VDCs and other organizations enrolment, there is a huge gap between premium collection and expenses incurred during treatment of the patient under the scheme.

With deficit every year it seems that institute alone is not able to run the program further due to financial constraint and it has been quite difficult to sustain the program of social health insurance. Although, there is provision to get enrolled in the scheme from marginalized community by paying 33% of the fixed premium, appropriate participation is not being achieved. It may be due to knowledge – do gap regarding health insurance scheme among the providers and also the community people. Another reason could be lack of full trust toward the organization and low income of the people.

The social health insurance scheme of BPKIHS is still on trail basis. It has great potency to increase the health-seeking attitude of the people and on the other hand it creates conductive atmosphere to have more access of health to the community people. The scheme has more social component rather than insurance aspect. Social health insurance can only be successfully introduced if the conditions are suitable. It must serve to improve both funding for health services and access to care for the population. Social health insurance must clearly be viewed as a policy toll, rather than an end in itself. If social health insurance is introduced into a country without careful consideration of the objectives and without proper preparation, it will fail. Efforts and resources will be wasted and it may be more difficult or even impossible to introduce the system successfully at a late stage.[10]

**Conclusions and Recommendations**

Different communities in Nepal have developed different forms of social protection depending on their needs and their patterns of social and economic development. Health protection can be provided at the institutional level as well as within family and community networks. Social interactions often play an important role in the development and management of health protection needs. BPKIHS Social Health Insurance Scheme is the outcome of the visionary thinking on social solidarity and as an alternative health care financing mechanism to the community. BPKIHS is mobilizing people's organizations and is offering health services through its health insurance scheme at subsidized expenses. This has helped people to avail with health facilities who otherwise would have been left vulnerable because of their penetrating health needs.

Experiences of people about the scheme are very positive and encouraging because of the health care services that BPKIHS provides through its scheme. But some dissatisfaction are; like attitude of health care providers at the hospital, administrative barriers, transport facilities, referral services and extension of the scheme to other teaching hospitals.[6] There is huge gap between premium collection and expenditures. The expenditures are more and this may be due to knowledge – do gap among the providers and receivers in the program. If conditions are unsuitable, SHI can lead to higher costs of care, inefficient allocation of health care resources, inequitable provision and dissatisfied patients. It can also be more difficult to realize the potential advantages of SHI in future.

The future challenges confronting the scheme are to give the continuity and sustainability of the program

to its catchments areas. This might entail a shift in its program operation mechanism. People's active involvement is required, which will further provide a sense of ownership in the scheme amongst the people.

The challenging task to give continuity to the scheme in the longer run requires certain following measures to improve the operation of the scheme.

1. More flexibility should be provided to the facilitating agency to encourage a larger coverage of beneficiaries.
2. Involvement of health care providers for extension of the program.
3. Interaction with partner agencies and beneficiaries need to be held on a regular basis to minimize the insurance risk. People's participation should be stressed.
4. Fraud cases should be minimized and adverse selection of members should be controlled.
5. On going behaviour change complain (BBC) is likely to be necessary as part of SHI scheme so that they actually use the insurance.
6. SHI scheme must be accompanied by interventions to address the other barriers that may prevent the poor from seeking health care, such as distance and limited awareness of the health services available.
7. Training on the technical functioning and management of health insurance should be provided to staff members for developing efficient functioning of work under this scheme.

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