Under one umbrella:

A long and winding road

Research on policy and implementation challenges in the national health insurance programme

ANWESHAN Pvt. Ltd
Redefining research

PUBLIC POLICY PATHSHALA
POLICY THINK TANK: RESEARCH, POLICY DIALOGUE, PUBLICATION, ADVOCACY, CAMPAIGN

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Acronyms

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Anweshan &
Public Public Policy Pathshala

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1. Background

"Everyone should have access to the health services they need without risk of financial ruin or impoverishment" is a statement that aptly captures the essence of Universal Health Coverage (UHC). In 2005, all member states of the World Health Organization (WHO) made commitments to achieve the goals of the UHC[1]. As a WHO member state and a signatory to the commitment, the Government of Nepal has formulated multiple policies to accelerate the UHC.

For instance, the National Health Policy of Nepal, 2014, aimed to reduce impoverishment and catastrophic health expenditure by recognizing that the health system could not fully identify and protect the poor[2]. This policy paved the way for health insurance in Nepal. A semiautonomous agency – the Social Health Security Development Board – was formed for the implementation of the health insurance program. At present, the National Health Policy Nepal (2019)[3] aspires to improve universal access to quality and equitable basic health services, whereas other healthcare services are covered through social health insurance and health safety net programs.

Health has been enshrined in the Constitution of Nepal 2015 as a fundamental right. It states that every citizen has the right to free basic health services, meaning that the people are entitled to sue the government should the latter fail to provide basic health services. The constitution, in its directive principles, states that the country will work to promote health insurance among its citizens. Healthcare costs will be shared through health insurance programs so that healthcare services are within reach of every section of the populace, even those that cannot afford treatment. Addressing the prevailing inequality in healthcare in this manner shows congruency between the health insurance program and the preamble of the existing constitution.

The spirit of the constitution is well reflected in The Public Health Service Act, 2018 by articulating it with the existing health insurance act[4] in this regard. Before that, the Health Insurance Act was endorsed in 2017 with some specific features. The first is that it carries an individual mandate, meaning that enrollment is a must for citizens. This further allows for risk pooling, equity, and broader political involvement for a shared public good. Secondly, the premium rate is minimum, and it is subsidized for the poor, disabled and elderly. Its third feature, and a first in the country's history, is the introduction of a payer-provider split history[5] (Thapa, Aryal and Maru).

The Health Insurance Program has been guided by the constitutional thrust[6], and the Public Health Service Act reflects the commitment of the government to end the financial hardships that result from catastrophic spending in healthcare. The current health insurance scheme, under the Health Insurance Act, is designed on the basis of family unit subscription; a good balance between the old and the young, as well as between the healthy and the unhealthy, can be achieved through this, and their respective risks can be cross subsidized. Furthermore, the benefit package includes services beyond those being provided free of cost by the government[7]. While this means that it is working to ensure access to quality health services to all, the country has a long way to go towards achieving this goal. There is a wide discrepancy between urban and rural settings in terms of access to and utilization of health facilities. Even though health services are available in all geographical areas (Terai, hills, mountains), there is a vast difference in the time it takes to access the facilities. For instance, reaching health facilities takes more than two hours for six per cent of the Terai population, whereas

[1] Dyes, C., Reeder, J. C., & Terry, R. F. (2013). Research for Universal Health Coverage. *Science Translational Medicine*, 1.
[2] Mishra, S. R., Khanal, P., Karki, D. K., Kallestrup, P., & Enemark, U. (2015). National Health Policy in Nepal: challenges for implementation. *Global Health Action*, 1.
[3] Ministry of Health and Population, National Health Policy 2019 (Unofficial Translation) (2019), https://drive.google.com/file/d/1jZ6KrLmjJNjMvbemJ6dSox-30PJndfAT/view.
[4] Government of Nepal, Health Insurance Act (Unofficial Translation) (2017), https://hib.gov.np/en/detail/b-ai.
[5]
[6] Government of Nepal, Constitution of Nepal, 2015 (2015), http://www.lawcommission.gov.np/en/archives/category/documents/prevailing-law/constitution/constitution-of-nepal.
[7] Pokharel, R., & Silwal, P. R. (2018). Social health insurance in Nepal: A health system department toward the universal health coverage. *Wiley*, 7.

in the mountains, the figure is much higher at 21 per cent[8] (MoHP, 2016). Financial, socio-cultural, geographical and institutional barriers still persist, affecting access to quality healthcare services for many.

There has been a significant increase in access to healthcare over the years. The wide network of health facilities – such as primary healthcare centers (PHCs), health posts and outreach clinics, along with community workers and volunteers at every ward level – have made access to healthcare easier than ever. Similarly, the introduction of the Free Health Policy in 2006 and the implementation of the Free Health Program in 2007 were milestones in increasing access to health for all. At the initial phase of the Free Health Policy, poor and vulnerable citizens were provided free essential healthcare services through PHCs and district hospitals, and additional free outpatient services were made available in the districts with the lowest Human Development Index. In 2008, a universal program was initiated with the aim of providing free essential healthcare services to all citizens, through health posts and sub-health posts, PHCs and district hospitals[9] (GTZ, 2009). However, it still has not been possible to cover everyone, and families still have to bear all medical costs on their own (MoHP, 2018). High out-of-pocket expenditure on health services remains a major concern for many Nepali people; in fact, it makes up more than half (55 per cent) of the costs[10]. People experience catastrophic financial exposure, which further drags the population below the poverty line[11] (WHO, 2017). Therefore, it can be comprehended that security in terms of health – including accessibility, availability, adequacy and quality – is closely related to financial security.

This global understanding on the merits of financial security, and its direct impact on the lives of people, led to the adoption of multiple social security programs, including social health insurance. The basis for the health insurance program in Nepal was conceived when the government proposed alternative financial mechanisms, including "community financing schemes and income generation at public facilities" with the endorsement of the Second Long-Term Health Plan 1997-2017. This was basically done to complement funding from the public sector and development partners to the health sector. Furthermore, in 2003/04, the Ministry of Health and Population (MoHP) introduced provider-based health insurance schemes in six districts as a pilot program for Community-based Health Insurance (CBHI). It started in two districts in the first phase – Morang and Nawalparasi – and, later, in 2005/2006, was extended to four more districts: Udayapur, Rautahat, Dang and Kailali[12] (GIZ, 2012). Although community health insurance practices had begun in different modalities in years prior, it was the first time that a government-owned CBHI had been introduced to the country. The Lalitpur Medical Insurance Scheme is regarded as the first non-profit health insurance scheme in Nepal. This community health insurance scheme began more than three decades ago, and was initiated by the United Mission, an international NGO. Similarly, BP Koirala Institute of Health Science (BPKHIS) in Dharan started health insurances in both urban and rural areas, offering the same benefit packages at different premium rates[13].

CBHI is an alternative for a cost-sharing healthcare system. It came into practice with a hope for the better utilization of healthcare services, and to reduce illness-related income shocks. It was anticipated to be a promising alternative since it would lead to a fully functioning and universal healthcare system[14] (Shimeles, 2010). In CBHI, members pool premium payments into a member-managed collective fund. It is run in either of two modalities: low cost high frequency of illness and high cost low frequency of illness. The former model covers primary healthcare services while the latter covers referral as well as primary healthcare services.

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[10] https://www.who.int/docs/default-source/nepal-documents/nepal-nha-2012-13-to-2015-16-ministry-of-health-and-population-june-2018.pdf?sfvrsn=64645c52_2

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[13] Rabindra Ghimire, *Community Based Health Insurance Practices in Nepal*, 2 Int. Res. Rev. 1–11 (2013).

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CBHI certainly had several positive impacts on the community but, at the same time, it had some shortcomings, with low population coverage being one example[15] The geographical coverage of this scheme was limited to the working area, and only an average of 3.4 per cent of the population were covered within their catchment area[16]. The scheme also did not have financial or administrative guidelines for the effective implementation of its activities. It neither had data to monitor financial viability nor a separate insurance management committee. Later, through subsequent legislations, CBHI was transformed into the concept of social insurance.

Then, in 2013, the National Health Insurance Policy[17] was introduced with an aim to increase access to health services for the poor and marginalized, and people residing in hard to reach areas. The core objective of the health insurance program was to enable people to have access to preventive, curative and rehabilitative health services. The scheme was administered by the Social Health Security Development Committee (SHSDC), a semi-autonomous agency formed in 2014[18] under the Development Board Act 2013, and led by the Secretary of the MoHP[19] However, there were several challenges for effective policy implementation with regards to the health system in itself, such as unequal distribution of healthcare services, poor infrastructure, inadequate supply of essential drugs, poorly regulated private providers, inadequate budget allocation for health, and poor retention of human resources[20].

Another program – the Social Health Security (Health Insurance) – was formulated with an understanding that free health service programs did not meet the healthcare needs of individuals. This program was initiated by the Social Health Security Development Committee with the objective of ensuring health services to everyone through means of social health insurance, in order to improve access and utilization of quality healthcare services to every individual.

Later, in 2017, the Health Insurance Act[21] was endorsed by the federal parliament, under which every Nepali citizen is mandatorily required to get his/her health insured. Along with the general population, the act mainly focused on incorporating family members of government employees, employees of private organizations, migrant workers, newborns, children and elderly citizens. The act also laid the foundation for an autonomous entity – the National Health Insurance Board – that would govern the scheme and make enrolment mandatory for every citizen both in the formal and informal sectors[22]. Some major constraints with regards to the Health Insurance Act were population coverage and limitation of revenue, which was mostly generated from the informal sector. Furthermore, the scheme under this act was based on unit subscription of families and it did not differentiate enrolment on the basis of any specific medical condition or age[23]. Similarly, another major shortcoming was social acceptability, which is closely dependent upon the availability of services, and the utilization and quality of the service experience. The Health Insurance Act somehow limited the availability of services. For instance, it mandated the insured to select public health facilities as their first service contact point, but other private providers could also be preferred by the insured as first service contact points.

In 2019, another health insurance regulation[24] was endorsed. Under this, full subsidies in contribution amounts were to be provided to family members of ultra-poor, elderly, and seriously disabled patients, as well as family members of those suffering from leprosy, HIV, and MDR-TB; additionally, half subsidies were to be given to family members of female community health volunteers. Furthermore, the regulation made it mandatory for all

[15] *Id.*

[16] Manfred Stroermer et al., Review of Community-based Health Insurance Initiatives in Nepal (2012), http://www.healthinternetwork.com/providingforhealth/countries/2013_04_Nepal_CBHI_GIZ_report.pdf.

[17] Government of Nepal, National Health Insurance Policy (Unofficial Translation) (2014).
[18] Government of Nepal, Social Health Security Development Board (Formation) Order 2014 (2015).
[19] Rajani Pokharel & Pushkar Raj Silwal, *Social health insurance in Nepal : A health system departure toward the universal health coverage*, Int. J. Health Plann. Manage. 1–8 (2018).
[20] Shiva Raj Mishra et al., *National health insurance policy in Nepal: Challenges for implementation*, 8 Glob. Health Action 28763 (2015).
[21] Government of Nepal, *supra* note 3.
[22] Pokharel and Silwal, *supra* note 11.
[23] Pokharel and Silwal, *supra* note 11.
[24] *Id.*

members of old-age homes, orphanages and rehabilitation centers to be enrolled for health insurance, and also for family members of people applying for foreign employment.

As of now, 58 out of 77 districts have been covered under the insurance scheme[25]. So far, 113,0575 people have been enrolled in the National Health Insurance Program, of which the highest number is from Province 3, while the lowest is from Karnali Province. Moreover, 904,769 people are newly enrolled, whereas 225,836 have renewed their previous insurance scheme (HIB, 2019).

The government is also giving high priority to the insurance program in its annual policies and programs. In its budget speech for the fiscal year 2020/21, the government announced its plan for the social health insurance program to cover 40 per cent of the population. The government has earmarked NPR 7.5 billion for this purpose[26].

1.1 Problem Statement

From 2015/16 until now, coverage with respect to the number of districts has increased. However, the number of household participation in the enrolment appears quite low[27]. Several problems and challenges seem to be associated with the low coverage of the health insurance program – the assurance of quality healthcare facilities, the provision of mandatory membership, participation of local/provincial governments and the full implementation of the Health Insurance Act are some of them. The lack of management with regards to human resources, infrastructure and materials in service providing institutions, and management issues regarding pharmacy and drug provisions are other challenges. Access and awareness are also major issues (Health Insurance Board, 2018). Other factors associated with the low enrolment for insurance are ethnicity, socio-economic status and previous experience of acute illness[28]

Nonetheless, for the successful implementation of the program, the depth of such challenges and problems need to be assessed at the national level from the aspect of both demand as well as supply.

1.2 Rationale

Though there has been a progressive geographical expansion of the National Health Insurance program, the available information shows that enrolment and renewal have been low. Therefore, it is essential to understand the reasons behind this stagnation. Local-level involvement and community participation are vital for the successful implementation of any community-based program, and even more so in the context of Nepal with its three-tier governance system. This is important mainly because it informs the need to review the operational aspect of the National Health Insurance policy and program design, and its implementation toward universal population coverage.

This study will analyze the current status of the program in the country, the challenges in its implementation, and the opportunities to improve it. It will also provide suggestions on both supply and demand, based on the findings and opinions of various stakeholders.

[25] Government of Nepal, Health Insurance Board Dashboard (2020), http://dashboard.hib.gov.np:81/ (last visited Aug 22, 2020).
[26] Government of Nepal, Budget Speech 2020/21 (Unofficial Translation) (2020), https://mof.gov.np/en/archive-documents/budget-speech-17.html?lang=.
[27] Government of Nepal, Economic Survey 2019/2020 (Unofficial Translation) Ministry of Finance (2020), https://mof.gov.np/uploads/document/file/Economic_Survey_2076-77.pdf.
[28] Prabesh Ghimire, Vishnu Prasad Sapkota & Amod Kumar Poudyal, *Factors associated with enrolment of households in nepal's national health insurance program*, 0 INT. J. HEAL. POLICY MANAG. 636–645 (2019), https://doi.org/10.15171/ijhpm.2019.54.

1.3 Objective matrix

Table 1: Objective matrix

Objectives	Research Question	Data collection Tools	Population to be studied
1. To explore the implementation challenges by collecting information from beneficiaries, the insured, health service providers, health service purchasers, and other related stakeholders	**1.What are the factors that motivate Nepalese people to enroll in health insurance programs?** • What group of the population has been enrolling in health insurance programs? • What were their motivating factors for enrolling in the health insurance programs? • Why are people not enrolling in health insurance programs? • To what extent were expectations fulfilled after using the services?	In-depth interview (IDI) guideline	• Enrollment assistants • Health service providers
		Key informant interview (KII) guideline	• Enrollment officials • Province coordinator
		Focus group discussion (FGD) guideline	• Insured and renewed population • Non-renewed population • Non- insured population
	2. What factors have been influencing the insured people to renew or to drop-out from health insurance programs? • What was their service experience like after acquiring insurance? • What influenced them to renew their health insurance programs? • Why influenced them to not renew their health insurance programs? • What are the perceived barriers for health service providers?	IDI guideline	• Enrollment assistants • Health service providers
		KII guideline	• Enrollment officials • Province coordinator
		FGD guideline	• Insured and renewed population • Non-renewed population • Non- insured population
2. To review the existing laws that guide the implementation of health insurance programs in Nepal, and to explore the associated policy challenges 3. To explore the policy challenges associated with health insurance programs	**3. Factors related to policy challenges:** • What are the factors associated with the technical feasibility of health insurance programs? • To what extent have health insurance programs received political acceptance?	KII guideline	• Enrollment officials • Province coordinator • Policy makers

through discussions with concerned stakeholders and policy makers 4. To document the policy as well as implementation challenges and possible ways out, and to disseminate the information to concerned stakeholders	• Is the program economically viable in the present context? • Is the health insurance policy and benefit package socially acceptable? • Is the existing health insurance act and regulation legally practical during implementation?	Desk review	• Policy papers • Insurance Act • Guidelines • Operating procedures

2. Methodology

2.1 Study site description

The primary sampling frame for the research were the districts where health insurance had been implemented for at least two years. Three districts from Province 1, Province 5, and Karnali Province were selected based on the criteria set prior to the study. These districts were chosen after exclusive discussions with the research team from Save The Children, and with representatives from the Health Insurance Board (HIB). Two selection strategy levels were applied in the study while selecting the districts of Illam, Bardiya and Jumla from others in the sampling frame.

Level I selection strategy

- The districts that were selected were from different provinces so that the study could access a wide range of participants
- Based on the latest updates of the 2047/75 HIB report, the provinces with the following criteria were selected:
  - Highest number of insurees (Province 1)
  - Mid-number of insurees (Province 5)
  - Lowest number of insurees (Karnali Province)

Level II selection strategy

From among the selected provinces, the districts were further narrowed down by considering multiple factors, and/or time limitations and feasibility of the study. The factors contributing to the district selection were:

- The health insurance programs had to have been implemented for at least two years (i.e. 2072/73 - 2073/74) in the district
- Districts had to have either the highest or the lowest insurance renewals within the selected province

2.1.1 Characteristics of the selected districts

Table 2: Characteristics of the proposed districts

HI District	Province	Year BS.	New enrollment	Renewal	Total	Selection Criteria
Ilam	**1** *Had the highest number of insurees*	2072/73	20397	15020	35417	• >Two years of program implementation • Had the highest renewal number
Bardiya	**5** *Had the middle number of insurees*	2074/75	58581	2032	60613	• >Two years of program implementation • Had mid-renewal numbers
Jumla	**Karnali** *Had the lowest number of insurees*	2073/74	14811	4371	19182	• >=Two years of program implementation • Had the highest renewal number as per the 74/75 Nepal Government HIB report

2.2 Study design

The study was qualitative in nature, and both primary and secondary data sources were triangulated for survey purposes. The primary data was collected through the implementation of multiple qualitative research approaches. For the secondary data, an online-based external desk review was conducted on the existing government documents, policies, acts, and regulations of the health insurance program.

2.3 Study population and sampling technique

To better understand the factors that influenced as well as hindered the use of the health insurance program, the study selected family members that were enrolled, and those that were not enrolled, in the national health insurance program. Among the insured, the renewed and non-renewed population were the study group for the focus group discussions (FGDs). Discussions also took place with the non-insured population to understand the underlying factors that had led to them not enrolling in the insurance program. The insured and non-insured members that met our study criteria were purposively selected with the help of enrolment assistants (EAs) working in the chosen districts. Since the study required participants that were relevant to the research questions, in-depth interviews (IDIs) were conducted with EAs and health service providers through purposive selection. Enrolment officials assisted in the selection of EAs from the high- and low-performing areas within the districts, and the health service providers were purposively sampled from the sampling frame of the insurance service points. One hospital and one primary healthcare center was selected from among the others; they were chosen due to their functional status regarding health insurance services.

For policy analysis, key informant interviews (KIIs) were conducted with policy makers, enrolment officials (EOs), and province coordinators in order to explore the policy and implementation challenges. Despite the proposed sample size as mentioned in *Table 3* below, the data saturation level was focused upon while collecting primary data.

2.4 Sample chart

A total of 30 interviews were conducted with the details mentioned below. The information collected from the FGD sessions will lead to a better understanding of the underpinning realities of the experience and practice of health insurance services after the clients purchase the benefit package. On the other hand, the rationale for selecting service providers and consumers as research participants are because health service utilization depends upon demand as well as supply side factors.

Table 3: Sample chart for the study

Study Population	Tools/Guideline	Unit Sample size	Details	Total sample
Insured and renewed population	FGD guideline	1	=1*3 district	3
Insured and non-renewed population	FGD guideline	1	=1*3 district	3
Non-insured population	FGD guideline	1	=1*3 district	3
Enrolment official	KII guideline	1	=1*3 district	3
Province coordinator	KII guideline	1	=1*3 province	3
Policy makers	KII guideline	1	=1*3 HIB member	3
Health service providers	IDI guideline	2	=2*3 district	6
Enrolment assistant	IDI guideline	2	=2*3 district	6
Total Sample Count				**30**

2.5 Research approach

Qualitative research methods such as focus group discussions (FGDs), key informant interviews (KIIs) and in-depth interviews (IDIs) were used to collect primary data. Each of these methods were guided by the semi-structured interview guidelines developed by Anweshan and Public Policy Pathshala in close coordination with the Save The Children research team.

The desk research technique was utilized for policy analysis. The method involved collecting data from existing government documents, journals, annual reports, acts, policies, and regulations related to health insurance programs.

2.5.1 Focus group discussions

Nine total FGDs were conducted in the study districts. In each district, the study participants were the insured and renewed population, the insured but non-renewed population, and the non-insured population. One FGD each was conducted with these study groups in Illam, Bardiya and Jumla. Enrollment assistants (EAs) working at the chosen districts were consulted while selecting the study participants, and socio-demographic aspects such as caste, ethnicity, gender, age-group, and education-level were taken into consideration during the selection process.

2.5.2 In-depth interviews

EAs and health service providers were the primary study participants for IDIs in each district. Twelve IDIs were carried out in total. Two EAs and two health service providers were interviewed in each study district. The EAs were purposively selected upon consultations with enrollment officers responsible for coordinating in the districts. One EA from a high performing area and another from a low performing area were considered during the selection process.

Likewise, the health service providers interviewed at the service points were the focal persons from the chosen hospital or primary healthcare centers. The health facilities for the study were selected after consultations with the Save The Children research team.

2.5.3 Key-informant interviews

The study participants for the KIIs were enrollment officers, policy makers and province coordinators. The study participants were purposively selected after consultations with the Save The Children research team and the National Health Insurance Board (NHIB).

2.5.4 Desk reviews

Online-based external desk reviews were conducted for policy analysis. Various search engines (Google, Google Scholar) were modulated to look for relevant information. Different search techniques, such as the use of Boolean and logical characters along with wildcards, were utilized to generate promising and related articles. Government portals were looked up for the latest insurance-related documents and annual reports, acts, policies and regulations.

2.6 Research tools and instruments

A semi-structured research guideline and interview protocol directed the FGDs, KIIs, and IDIs. The tool was designed and developed by Anweshan and Public Policy Pathshala, with the close coordination and guidance of the Save The Children research team, the health insurance board, and commissioners. The interview protocol guided the administration and the implementation of the interview process. It provided the instructions that needed to be followed for the interviews to be consistent so that the reliability of the findings could be increased.

Face-to face interviews were conducted using the interview guideline. However, due to the COVID-19 pandemic, a few of the KIIs within Kathmandu Valley had to be conducted virtually through Zoom calls.

In order to understand the perspectives of both the demand and supply sides, different theme-based qualitative tools were developed for the study participants. For the supply side, the tools helped in assessing implementation-related issues from the service contact points. And for the demand side, the research tools were useful for understanding the health insurance experiences and practices of the insured population.

2.7 Data collection quality

To ensure that high-quality data was collected from the field, skilled researchers with sound knowledge of qualitative study were selected from the chosen districts. They were well-informed about the socio-cultural values and norms, and the local languages and dialects used in the selected districts.

The researchers were trained virtually on 27-28 August 2020, prior to the field study. The training schedule was designed to better acquaint them with the purpose of the study, and the technicalities to be followed during the survey. The training covered the following aspects:

- Rapport building with participants, and respecting their response
- Understanding the health insurance program in Nepal
- Study objectives and qualitative research methodologies
- Consent forms and importance of research ethics
- Creating comfortable environments for the respondents in terms of time, place, and convenience, and ensuring proper recording settings for the interviews
- Avoiding technical terms and jargon; using simple language
- Avoiding ambiguous and multiple questions
- Observing gestures and silence of participants
- Avoiding leading questions, and using appropriate probing and follow-up questions
- Summarizing the information provided by participants for assurance of common understanding
- Active note taking and listening, including what the participants are not willing to say, as well as explicit quotes

Additionally, themes, questions, and probing strategies were thoroughly explained to the field researchers.

The overseeing and monitoring of the field work was carried out by supervisors from Anweshan, and updates and problems (if any) were shared with them the same day. Issues that arose in the field were thoroughly communicated to the Save The Children research team.

2.8 Data collection process

Data was gathered in two phases for this study. In the first phase, KIIs were conducted virtually via Zoom with policy makers, enrollment officers, and province coordinators from 6 to 25 August by the core research team at Anweshan. Verbal consent was taken with the participants to record the interviews, which were conducted according to the participants' schedules.

The first phase interviews guided the second phase. The KI interviewees were consulted throughout the process of tracking and developing the sampling frames for the second phase interviews. The list of EAs and health service providers, along with the enrollment officers to be interviewed, were finalized through consultations with the key informants.

The second phase of data collection began soon after the researcher training was carried out. Data was collected in the study districts from 29 August to 4 September. Adhering to COVID-19 preventive measures, the interviews saw social distancing being followed by study participants and field researchers, with both groups also being provided surgical masks. Both verbal and written consent were taken for conducting and recording the interviews.

In each district, two field researchers were appointed and trained on the study objectives and the research guidelines.

Official letters were issued from Anweshan; the organization was also responsible for the first level of coordination with district enrollment officers. The researchers were constantly supervised and guided throughout the survey period for any confusions they had regarding the data collection and management process.

2.9 Data Procession and Analysis Plan

2.9.1 Qualitative data

2.9.1.1 Transcription and translation

To maintain backups of the data, all the interviews were audio recorded and uploaded to Anweshan's encrypted server. The verbatim transcription began soon after the core team received the recordings. The FGD files were transcribed by the field researchers themselves, while research assistants with prior transcription experience were hired to put the KII and IDI files into writing. The transcribers were thoroughly instructed on the objectives and purpose of the study.

Each of these transcripts were proofread by Anweshan's research officers before the files were given for translation, which was performed by the verified research assistant at Anweshan. The translated files were then edited while ensuring that the meaning of the texts were not lost in any form.

2.9.1.2 Thematic analysis

Coding is a way of indexing or categorizing the text in order to establish a framework of thematic ideas about it (Gibbs, 2007). The translated data from this study was analyzed based on systematic coding and broken down further to develop a code list. A deductive coding approach was applied wherein the core project theme guided the coding process. Initially, a rough codebook was developed that was based on the study objective; new codes were then added to it from the data when the analysis process advanced. Data that counteracted or contrasted with any existing understanding of the issue was thoroughly scrutinized. The codes were categorized and reorganized to structure the data that was collected, and then fit into the theme that was deduced.

2.9.1.3 Coding procedure

The translated raw data was revised multiple times for coding, and new codes were generated by multiple coders to maintain validity and reliability. The important points, mainly in line with the deduced theme that arose during the reading and re-reading of the interview data, were highlighted and coded appropriately. The coding procedure underwent multiple stages. Initially, the content and statement addressing similar ideas were addressed with similar codes after a thorough reading of the data. Then, line-by-line coding took place to generate profound and detailed codes. Multiple colors were used to mark the different ideas and issues for each code. In order to structure the data, the colored statements were extracted into an Excel sheet. NVIVO and MS-Excel were used for the coding and data management process of qualitative data.

2.9.1.4 Categorization and determining themes

The categorization of the codes reflected the themes. The bigger categories created the overarching themes, which were then supported by the subcategories. This process helped in structuring the data and aided in fitting the categories into the deduced themes in the rough codebook. The finalized theme was developed later at the end of the step.

2.10 Desk review data

The secondary data generated from the desk research was filed and managed in folders to track and backtrack all the existing policy papers, journals, acts and regulations on health insurance programs. The documents extracted from online systems and government portals were then critically analyzed and reviewed.

2.11 Data triangulation

Data triangulation was adopted for the validity of the study results. One-on-one interviews and focus group discussions, along with desk research, were incorporated in the study. The findings elucidated through the application of each method were triangulated to generate this comprehensive report.

2.12 Qualitative data management

Summary notes and recording files will be guiding the research reports. Therefore, the recorded files were saved with unique file names, while the transcriptions and translated files were saved with names that matched the titles of their respective audio files. The field researchers were taught to rename the files accordingly during training sessions by supervisors. The format for transcription, the summary report, and translation was shared with all the field researchers and translators respectively in order to have a consistent data format for further processing.

2.13 Ethical consideration and safeguarding policy

The study followed the standard ethical principles of interview guidelines. Both verbal and written consent of the participants were taken prior to the study so as to build rapport and trust. The participants were provided with the authority to decide on their participation in the study; they were assured about their freedom to withdraw at any time. In the case of illiterate participants, the researchers clearly read out the consent form, on which they obtained their thumbprints. The participants were provided with the opportunity to put forward their questions before the interviews or during the discussion process. They were informed about how they would be able to reach out to the researchers in the future if they wished to. The contact details were also provided in the consent forms.

Considering the power relationships within the culture of the research setting between the researcher and the researched, we duly put our efforts to make the interviewer 'value neutral' and 'non-judgmental'. For this, the researchers were oriented on value issues.

The anonymity of the interviewees was duly maintained, meaning identifiers like names and locations were removed before the transcripts were shared.

Regarding the safeguarding policy, we complied with Save The Children's Policy on Child Safeguarding.

2.14 Limitations

- The COVID-19 pandemic led to the extension of the project period and greatly affected the study methodology.
- A few focus group discussion (FGD) sessions in Jumla could not be conducted due to the sudden rise of COVID-19 cases in the area.
- Key informant interviews and some in-depth interviews (IDIs) of health service providers in the field were conducted virtually due to the COVID-19 threat.
- The information gathered from the field through FGDs and IDIs might not represent the scenario of the whole district. Therefore, the study might not be generalizable.
- The study did not have differently-abled individuals as study participants due to ethical concerns. Thus, it might lack the perspective of these minority groups.

In the case of the desk review, most of the government websites that were accessed were not up-to-date. Therefore, the latest changes in government decisions that have not been documented officially have not been incorporated into the study.

3. Findings and discussions

The findings – which have been categorized as themes – are the emergent issues and ideas obtained from participants through literature reviews, key informant interviews, and focus group discussions. They include supporting narratives and quotes from the participants. Additionally, the clauses and sub-clauses are also cited as and when required.

3.1 Issues with implementation of the policy and laws

The health insurance program in Nepal is governed by the Health Insurance Act 2017 and the Health Insurance Regulation 2019. There are many provisions within these legal documents that are yet to be fully implemented, and this has affected the overall insurance program.

3.2 A link between Act and Regulation

The Health Insurance Act mandates that all Nepali citizens should be insured under the health insurance program. It is a top-priority initiative, and so is strictly implemented by the government.

While the act provides a legal ground and envisions a broader concept of the program, it is the subsequent Health Insurance Regulation that needs to show a concrete way forward for its implementation. However, there are multiple gaps in the regulation itself. For instance, the Health Insurance Regulation Clause 2 states that the health insurance program is voluntary, while the Act had made it mandatory. Additionally, the regulation has not provided a concrete legal framework to include formal sectors into the program.

More importantly, the Health Insurance Regulation still treats the health insurance program as the social security health program, which was implemented as a pilot project before the formation of the Health Insurance Act. However, the way in which the health insurance program is currently being implemented has made it unsuccessful in departing from its earlier version, and on several occasions does not carry forward the spirit of the Act.

3.3 Formation of Provincial and Local Health Insurance Coordination Committee

Despite a clear provision by the Health Insurance Regulation, the Provincial and Local Health Insurance Coordination Committee still has not materialized. Without it, there is no formal mechanism in the provincial and local context to take ownership of the health insurance program. In addition, coordination in the provincial level depends on the province coordinators and enrollment officers, and how proactive they are. The purpose of such a committee is to garner ownership of the program, while also making local governments accountable towards the national priority initiative.

3.4 Formation of sub-committee on monitoring of service quality and drug pricing

The Health Insurance Board has also not been able to form a sub-committee to monitor service quality and drug pricing, as mandated by Clause 30 of the Health Insurance Regulation. This is particularly important for the success of the program for two reasons: first, the drug prices are revised each year and the rates of the drugs issued to service points do not consider these changing prices; second, procuring drugs at expensive rates and selling them at much lower prices demotivates health facilities in continuing the program.

"It is not possible to specify the brand while deciding the price of medicines. Doctors prescribe medicines of a specific brand to the insurees but the pharmacists give them other medicines instead. They are of similar compositions but different brands, and are imported through a tender process. Then, the pharmacists tell the insurees that the medicines they provided are in fact the ones covered by their insurance."

KII, Policy Maker

The monitoring aspect is somewhat weak. Well the delegates from central level and provincial level is expected to come and monitor the PHCs, hospital, pharmacies, and the also check the quality of medicines in the pharmacies. But it is not so. The monitoring aspect is weak.

3.5 Blanket age limit

The Health Insurance Regulation (Clause 16 [c]) states that local governments should bear the cost of premium of people who are aged 70 and above. This assumption is based on the average life expectancy of Nepali people, which is 70.5 years. However, this blanket age limit does not account for the varying degrees of life expectancy at birth within the different provincial and local levels of the country. For instance, the average life expectancy at birth in Jumla (Karnali Province), where the health insurance program is run, is 63.14 (NPC; UNDP, 2014). This means that the health insurance program completely overlooks the average life expectancy at birth in Jumla and imposes a blanket age limit, thus affecting the enrollment of people in the program.

However, there are a few social security programs run by the government that do not follow such blanket age limits. For instance, the old-age allowance provided by the government for citizens aged 70+ years also mentions that people aged 60 and above in Karnali Province are eligible for the allowance. There are also other affirmative actions for different groups, including Dalits and single women.

"In the Karnali region, the average life expectancy is 51 years, and people who are 65 years or above are considered senior citizens. But our policy has not defined this and so it needs to be amended by taking the Karnali region into account."

KII, Policy Maker

3.6 Inter- and intra-government coordination

The full-fledged implementation of the insurance program requires coordination among all three tiers of the government and its units. Many provisions set by the Health Insurance Act and the Health Insurance Regulation require meticulous coordination among these agencies to meet the overarching goal of ensuring health insurance for the entire population by 2030. This includes enrolling all civil servants in the program. For this, 1% contribution is to be made from the "first salary scale" while the remaining 1% will be paid by the government, although the total contribution amount is not to exceed Rs. 10,000. However, civil servants already enjoy health-related services provided by the Employment Provident Fund, the Social Security Fund, and other social security schemes. This shows the scattered nature of the social security program.

The central government also needs to coordinate with the provincial and local governments. However, apart from placing an insurance coordinator and enrollment officers, there are limited tasks that have the potential to motivate the provincial and local governments to take ownership of the program.

Another major issue that requires earnest coordination is the distribution of poverty cards and the identification of the poor. The delay in identification of people living below the poverty line has also affected the implementation of affirmative action envisioned by the health insurance laws, which require the insurance premium of households with poverty cards to be paid by the government. This needs extensive coordination with the Prime Minister's Office, the Ministry of Land Management, Cooperatives and Poverty Alleviation, and the Central Bureau of Statistics, among other agencies. These issues are barely addressed by the laws, thus impeding the rapid expansion of the program.

It is therefore apparent that the existing laws do not address these issues, and even if they do, they are yet to be translated into action in some cases.

3.7 A question of equity

WHO defines equity as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically." It is important to understand that the concept of health inequities go beyond inequality, where people lack or are denied access

to resources they need to improve and maintain health or health outcomes [CITE WHO WEBSITE https://www.who.int/healthsystems/topics/equity/en/].

The health insurance program also adopts the principal of equity, at least when it offers waivers in premiums to those who are deemed poor by the government, and people who are 70 years and above, among others. Yet the decision to impose a blanket of Rs. 3500 as premium, regardless of peoples' ability to pay, interferes with the state's objective. Since the government lacks data on people living below the poverty line in around 70 percent of the districts of the country, this move has excluded people who cannot pay the premium amount in areas where the insurance program has been implemented.

Although equity encompasses multiple dimensions, especially in the case of health insurance programs – including social justice, inclusion, efficiency and sustainability – many of these have not been successful when implementing the health insurance scheme (Paul, et al., 2019).

The unequal distribution of health facilities, the delays in equipping them with the services that are listed in the insurance program, and the unavailability of drugs, which has forced people to pay for services themselves, are persistent structural issues that reinforce the case of health inequities in the program. For many marginalized groups of the country, paying the premium alone does not guarantee the utilization of the services. For instance, a recent technical brief published by the NHSSP/DFID states that "institutional deliveries have been consistently the lowest among Dalits since 2001. Between 1996 and 2016, the average increase in utilization per year was also lowest among Dalits at 2.0 PP (percentage point), while it was highest among Brahmins/Chhetris at 2.9 PP". This is a critical finding at a time when the government has been providing delivery services for free while also handing over cash, as a transportation incentive, before the clients leave for home after the delivery. Despite the incentives, access to the facility is still barred by multiple socio-cultural practices. Yet, the insurance laws do not address this urgent matter.

While the Act and Regulation still need amendments to make the health insurance program function in terms of equity principles, there are already grounds for it to do so. For instance, the Health Policy 2019 talks about "diversification of equitable health insurance". This means that the recently formulated health policy intends to make changes in the existing health insurance program, such as the amendment of the blanket implementation of the premium. In this case, the premium of the program will depend on clients' income, with higher-income people paying more to cover the services of those with lower incomes. This risk pooling mechanism will "spread financial risk across the population so that no individual carries the full burden of paying for health care".

3.8 Federalism and existing health insurance laws

The Health Insurance Act identifies to a nominal degree the role of the provincial and local governments, and is mostly limited to premium payment. While the act has envisioned the formation of committees, it is yet to take shape. In this new context of devolution of power, the insurance program has left out the roles of provincial and local governments. This means that interested local governments must be active in promoting the programs; if not, enrollment officers and enrollment assistants (EAs) will be left to work on their own. Moreover, local leaders do not have any jurisdiction except for a provision where the ward chairperson, along with an additional two members, can recommend the hiring of EAs.

It is important to note that a few of the local bodies have been proactive in ensuring that a majority of their residents are insured. However, not all local bodies are as motivated in taking the program forward.

> *"When the elected representative, ward chief, and chief at local level are not willing to enroll into the insurance program, it is obvious that the EAs get disappointed." KII, …*

3.9 Confusion among government agencies regarding the health insurance program

Government bodies are often confused about the difference between basic health services and the health insurance program. This was made clear in the budget speech for the fiscal year 2018/19, when the government

stated that "health services will be made easily accessible, reliable and qualitative. The health insurance program will be expanded all over the country in order to ensure universal coverage in basic health services."

The right to basic health services is a fundamental right that is enshrined in the Constitution of Nepal 2015. Article 35 on the right relating to health states that "every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services." This also means that people are entitled to sue the government should the latter fail to provide basic health services. However, five years on, the government is still deciding on the services that come under the basic health package.

Currently, the health insurance program is governed by the Health Insurance Act and caters services that are not covered by basic health. Therefore, the government made an error when it mixed up the two concepts in one sentence.

3.10 Inadequate human resources

One of the emergent themes of the study was the shortage of human resources in the health insurance board, including the central, provincial and local offices. This had severely impacted the scaling up of the program in new districts, and had made it difficult to expand coverage and increase enrollments in districts where the insurance program had already been implemented.

The National Health Insurance Board (HIB) exists as an autonomous body whose purpose is to govern the implementation of the health insurance program. Currently, there is a working committee of nine members in the National Health Insurance Board. Under this committee is the executive director. There are 10 units governed by the executive director:

1. Internal Administration
2. Finance Administration
3. Planning Unit
4. Training Unit
5. Complaint Management Unit
6. Monitoring and Evaluation Unit
7. Health, Information and Communication Unit
8. Claim and Reimbursement Unit
9. Information Technology Unit
10. Province Office
    - Sub Unit: District Office

The HIB still operates under the temporary organizational structure, meaning that an Organization and Management survey has not been conducted for the organization. The fact that such a survey has not taken place has crippled the implementation of the policies and its overarching vision to ensure health insurance for all Nepalis by 2030.

Similarly, there are no human resource bylaws for the HIB to hire staff on their own. The workforce at the central level are from the Ministry of Health and Population, while those in the provincial and local levels are hired on a contractual basis.

The limited number of employees at the Claim and Reimbursement Unit has also affected the disbursement of funds to the respective health facilities.

While the executive director leads the entire team, each province office is managed by a province coordinator who looks after the districts that have implemented the health insurance program. Of the seven provinces, Province 2 has two province coordinators delegated in Janakpur, while the other six provinces have only one each.

The enrollment officials in each district work under the province coordinator. The appointment of enrollment officials differ with the districts even though the Health Insurance Regulation states that each district should have at least one enrollment official. For instance, there are three enrollment officials for Jhapa District in Province 1, while only one enrollment official has been recruited for two Province 1 districts: Bhojpur and Terathum. The number of enrollment officials differ in Province 2 and Gandaki Province as well.

Regarding enrollment assistants, each ward level has a single EA.

The human resource issue is especially critical because the staff on the ground stated that they had been stretched to their limits and thus had not been able to perform the tasks mentioned in the Health Insurance Regulation 2019. For instance, enrollment officers had to collect the premium for enrollment and renewal, run promotional programs, and resolve disputes, among others. However, the officers were too busy collecting forms and depositing the premium amounts. They had little time to monitor the work of the EAs or to work on promotional activities.

3.11 Human resources on the ground

3.11.1 Province coordinator

The shortage of human resources posed a major challenge at the provincial level as well. For instance, the provincial coordinator was the only staff member at the province office; there were no office assistants or helpers. Managing the entire province single handedly was thus a challenge. Due to this reason, provincial coordinators had not been able to visit all the local levels and, hence, were unaware about local level issues.

Another challenge was the delay in reimbursement for health service providers, which could be traced to internal issues at the central level. According to the study, this had hindered the perception of health service providers towards the insurance program. At times, the claimed and reimbursed amounts did not match since each claim needs to be valuated meticulously. This again comes down to the shortage of human resources.

The lack of organograms had also made the effective implementation of the program difficult. Although a temporary organogram was claimed from the provincial level, it had not yet been passed from the central level. In fact, the Organization and Management survey itself had not been conducted despite the HIB being such a huge structure.

> *"The delay in performing an Organization and Management survey has made human resource management difficult." (PC, Province 1)*

However, the province office promptly responded to any issue arising at the local level, especially with regards to those between health service providers and clients. They used whatever communication medium was appropriate depending upon the situation.

> *"If the issue is not resolved through phone calls or through letters, we address it on the spot itself. We apply both approaches." (PC, Province 1)*
>
> *"As far as possible, we have been addressing complaints from the side of the clients as well as the service providers." (PC, Province 1)*

The provincial coordinators had also been closely monitoring the health service providers. In this regard, they cross verified if they had doubts on the amounts claimed by the health service providers. Apart from this, they also played the role of facilitators for the local level.

3.11.2 Enrollment officials

The enrollment officials at the district level believed that there was a lack of awareness about the health insurance program at the local level. However, due to limited resources, they had not been able to conduct awareness campaigns or programs.

> *"There is no provision for the district level to plan programs or campaigns about insurance at the district level autonomously." (EO, Ilam)*
>
> *"Many people in the community are still unaware about the health insurance program. They still don't know what health insurance is. In order to make them more aware, we need to conduct awareness programs on our own in the community." (EO, Bardiya)*

Another challenge from their perspective was that people preferred visiting private rather than government institutions for health services. The public found the entire insurance procedure a hassle since they were used to the quick process of paying cash. Topographical factors also played a part, with other health institutions being more accessible than the primary service points under the insurance program.

> *"When we take feedback from the public, they say that the insurance procedure has been troublesome for them." (EO, Bardiya)*

The shortage of human resources could be witnessed at this level as well. Not all EAs that were appointed in each ward were actively involved. Moreover, Nepal's rough topography also made it difficult for EAs to access every household of every ward.

> *"There are 58 EAs in 60 wards because two of them resigned. And among them, only a few are actively engaged." (EO, JUmla)*

According to our findings, enrollment officials have had to play the roles of grievance managers as well. The public approached them in case of any issues or even simply to inquire about the program. Clients sometimes even called them outside office hours with their problems, which they addressed promptly.

> *"We sometimes have to provide emergency services similar to that in hospitals. People even visit the office at night." (EO, Jumla)*

3.11.3 Enrollment assistants

The study found that the major challenge for enrollment assistants (EAs) was the lack of incentives. The EAs had to travel a great deal, especially in hilly areas where settlements are scattered, but they neither received travel allowances nor were they assured of cost recovery in case of accidents. The EAs earned on the basis of the households that they covered, but in hard to reach places with low population, the 10% commission that they got was hardly sufficient.

To add to it, they did not receive their payment immediately but only after the completion of a cycle. In some cases, it was even more delayed. At times, they had to travel far and wide only to meet people who were unsure about the insurance scheme. All of these added up, leading to a lack of motivation on the part of the EAs.

> *"Sometimes we have to go to the households repeatedly to make them understand. We face a lot of stress. If we receive up to Rs. 500 for every family that we enroll, it would probably motivate us to work more." (EA, Bardiya)*

EAs often had to listen to complaints from clients, especially regarding discrimination or ill-treatment at service points. The lack of awareness about the service package itself had created a lot of challenges. The poor delivery of services had also interfered with people enrolling in the program.

> *"When clients go to the hospital and don't receive proper services, they call and scold us. When others in their community hear about it, they refuse to enroll in the service." (EA, Bardiya)*

On the other hand, EAs had been receiving proper help and guidance from enrollment officials. In some cases, communities had been supportive and motivated enough to enroll in the program.

> *"My community has been supportive of the insurance program. Many people have already enrolled, even those in higher positions." (EA, Ilam)*

According to our findings, the health insurance program had been very effective for ultra-poor and marginalized people.

> *"A very low-income person, who was enrolled in the insurance program, had a serious case of appendicitis. It was so serious that he could have died. He had to be taken to the hospital for an operation but he did not have to spend even a penny of his own money. He returned home after spending several days in the hospital. When he*

was able to walk, he brought me a small box of sweets, and told me that he was alive due to my work. That is an incident I'll never forget." (EA, Jumla)

3.11.4 Issues with service and referral facilities

3.11.4.1 Service facilities

One of the main problems regarding service facilities at primary service points was how the insured population were treated by health service providers. It should be noted that this is from the point of view of the clients. The insured participants in the study stated that they were placed low on the priority scale, and the services for them were often delayed. This led to a negative perception towards the health insurance program.

"Insured people are made to wait. This is shocking because patients can lose their lives even if there is a slight delay in treatment." (FGD, Ilam)

"The reason I did not renew my insurance is because insured patients are always asked to wait." (FGD, Ilam)

Additionally, since the insured had to wait for long periods, they preferred buying medicines from pharmacists close to their homes rather than visit service points. The insured clients also felt discriminated against; many were not treated well at OPD counters or by health workers, including doctors.

"My mother, whose nose was bleeding heavily, wasn't admitted to the hospital for almost 28 hours since we were under insurance." (FGD, Ilam)

"The staff appear to be irritated when they see our insurance cards." (FGD, Bardiya)

"We tend to be negatively affected when we hear the staff members say that dealing with insurance is too much of a hassle." (FGD, Bardiya)

The study participants also said that pharmacies gave priority to people paying cash. Such actions had affected their views of the program.

"We have to wait for our turn in pharmacies, while those without insurance are provided services first." (FGD, Bardiya)

Additionally, the insured population did not receive certain medicines, even those that have been listed under the insurance scheme. An example of this was hypertension drugs. Another problem was timing; the insured population has a fixed window (10am to 2pm) within which they are provided services. Often, due to technical issues such as Internet problems within this time, the clients did not receive the services that they needed.

"Even though I had reached the service point at 2 o' clock, I was told that the billing counter had already closed an hour earlier." (FGD, Bardiya)

Still, when people have to undergo surgeries, the insurance covers one lakh from the total cost. This had encouraged clients who had received or had heard about the service in continuing with the insurance scheme.

From the service point of view, the lack of awareness about the scheme among the insured themselves was a major issue. People did not have clear information regarding the facilities that are included under the scheme. Some clients even tried to utilize their premium amount within the given year even though they did not need the services.

"Patients come to us to have x-rays performed on them several times a month just because their insurance is about to expire." (HSP, Ilam)

"Getting yelled at is normal now. This is because the health insurance program is new and people are not fully aware of what it includes yet." (HSP, Ilam)

The other major issue here once again was the shortage of human resources, specifically the presence of specialized doctors. This had made it difficult for service points to appropriately diagnose the health problems of the patients. Similarly, the lack of regular orientation and training for health service providers had raised challenges in service utilization. Workers who had received health insurance training when the program was first implemented were no longer present at the service points, while their replacements were not aware about the particulars of the scheme. In addition, there was a lack of proper resources, such as well-equipped laboratory services and surgery wards.

> *"If we had specialized doctors, we could diagnose all the diseases and not have to send the patients to other places." (HSP, Ilam)*
>
> *"No one here has had health insurance training." (HSP, Jumla)*

Another issue was related to the availability of medicines in primary point of services, especially PHCs. In these service points, the medicines that were available were only for the health services that were provided there. And so, clients often could not procure the medicines that they needed. Additionally, when any equipment broke down, it could not be fixed for a long time.

To add to the issues, other health insurance-related services under the Employment Provident Fund, such as those for Parkinson's disease, Alzheimer's and AIDS control, had resulted in the duplication of health services.

3.11.4.2 Referral mechanism

According to the Health Insurance Guideline 2075, if the point of service is not able to provide the required health service of the insured, a clear referral shall be prepared and sent to the nearest point of service that has the needed services. In service points other than the primary point of service, health services shall be provided only on the basis of the referral card, except in the case of emergencies. Both service points – primary and referral – must keep all patient documents safe. The insured should also be well-informed about the estimated cost required for their treatment.

The referral mechanism was followed by the service points as per the guideline. This was usually done when the required health service or medicines were not available in that particular point of service. The primary point of service also coordinated with the referral point after the referral card was provided to the patient, as is the requirement.

> *"We only conduct OPD and basic emergency services. If the services are included in the service provided by the PHC following the HIB criteria, we try to manage the service or postpone it for the next day. Or else, we refer them to another health facility." (HSP, Ilam)*

One major problem in referral sites was that clients often forgot to bring their referral cards with them. Technical issues, such as unclear scanned documents of the patients, was another problem. Since referral points can be far from the primary point of service, transportation costs were a major issue for clients, especially those belonging to low-income households. Clients could also be difficult, with some wanting to be referred to other hospitals even when it was not required.

> *"They ask for referrals even when there are no reasons to do so. They even try to get referrals by approaching the local representatives."*

3.12 Insufficient promotional activities

The fact that the health insurance program is new to the Nepal government, and that the people are largely unware about the particulars of the scheme, was often mentioned in the discussions and interviews. Firstly, there was no clarity among the insured population regarding the services for which they paid premium amounts. In many cases, they expected travel and other expenses to also be covered by the insurance. When these expectations were not met, they preferred not to continue with the program. Secondly, the insured were not aware about the time it takes for the service to be activated after enrollment, which is three months. In some

cases, they visited the service points the day after they were enrolled. Thirdly, the insurance population did not have a clear understanding about health and life insurance.

There was also a gap in information dissemination from enrollment assistants to the public.

> *"While the clients do not have a clear understanding of the program, the EAs have not been able to explain it in detail either." (HSP, Ilam)*

In a number of cases, the service providers themselves had not fully understood the health insurance concept. As mentioned earlier, training and orientation was provided only when the program was first implemented. The workers that had been trained then had since been replaced.

The finding also shows that promotional and awareness programs were lacking at the ward levels. The enrollment officials, who are responsible for promotional and awareness activities, had not been able to reach all local units since they were overburdened with work.

> *"It takes an entire day to get from one ward to another. Therefore, it is very challenging to raise awareness among the population." (Policy Maker, Kathmandu)*

The findings also show that training and discussion sessions were carried out only at the central level. One reason for this was the limited budget. This study found that ground level counselling, promotional activities and training sessions, with the active participation of local representatives and service providers, was necessary to raise awareness and understanding among the public. IEC materials were also required to advertise the program.

> *"Some PHCs asked us to display flex boards with information about the EAs to raise awareness about the health insurance scheme. Since these boards would be put up in different areas, it would make people aware about the program even if EAs could not reach all households."(EA, Bardiya)*

3.13 Information gap

The study found that there was very little clarity in information about the overall health insurance program.

Firstly, the public had not been provided proper information about the services and medicines included in the package. Providing this knowledge is the responsibility of the EAs. Due to this lack of clarity, the clients tended to be disappointed when they did not receive the services that they thought were under the scheme.

> *"Patients were given the information that CT scans and MRIs were also covered by their insurance. When they found out that these services were not covered by the scheme, they were frustrated and cancelled their insurance program." (HSP, Ilam)*

This then led to others in the community being unwilling to enroll in the program.

> *"Rather than social welfare, I think the EAs are more focused on their income and the number of people they enroll." (FGD, NI, Jumla)*

Some of the insured people were not aware that they would be able to avail of the services only after the activation of their insurance card, which is three months after the date of enrollment. Many were ignorant about the concept of health insurance itself – some clients wanted to know whether they would receive their premium at the end of the year. There were also clients who only wanted to spend their premium and so tried to make use of the health services even when they did not need it.

In the case of the EAs, many did not follow-up or even contact the clients once they had been enrolled into the program. Hence, the public were often unaware about whether their insurance cards had expired or were still working.

"We have not had any contact with the EAs since we enrolled. We were given a form, and that's it. We had to go to the insurance office for renewal." (FGD, Jumla)

"I found out my insurance had expired only after I visited a health facility for my checkup." (FGD, Jumla)

For the service providing institutions, training and orientation sessions were given to the staff only at the beginning of the program. The scheme was introduced in Jumla and Bardiya in 2074 BS, and a year prior in Ilam. Within that time, staff members had been replaced or had resigned, and new delegates had been hired, but there had been no refresher training for older staff or orientation for new staff. Therefore, most of the workers were unaware about the details of the health insurance program, which had created a huge gap in service provision.

"We don't know much about the program. We are giving the insured clients the same services that we provide to other patients." (HSP, Jumla)

As a result, this gap in information had affected the public, who were already ignorant or misinformed about the insurance program.

3.14 Claim and reimbursement

For claiming payments, an open IMIS system exists in every service point in which the claim amount, along with supporting documents, are to be uploaded. The documents are then verified meticulously at the central level, after which the service points receive their reimbursement.

The findings show that the claim process had several issues. First, the scanned receipts tended to be unclear, which was confusing for the staff at the service points. Due to this reason, the entire reimbursement process slowed down.

"The bill for insured patients and the one used for normal patients are two different shades of red. So, it can be particularly confusing when the colors are faded." (HSP, Jumla)

The other issue was related to proper Internet connections. Since the claim and reimbursement system is online-based, the service points were unable make claims when their connection slowed down. Additionally, because the staff had not been provided any sort of training, some had problems in getting used to the computer-based system.

"The service point in Laha, for instance, has faced difficulties in claiming their payment because they don't have a good Internet connection." (HSP, Jumla)

"There were a couple of training sessions in the beginning. The truth is, we still have no idea how the claim process works." (HSP, Jumla)

Since claims were not reimbursed on time, service delivery had been a challenge for the health service providers. To add to their problems, at times the reimbursement that they received tended to be lower than what had been claimed.

"It's a huge problem when the reimbursement amount is, say, 50 lakhs, and the amount actually received is two or three lakhs. We have already informed the director as well as the district level about this." (HSP, Ilam)

Once again, the issue here can be traced to the shortage of human resources. Even though the number of health service providers and enrollees have increased, the number of workers is still low. And this is especially concerning since every receipt and supporting document needs to be meticulously validated and then re-validated at the central level.

"The management of human resources has not been adequate. However, hospitals have not been uploading the documents as per the guidelines either, due to which we have pending claims." (HIB, Kathmandu)

4. Conclusion

The study reviewed the existing laws and policies related to the health insurance program and assessed its implementation challenges. Fieldwork was conducted in Ilam (Province 1), Bardiya (Province 5) and Jumla (Karnali Province). Focus group discussions were conducted among the insured and renewed population, and also included people who had never been part of the insurance program. Additionally, key informant interviews were conducted with experts, the central-level Health Insurance Board (HIB) team, provincial and local level officers, and enrollment assistants.

The prominent finding of the study is the presence of a big gap in the implementation of the Health Insurance Act and its Regulation, with it clearly affecting the health insurance program. While the Act envisions mandatory health insurance for all Nepali citizens, the Regulation states that it is voluntary.

Furthermore, the HIB had not been able to earnestly implement some of the important provisions of the Regulation, including the formation of a service monitoring committee and drug price review committee. The two committees are important to gauge the quality of the services provided by health facilities, and to review the prices of the services offered under the health insurance program.

The study highlights how multiple coordination committees have not been formed despite provisions in the laws. The absence of coordination committees in the provincial and local levels, as envisioned by the Regulation, means that the health insurance laws ignore the vital role that provincial and local governments can play in taking the program forward. Without any jurisdiction allotted to these governments, the HIB cannot make the provincial and local levels accountable towards the program. Furthermore, the formation of these committees would also mean sharing ownership of the program to expedite its coverage.

This again is a reminder of the meticulous coordination mechanism that is required within different government agencies to ensure that all citizens are enrolled in the insurance program. However, apart from a few job descriptions, both the Act and Regulation do not touch on these coordination mechanisms. The coordination, whatsoever has haapened, is more of an individual-centered effort than an institutional structure with a board. However, the frequent political meddling with the HIB and the unstable position of the executive director has made it even more important to have an institutional structure dedicated to coordination.

The shortage of human resources is another important finding that has had a direct effect on the implementation of the health insurance program. This issue is further exacerbated by the fact that the HIB is yet to have its own Organization and Management survey, which would project the total human resources required for the board and would also give it its own hiring authority. Until now, seconded staff from the Ministry of Health and Population have been working at the HIB, and the workforce at the provincial and local levels are hired on a contract basis. The limited number of enrollment officials at the district level has also affected the program, mainly on the promotional activities that should be conducted to insure more people. Although the Act mandates that all Nepali citizens should be insured, it is not the case as of now. Therefore, when the study notes that more people can be insured, it is just assuming the fact that the current enrollment is completely voluntary.

The study also found that the insured people felt like they were given less priority by the service providers. These experiences had been demotivational for them. Additionally, the longer amount of time it took for them to purchase medicines compared to regular customers, and the inability to procure the drugs they needed, which eventually forced them to buy the medicines on their own, had held them back from renewing their insurance packages. However, people who had made use of surgical facilities were quite content with the services and were willing to renew their memberships.

Another shortcoming was that the insurees had not been provided clear information about the package. This meant that some of the clients pestered the providers to utilize their premium amount within the given year despite not needing the services.

There was also a scarcity of information at the local level, especially in the wards, in making the community aware of the program; promotional activities too were absent. This had led to a lack of clarity of the services, with people expecting facilities not covered by the program. The enrolment assistants had also not been able to clearly disseminate information and, often times, were confused themselves.

Similarly, the delays in reimbursement, and the discrepancies in claimed and reimbursed amounts, had made the health facilities question the service. This was especially serious among private service providers who even quit the program due to these issues.

It is, therefore, apparent that even though the health insurance program is a government priority, it is fraught with multiple problems. Some of these issues arise from its laws, while others are part of operational challenges. This study concludes that concrete actions are needed to amend a few provisions in the Health Insurance Act and Regulation, while a strong and stable leadership with a tangible action plan is essential to ensure that all Nepali citizens are insured under the health insurance program by 2030.

5. Recommendations

5.1 Policy recommendation

5.1.1 *Earnest implementation of Act and Regulation*

The provisions that have been mentioned in the Health Insurance Act and Regulation should be implemented as soon as possible. Furthermore, a review is needed to assess whether or not the spirt of the Act has been reflected in the Regulation.

5.1.2 *Clarify duplication*

Certain services that appear in other policies, laws, acts, regulations, and programs – such as the social security program – have been included in the health insurance program as well. These duplications must be clarified and immediately amended so that the insurance program can be taken forward.

5.1.3 *Clarify the confusion between the health insurance package and basic health services*

The Public Health Service Regulation that defines the Basic Health Service Package (BHSP) has not been finalized, and instead has been hedged for more than a year. It is necessary for the BHSP to be defined so that the two service packages can be implemented with more clarity and efficiency without creating confusion for the public. For that to happen, the services under the health insurance package should also be reviewed and clearly defined.

5.1.4 *Defining the roles and responsibilities of all three tiers of government*

In order to run the health insurance program effectively, the engagement of provincial and local governments is a prerequisite. Thus, the roles and responsibilities of each level of government should be clearly defined for the program to run smoothly and to ensure maximum coverage.

5.1.5 *Strengthen the health system*

The insurance program will be pointless unless a strong and well-functioning health system is in place. This would guarantee the quality of health services, which would then motivate people to enroll in the program. Therefore, structural barriers should be clearly addressed to strengthen the health system.

5.1.6 *Region-specific age limits*

It is evident that circumstances in geographical locations differ from each other, and the same holds true for life expectancy as well. For instance, the life expectancy in Karnali is much lower than that of other provinces, and therefore the age of people considered "elderly" in the region is lower as well. Applying a blanket age-limit of 70+ years, as is the case right now, has thus deprived many people in Karnali from enrolling for free in the program even though they are clearly in need of health insurance. This is a facet of the program that needs serious reconsidering.

5.2 Recommendations for coordination and participation

5.2.1 *Formation of coordination committees*

The Act mentions that Health Insurance Coordination Committees shall be formed in provincial as well as local levels. This, however, has not happened. The Health Insurance Board (HIB) should immediately establish these structures, and ensure ownership and accountability of provincial and local governments towards the program.

5.2.2 *Coordination with government agencies*

The HIB should coordinate with all other government agencies, including the Prime Minister's office, the Ministry of Finance, and the Central Bureau of Statistics, among others. This will expedite the identification of the poor so

that the needy are not deprived of the insurance program. A similar coordination is required to enroll all civil service employees in the program as well.

5.2.3 *Coordination with service providers and partnership with the private sector*

The study shows that service providers themselves lacked clarity about the health insurance program. Still, the program has a lot of potential, even more so if support is provided by sections of the private sector. Therefore, it is necessary to establish a coordination mechanism and partnership with relevant private sector entities and the service providers that are already part of the program.

5.2.4 *Formation of a coordination structure within the HIB*

There is a need to form a structure within the HIB that is solely responsible for coordination in the provincial and local levels. Its task would be to ensure accountability and ownership towards the program.

5.3 Management and operational recommendation

5.3.1 *Participation of local governments*

Local governments are the core managerial bodies at the ground level. The participation of the public is closely linked to their local governments. The participation of the local level is therefore pivotal in making the program run more effectively. There should be a clear implementation plan regarding budgeting as well as policy to engage the people on the ground.

5.3.2 *Timely availability of services*

All services under the health insurance program, including equipment and drugs, should be provided to the public on time. This is a matter of great importance since a failure on the part of the service providers to deliver services on time can discourage the public from renewing or enrolling in the program.

5.3.3 *Ease access to services*

Due to the rough topography of Nepal, many parts of the country are difficult to access. This needs to be taken into consideration, while also putting forward methods to ease access to facilities. Besides this issue, many facilities under the service package are not available at primary service points; it is essential for these to be provided to the clients. Additionally, the time window (10am-2pm) for insured clients at service points needs to be extended.

5.3.4 *Quality of service*

Whether or not a client chooses to continue with a program depends on the quality of the provided service. Due to this reason, it is imperative to ensure the quality of services at service points. This should include diagnosis and the availability of medicines. Furthermore, there is also a need to assess the current service and to rearrange the program.

5.3.5 *Easy referral system*

In most cases, the points of referral are at a distance from primary service points. They can be hard to reach, and clients have to pay for extra transportation. This is another aspect of the program that needs management. The referral system should be as easy as possible for the public.

5.3.6 *Response towards the clients*

An often-raised topic was the discrimination and mistreatment that the insured population perceived at service points. A thorough investigation upon this matter is required to assess whether or not this is the actual scenario. If the clients are found to have been discriminated against, then appropriate action should be taken against the service points.

5.3.7 *Frequent training and orientation*

One reason for the vague understanding about the health insurance program among the public was because enrollment assistants (EAs) themselves had not been able to explain the details effectively and convincingly. Apart from the EAs, the staff at service points also did not have a clear understanding about the program and its mechanisms. Hence, frequent trainings and orientation programs are needed so that the gap of understanding between all three parties–the public, the EAs and service providers–can be bridged.

5.4 Human resources

5.4.1 *Organization and Management survey*

The health insurance program handles and manages a large amount of premiums and reimbursements. However, the lack of a proper and formal organogram in the program has made work difficult for current employees as their respective roles and responsibilities are still unclear. Hence, there is an immediate need for an Organization and Management survey, and its subsequent projections. The survey should then facilitate the hiring of the necessary human resources. Only then will the HIB be able to effectively implement the program.

5.4.2 *Additional recruitment of human resources*

There is a shortage of human resource at all levels: central, provincial, district and ward. Due to this, the personnel have been overwhelmed, thus affecting the quality of the program. This issue needs to be addressed as soon as possible.

5.4.3 *Establish a smooth claim mechanism*

The claim and reimbursement mechanism of the health insurance program is completely Internet-based. However, it should be noted that not all health service points have IT experts or employees with sound knowledge of computers. In such cases, the mechanism at present should be reviewed or modified, which could mean adding more human resources or establishing additional mechanisms.

5.5 Need of promotional activities

Promotional activities need to be taken seriously. With health insurance only recently introduced to Nepal, the public do not have a clear idea of the concept. Even the insured population had a vague understanding of the contents of the service package, according to this study. Unless the public have proper knowledge about health insurance, the program will not run effectively. Hence, promotional campaigns and awareness activities should be immediately and regularly put into action at the local level.

5.6 Consistent medicine costs

A big chunk of the insurance premium amounts are used to purchase medicines. However, the prices of medical drugs have not been reviewed in most service points. A crucial responsibility of the government is to review and redefine the cost of medicines.

5.7 Other recommendations

An important objective of the health insurance program is to reduce out-of-pocket-expenditure and ensure equitable and quality services, regardless of peoples' ability to pay. Therefore, there is a need to study the effect of the insurance program on out-of-pocket-expenditure in districts where the program has been implemented for over five years. The findings from this study will serve as a reference while reviewing the program.