

NATIONAL SOCIAL HEALTH INSURANCE IN NEPAL: WHAT WILL IT TAKE TO MAKE IT WORK?

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Nepal

53rd Master of Public Health/International Course in Health Development
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Royal Tropical Institute (KIT)
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NATIONAL SOCIAL HEALTH INSURANCE IN NEPAL: WHAT WILL IT TAKE TO MAKE IT WORK?

A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Public Health

By:

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "**National Social Health Insurance in Nepal: What will It Take to Make It Work?**" is my own work.



Signature.....

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LIST OF ABBREVIATIONS

BPKIHS	BP Koirala Institute of Health Sciences
CBHI	Community Based Health Insurance
EDPs	External Development Partners
GDP	Gross Domestic Product
HHs	Households
HICs	High-income Countries
JKN	Jaminan Kesehatan Nasional
LLMICs	Low-income and Lower Middle Income Countries
MoHP	Ministry of Health and Population
NDCs	Non-Communicable Diseases
NHIP	National Health Insurance Policy
NHIS	National Health Insurance Scheme
OOPPs	Out of Pocket Payments
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QoC	Quality of Care
RSBY	Rashtriya Swasthya Bima Yojana
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SHSDC	Social Health Security Development Committee
SHSP	Social Health Security Programme
UHC	Universal Health Coverage
WHO	World Health Organization

GLOSSARY OF TERMS

- ✚ **Adverse Selection** is a phenomenon where individuals with poor health and risky behaviors purchase insurance more than others. This leads to scheme covering a disproportionate share of people with a high probability of incurring expensive medical costs (1, 2).
- ✚ **Catastrophic Health Expenditure/Payments** is defined as the out-of-pocket spending for health care that exceeds a certain proportion of a household's income with the consequence that households suffer the burden of disease. A household is said to have been impoverished by medical expenses when health-care expenditure has caused it to drop below the poverty line (3, 4).
- ✚ **Co-payments** are the flat amounts that those covered by the insurance must pay out-of-pocket for each service used (2).
- ✚ **Error of exclusion** means excluding the poor households from premium exemptions. **Error of inclusion** occurs when the non-poor households are provided with the premium exemptions (5).
- ✚ **Fiscal space** is the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position (6).
- ✚ **Moral Hazard** is the situation where insured individuals tend to use more services than if they faced the full cost of care (1). It can take two forms. First, the presence of insurance coverage may affect actions that affect an individual's probability of illness, example neglecting preventing behaviors (type-1 moral hazard). Second, the presence of insurance may also affect the amount and cost of care once illness has occurred (type-2 moral hazard). Example: insured individuals demanding more medical care and possibly more expensive types of medical care (7).
- ✚ **Out of pocket payment/expenditure** is any direct payment made by the individuals or households at the time of receiving healthcare services. It is a part of private health expenditure (8).
- ✚ **Provider shopping** means a subscriber moves from one provider to the other with the same sickness within a short period of time or within the same day with the aim of securing medicine which they then can sell (9).

- ✚ **Social health insurance** is a financing approach for mobilizing funds and pooling risks. The newly mobilized funds should be allocated for the poor and near-poor to improve their financial access to health care (10).

- ✚ **Supplier Induced Demand** is the artificial creation of circumstances for patients to utilize more health services. This arises from patients' reliance on providers for information about their need for specific services (2, 11).

- ✚ **Universal health coverage** is defined as an access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access (12).

ABSTRACT

Background: With an overarching objective of ensuring Universal Health Coverage, Nepal adopted National Health Insurance Policy (NHIP) in 2013. The policy is currently being operationalized by Social Health Security Development Committee (SHSDC), in the form of Social Health Security Programme (SHSP). But considering Nepal's current socio-economic, political and health system context, how effective can this policy be in achieving its objective? And, what are the possible implementation issues? Answers of these questions can help facilitate scaling up SHSP effectively.

Methods: The NHIP document was assessed. Relevant literature from Nepal and selected low-and lower-middle-income countries (LLMICs) was reviewed. For analysis, Florence Morestin's healthy policy analysis framework was used.

Findings: First, the NHIP has several shortcomings. It fails to address the policy's wider implementation context. Second, Nepal's evidence base on the policy and SHSP is weak. Third, a range of findings from LLMICs provide critical insights vis-à-vis social health insurance (SHI) implementation in Nepal. For instance- low enrolment persists in most countries. SHI increases service utilization but its impact on preventing catastrophic expenditure is inconclusive. SHI can jeopardize equity and quality of care by inducing negative supply and demand-side behaviors. Stakeholders' role is central in the entire SHI development processes.

Conclusion: The apparent gap in NHIP and prevailing socio-economic, political and health sector challenges raise concerns over the effectiveness and sustainability of SHSP. The Government should strengthen an entire health system rather than solely focusing on the insurance scheme. The SHSDC should take evidence-informed decisions to avoid pitfalls during the policy's implementation.

Key words: National Health Insurance Policy, Social Health Security Programme, Social Health Insurance, Universal Health Coverage, Policy Analysis

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INTRODUCTION AND ORGANIZATION OF THESIS

Signed by over 90 countries, Universal Health Coverage (UHC) is at the heart of the historic Sustainable Development Goals (SDGs) Declaration (13). Health financing is a key aspect of national health system to achieve the goals of UHC (14, 15). According to the World Health Organization (WHO), there are three interconnected roles of health financing; namely- funds collection and mobilization; pooling of pre-paid funds and allocation of resources (12). Low-income countries like Nepal struggle to sustain their financing for health sector. Provision of quality health services to the poor and marginalized groups remains a challenge in this part of the world. In response to this dire situation, countries are experimenting with different models of health financing including social health insurance. Nepal adopted National Health Insurance Policy (NHIP) 2013 with the objective of providing quality health services to its citizens while ensuring financial protection (16). Establishment of Social Health Security Development Committee in 2015 paved Nepal's path to put NHIP's aspirations to action (17).

Needless to say, operationalizing policies comes with certain implications. This demands a careful examination of existing policy environment and other issues arising in foreseeable future. Without an adequate evidence base, these issues may challenge the policy's successful implementation. The socio-economic, political and health system context of Nepal is unique and requires a cautious anticipation of such issues. Following on the global footsteps, Nepal has begun to roll out its first ever national social health insurance. But as the country embarks on this momentous journey, two important questions seek for a critical reflection- first, does the NHIP work in the context of Nepal? And second, how can we make NHIP work in the Nepalese context? Answer to the first question requires looking into the effectiveness of the policy while the second question seeks analysis of possible implementation issues. These answers can help Nepal avoid any possible pitfalls and therefore are of significant relevance in the present context.

Organization of Thesis:

The entire thesis is divided into five main chapters. **Chapter I** introduces Nepal, with key background information. **Chapter II** provides the statement of the problem and justification and comes to the objectives. Theoretical and conceptual framework is also described here. **Chapter III** presents findings in two sub-chapters. Sub-chapter 1 explores the literature from Nepal. Sub-chapter 2 presents findings from low-and lower-middle-income countries, thematically based on the six analytical dimensions of the framework. **Chapter IV** discusses on the overall findings of literature review. Finally, **Chapter V** draws conclusions from previous chapters and provides actionable recommendations to the Government and SHSDC.

Before moving forward with my research, I successfully completed the e-course, "A Framework for Analyzing Public Policy" hosted by the National Collaborative Centre for Healthy Public Policy, Canada. This helped me while working on the analytical framework.

CHAPTER I: BACKGROUND INFORMATION ON NEPAL

1.1. Geographical and Demographic Context

Nepal is a small landlocked country in South Asia located in between China and India. It has a total population of 28.5 million, with an average growth rate of 1.35%. The sex ratio of Nepal is 94 and its literacy rate stands at 67% (18, 19). The life expectancy of Nepalese population significantly rose from 50 years in 1981 to 67 years in 2011 (20). After a long political hiatus, a new constitution was promulgated in 2015 in Nepal. The Constitution divides the country into three tier system- the federal, the province and the local level. The previous five development regions have now been replaced with 7 states, with each state having rural municipalities (called *Gaonpalika*) and urban municipalities (called *Nagarpalika*) (21). At present, Nepal has 263 municipalities, and 59% of its total population reside in these urban areas (22). Department of Health Services under the Ministry of Health and Population (MoHP) is primarily responsible for providing preventive, promotive and curative services to the population. At present, MoHP is undergoing a re-structuring process as a response to the shifting political structure of Nepal.

1.2. Socio-economic Context

Nepal ranks 144 out of 188 countries in the Human Development Index, which reflects on its fragile socio-economic position (23). About 24% of Nepalese population lives below poverty line, which is further expected to increase because of the 2015 mega earthquake (24). More than half of Nepal' population is engaged in agriculture sector, which contributes to one third of the country's Gross Domestic Product (GDP) (20). The International Labor Organization estimates that more than 70% of the economically active Nepalese population is involved in informal sector. This sector is also rapidly expanding due to changing employment patterns in recent times (25). Nepal saw an increasing trend of internal and external migration over the years with remittances mounting to 29% of its GDP. At present, the country's GDP is US\$21.19 billion with an annual growth rate of 2.7%, a fall from 4.8% in 2010 (18). Notably, the percentage of women engaged in self-employed activities is significant in Nepal. Their involvement is the highest in unpaid domestic labor. Low education status and social position of women in Nepalese context has contributed to this situation (20). Marked disparities among socially excluded groups like Dalits in terms of education and economic condition persist. This has further caused inequities in healthcare access and utilization in Nepal (20, 22).

1.3. Health System Context: Equity, Quality and Shifting Health Problems

Over the years, Nepal has made remarkable progress towards achieving its health system goals. For instance- the under-five mortality rate decreased from 54 per 1000 live births in 2011 to 39 in 2016. Similarly, increased deliveries by skilled provider (58%) and deliveries in health facilities (57%) contributed to reduced maternal deaths. Nonetheless, marked

discrepancies in health outcomes exist among population groups based on their place of residence and socio-economic statuses. In fact, Nepal Demographic and Health Survey revealed that the delivery by skilled provider is 67% in urban areas against 46% in the rural. This difference is also observed in terms of wealth quintiles, with a huge gap of 57% between lowest and highest quintiles. Likewise, Nepal Multiple Indicator Cluster Survey showed that under-five and infant mortality rate was higher in rural areas than in urban. In addition, the likelihood of children from the poorest households (HHs) dying before the age of one was twice as high as those from the richest HHs. The survey further highlighted the inequity in contraceptive prevalence among women from rural areas, and of younger age (26). In 2012, as many as 43% of Nepalese from poorest quintile did not seek healthcare due to anticipated catastrophic expenditure (27).

Quality of care (QoC) is another challenge in Nepal's health sector. Expansion of services to remote areas has been the primary focus of many national programmes. This focus has undermined the quality of such expanded services. Inadequate skilled health workers, non-functional medical equipment, stock-out of medicines and supplies are some obstacles in providing quality services (28). Ineffective gatekeeping system is another challenge. Due to the perceived low QoC, poor referral structures and non-restrictive delivery system, bypassing lower-level facilities for tertiary-level facilities is rampant (29). Besides, Nepal's health scenario has gradually shifted from communicable to non-communicable diseases (NCDs). Prevalence of NCDs increased from 51% in 2010 to 60% in 2014 (30). Moreover, the Global Burden of Disease study 2015 showed that ischemic heart disease was the second leading cause of premature deaths in Nepal (31). In the past decade, Nepalese health sector has also witnessed a growing private investment, from large specialized hospitals to small informal pharmacies. While such hospitals are mostly centralized, large chunk of rural population rely on private outlets like pharmacies for services. Hence, recognizing the significant role of such private providers, public-private partnership remains at the center of health policies in Nepal (28, 32).

1.4. Healthcare Financing and Financial Protection

In Nepal, the total health expenditure represents 5.8% of the GDP, and healthcare spending per capita is around US\$ 40. Out-of-pocket payments (OOPPs) continues to be the largest source of health financing in the country, standing at 48%. The 'sin tax' from cigarettes used to be accumulated on Health Tax Fund, earmarked for health. This, however, no longer exists, and only the excise tax on cigarettes is collected in the Fund now (33). The contribution of external assistance remains crucial in health sector financing in Nepal. In fact, 45% of the total expenditure of MoHP is currently being shared by the External Development Partners (EDPs) (34). Significant volume of evidence correlates high OOPPs to catastrophic expenditure on health, which further leads to household impoverishments. It is especially the case in resource-constrained settings like that of Nepal. Through interventions like maternity incentive scheme in 2005, free essential health care programme in 2008, and free

kidney dialysis in 2017, Government of Nepal (GoN) has constantly attempted to provide financial protection and reduce existing health inequities (28). However, hidden costs (informal payments, opportunity costs, indirect costs) undermine the effectiveness of these schemes in Nepal (35).

In 2013, the GoN adopted National Health Insurance Policy with an objective of “capturing the unregulated out-of-pocket spending and facilitating the effective, efficient and accountable management of available resources” (16). District health assessments were also carried out in 5 districts in order to guide the schemes during the pilot phase. On 9th February 2015, Social Health Security Development Committee (SHSDC) was established and tasked to operationalize the policy. As a semi-autonomous institution under MoHP, the Committee has gradually stepped up to implement Nepal’s health insurance policy in the form of Social Health Security Programme (SHSP). The SHSP is currently being rolled out in different districts in phase-wise manner. The Government intends to make the programme available to all 75 districts of Nepal by the year 2020 (36).

CHAPTER II: PROBLEM STATEMENT, JUSTIFICATION AND OBJECTIVES

2.1. Problem Statement and Justification

Rising concern over high OOPs and its adverse impact on accessing healthcare brought about policy discussions on alternative health financing mechanism in Nepal, leading to the adoption of National Health Insurance Policy. In general, the field of health insurance is relatively new to the country. Nepal's experience in implementing Community Based Health Insurance (CBHI) schemes have shown that the path is not as rosy as it was expected to be. In fact, the review on impact and scope of the existing CBHI schemes did not reveal promising results. The schemes' low population coverage, absence of 'voice' mechanisms, ad-hoc management and concerns of financial viability and inequity limited their scope to provide quality health services (37). The experience of the BP Koirala Institute of Health Sciences (BPKIHS) in implementing health insurance was not positive either. The assessments revealed a marked gap between premium collection and expenditure, adverse selection and administrative constraints. The continued deficit ultimately resulted in BPKIHS shutting down its programme in 2005, just after five years of implementation. Knowledge gap, misuse of insurance card by clients, low enrolment, client dissatisfaction in services being provided and the use of services by uninsured through personal influence were some of the obstacles identified (38-40). However, these reflections come from small fragmented schemes, and makes them utterly insufficient to be the sole basis for designing a nation-wide SHI system.

The main essence of risk pooling is to prevent catastrophic expenditure in an unexpected health event through pre-payment mechanisms. Effective insurance, however, is not just limited to financial protection. It also implies that the insured have access to desired quality health services (2). In order for this to happen, some pre-requisites such as support structures (administrative, legal and regulatory) are essential, both in supply and demand side (39, 41, 42). While the question of whether such pre-requisites exist in Nepal needs serious consideration, it is equally important to acknowledge the country's changing socio-economic, political and health system context and what that means to implementing an insurance policy. A rich body of literature from around the world indicate mixed experiences of countries in applying health financing reforms like this. However, Nepal's evidence base regarding the matter is very weak. Only a handful of studies have looked into the possibility of reaching UHC in Nepal through insurance mechanism. No studies have so far critically examined the current health insurance policy of Nepal through different analytical perspectives. Hence, comprehensive analyses of the challenges Nepal may encounter while translating the policy into action are virtually absent.

Globally, health insurance is being viewed as a panacea to health financing reform for UHC. But when applying the initiative on ground, its specificity is often overlooked. The focus, at times, is towards rushing the implementation, rather than understanding the complexity of the implementation context. For a country like Nepal whose general socio-political

environment is rapidly transitioning, it becomes crucial to go deeper into critically understanding this new approach. Sufficient information on the content and context of the matter is a must to guide the policy operation in the country. With overarching objectives of increasing access and utilization of required quality healthcare services, Nepal is at the early stage of implementing its health insurance policy in the form of Social Health Security Programme. In this situation, two pivotal questions emerge- ***how effective can this policy be in achieving its objective in Nepalese context?*** And, ***what are the possible issues arising from the implementation of such a policy?*** Fortunately, global experiences with regard to implementing SHI is abundant. Nepal has the opportunity to reflect on experiences from other countries such that these questions are answered. Critically drawing upon the existing evidence base and anticipating contextual implementation challenges can help prevent Nepal from going through the same pitfalls other countries went through. Hence, in this policy analysis, the evidence from low and lower-middle-income countries (LLMICs) is examined. The findings from this study are expected to support the Government and the SHSDC in scaling up ongoing health insurance program through evidence-informed actionable recommendations.

2.2. Objectives

2.2.1. Overall Objective: To critically analyze the National Health Insurance Policy 2013 of Nepal and explore relevant experiences of low and lower-middle-income countries in order to provide recommendations to the Government and Social Health Security Development Committee to effectively scale up the implementation of the policy.

2.2.2. Specific Objectives:

- i. To analyze the National Health Insurance Policy 2013 of Nepal.
- ii. To explore available literature in Nepal with regard to the implementation of the policy.
- iii. To explore relevant experiences of low and lower-middle-income countries in implementing their health insurance programme.
- iv. To provide recommendations to the Government and Social Health Security Development Committee for effectively scaling up of the ongoing health insurance programme.

2.3. Methodology

2.3.1. Policy Analysis Theory and Approach

The foundation of this research is based on policy analysis theory. Policy analysis is multi-faceted, and hence there is no single approach to it (43). Primarily, there have been two kinds of conventional policy analysis frameworks, determined by the nature of the research problem and research questions. The first is the analysis *of* a policy, defined as a descriptive, interpretative or explanatory academic discourse. The use of this framework is often conducted as “policy research studies” or “policy case studies”, whose main objective is to revise the existing policies by looking critically into the rationale of such policies and their components. The recommendations from such policy research studies can also build up future policy making processes. The second framework, analysis *for* a policy, is defined to be ‘prescriptive’ or ‘interventionist’ as it is used in actual production of the policies, most often commissioned by the policy makers themselves (43, 44). Both of these frameworks have been used in health policy analysis by a number of policy analysts.

According to Walt et al., health policy analysis ‘explains the interaction between institutions, interests and ideas’ (45). With regard to the intent of this research, this is the analysis *of* a health policy, specifically Nepal’s National Health Insurance Policy. In order to do this policy analysis, I will make use of the policy document itself, the available literature on the policy from Nepal and the experiences of other low-and lower-middle-income countries in implementing similar initiatives. As such, this research will start by critically looking into the National Health Insurance Policy 2013 of Nepal. This will further be followed by a literature review of relevant experiences of Nepal and other countries. For the literature review, Morestin’s healthy policy analysis framework will be used (46).

2.3.2. Theoretical and Analytical Framework of the Research

The framework given by Florence Morestin provides public health perspectives into healthy policy analysis. The framework uses the definition of healthy public policy as “healthy public policy improves the conditions under which people live: secure, safe, adequate and sustainable livelihoods, lifestyles, and environments including housing, education, nutrition, information exchange, child care, transportation and necessary community and personal social and health services” (46). The two main axes are incorporated in the framework:

Axis 1: Analysis of effects (“Does the policy work?”)

Axis 2: Analysis of implementation issues (“How can we make the policy work?”)

Within these two broad axes, there are six analytical dimensions, namely; effectiveness, unintended effects, equity, cost, feasibility and acceptability. An important aspect, sustainability/durability runs through all six dimensions (46). Each of these dimensions correspond to specific questions regarding the policy as shown in table 1.

Effects	Effectiveness	What effects does the policy intend to have on the targeted health problem?	Durability
	Unintended effects	What may be the unintended effects of this policy?	
	Equity	What may be the effects of this policy on different groups?	
Implementation	Cost	What may be the financial cost of this policy?	
	Feasibility	How (technically) feasible is this policy?	
	Acceptability	Do the relevant stakeholders view the policy as acceptable?	

Table 1: Dimensions of healthy policy analysis (46)

This analytical framework further elaborates on the interrelationship between the six analytical dimensions. As depicted in table 2, acceptability is influenced by all other dimensions; while feasibility is influenced by acceptability and in turn cost is influenced by feasibility. Notably, whether the health policy bears any effect/result is largely influenced by the implementation conditions (in other words, acceptability, cost and feasibility dimensions) (46).

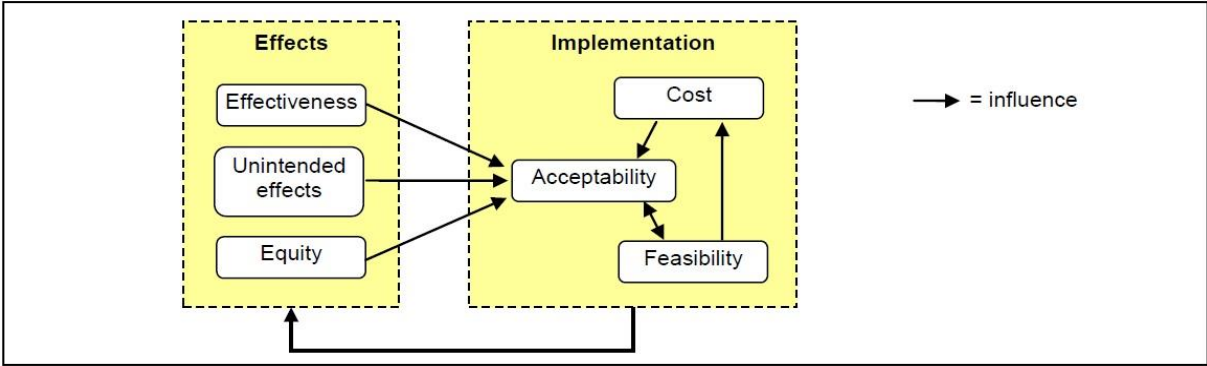


Table 2: Interrelationships between the six dimensions of healthy policy analysis (46)

As such, Morestin’s framework is a comprehensive tool for analyzing a healthy public policy. It not only recognizes the importance of analyzing effectiveness of any policy, but also considers how the policy translates into unintended results, both positive and negative, within or beyond the policy’s domain. The framework largely takes into account significant issues such as equity, cost, feasibility and acceptability that may arise as a consequence of policy implementation. The context or the environment within which the policy is implemented is another important aspect heeded in the framework. Applicable to a wide range of topics, this framework is also simple to apply to one’s research on policy analysis, with clear directions and steps on using it (47). Two broad axes of the Morestin’s framework overlaps with the two research questions being addressed in this study. Each of the six dimensions of the framework are described and discussed thematically in the findings chapter.

2.3.3. Methodology to Address Specific Objectives 1&2

To address the specific objectives 1 and 2, a review of the policy document and other relevant documents from Nepal was done. Hence, at first, Nepal's National Health Insurance Policy 2013 was searched on the website of MoHP. Secondly, websites of SHSDC, WHO and The World Bank were searched to gather relevant documents and information on the implementation of the policy. Finally, online databases PubMed and VU library were used to search for relevant published articles. Below is the key terms and inclusion criteria used during the search:

Search terms	'National health insurance policy' AND Nepal, 'universal health coverage' AND Nepal, 'social health protection programme' AND Nepal, 'health insurance' AND Nepal, 'social health security programme' AND Nepal, 'social health insurance' OR 'national health insurance' AND Nepal, effect* AND 'health insurance' AND Nepal, equity AND 'social health insurance' AND Nepal, finance OR budget AND 'social health security programme' AND Nepal, sustain* AND 'health insurance' AND Nepal, equity AND 'health insurance' AND Nepal, governance OR accountability AND 'health insurance in Nepal', feasibility AND 'health insurance' AND Nepal, impact AND 'social health insurance' AND Nepal, implement* AND 'social health insurance' AND Nepal, challenge AND 'health insurance policy' AND Nepal
<p>Inclusion criteria:</p> <ul style="list-style-type: none"> ▪ Accessibility of full article ▪ Published in English or Nepali ▪ Focus on Nepal's National Health Insurance Policy ▪ Focus on Nepal's Social Health Security Programme 	

Table 3: Key search terms and inclusion criteria (specific objective 1&2)

2.3.4. Methodology to Address Specific Objective 3

A review of literature from various low and lower-middle-income countries was done in order to address the specific objective 3. For the purpose of gathering relevant studies, several online databases such as PubMed, Scopus and Vrije University library were searched systematically during May-July 2017. The online VU library was sought for accessing the articles which was not publicly available. Key search terms and their synonyms were combined using Boolean operators (AND, OR and NOT) during search. Truncation was used for words such as 'effect*', 'sustain*' and implement*. After the literature was gathered, a comprehensive list of the articles was made, during which the documents not meeting the

inclusion criteria were excluded from analysis. Below is the key search terms and inclusion criteria used during this search:

Search terms	'health insurance' and 'low income countries', 'LMICs' AND 'health insurance', insurance AND equity, 'access to care' AND insurance, national health insurance policy, effect* AND 'health insurance', implementation AND challenges AND 'health insurance' AND Asia OR Africa, 'health financing' AND low-income OR LMICs, impact AND 'health insurance' AND 'developing country' OR low-income OR 'lower middle income country', 'sustain*' AND 'health insurance', cost AND 'health insurance', , implement* AND 'social health insurance' AND 'low and middle income countries', 'social health insurance' AND least developed countries' OR 'low income countries', politics AND 'social health insurance, stakeholders AND 'social health insurance', governance OR accountability AND 'health insurance', 'informal sector' AND 'health insurance' AND 'LMICs'
<p>Inclusion criteria:</p> <ul style="list-style-type: none"> ▪ Accessibility of full article ▪ Published in English or Nepali ▪ Focus on countries' health insurance policy ▪ Focus on analysis of social health insurance programmes in low and lower-middle-income countries which are on 1st and 2nd stage of UHC¹ ▪ Relate to the components of Morestin's framework 	

Table 4: Key search terms, inclusion criteria (specific objective 3)

2.3.5. Selection of the Literature

To select the literature in a systematic order, the procedure followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline (48). The procedure included two rounds to search literature from Nepal and from other LLMICs. A detailed flow diagram of the selection procedure is shown in figure 1.

In the first round, the selection of literature from Nepal was done. There were only a handful of documents. The initial search from PubMed and VU Library yielded a total of 15 documents. After the duplicates were removed, titles and abstracts screened, this number went down to 3. Published between 2015 to 2017, only one of them was a peer-reviewed

¹ In its 2014 report 'Universal Health Coverage for Inclusive and Sustainable Development', the World Bank describes four different stages of UHC development (refer to Annex 2). For the purpose of this research, all the country cases belong to either stage 1 or stage 2.

article, the rest were grey documents. Besides, search in the relevant websites helped retrieve 4 additional documents. Of these, two were the most recent annual reports from the Department of Health Services and SHSDC, one was a comprehensive report on Nepalese social health insurance published by SHSDC and the other was the National Health Insurance Policy 2013 document. In total, there were 7 pieces of literature from Nepal.

In the second round, the search for literature from LLMICs yielded 1450 studies. After removing the duplicates and irrelevant studies, the number reduced to 1086. Screening the titles and abstracts further decreased the number to 61. When all the inclusion criteria were applied, 28 studies were found to be eligible. Conducted between 2010 and 2017, the documents include 2 systematic reviews and 26 peer reviewed articles.

Including both rounds, a total of 35 different documents have been reviewed in this research (refer to annex 3&4).

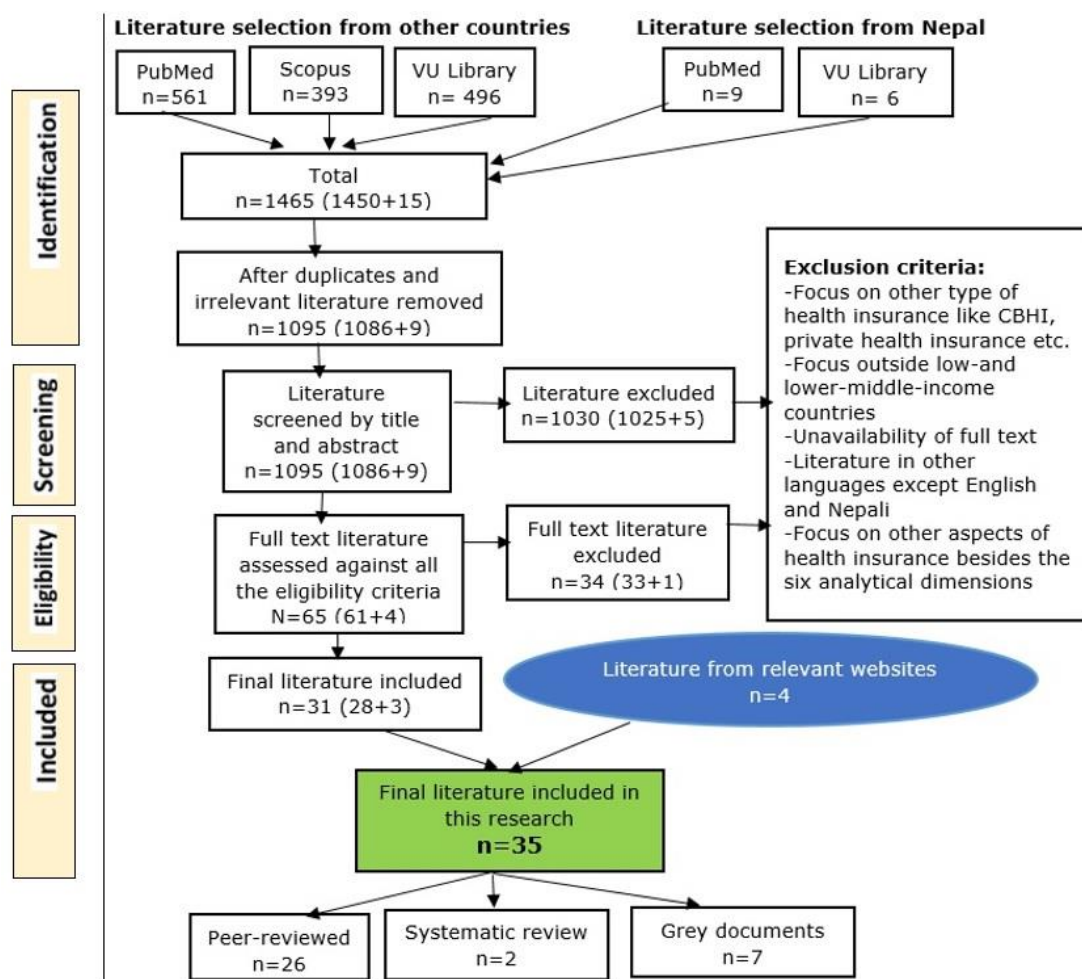


Figure 1: Flow diagram of the literature selection using PRISMA guideline (48)

CHAPTER III: FINDINGS

3.1. Description of the literature

In total, 35 different documents, both grey and peer-reviewed articles were referred to, to build-up the findings chapter. The entire literature came from 11 LLMICs of Asia and Africa (refer to annex 3&4). Including both the single-case and multiple countries studies, there were 10 different articles from Ghana, 7 from Nepal, 5 from Nigeria, 4 each from India and Indonesia, 3 each from The Philippines and Vietnam, 2 each from Kenya and Tanzania and finally 1 each from Uganda and Afghanistan. Half of the documents from Nepal included analytical commentaries on NHIP implementation and the rest were grey documents. It was thus difficult to vouch for their methodological robustness. The documents from other LLMICs included 2 systematic reviews and 26 peer reviewed articles. The studies in general had extensively used local qualitative and quantitative data in their analyses. The studies from Kenya, Nigeria and Uganda had done a retrospective policy analyses on their respective health insurance policy development. There was one experimental study obtained from Ghana. Of the 2 systematic reviews, the one by Acharya et al. looked into 25 papers on SHI and analyzed the programme's impact among the poor and informal sector in low and middle-income countries. The systematic review by Prinja et al. was focused on India and reviewed 43 studies. In this review, the analysis of the impact of SHI was done in terms of service utilization, OOPs and health status.

The findings obtained through literature review is divided into two sub-chapters. Sub-chapter 1 presents the analytical summary of findings from 7 different documents gathered from Nepal. Sub-chapter 2 showcases the results from the final set of 28 articles retrieved from selected low and lower-middle-income countries.

3.2. Sub-chapter 1: Review of Literature from Nepal

3.2.1. National Health Insurance Policy: What does it contain?

The first ever National Health Insurance Policy of Nepal came in 2013. The eight-page document (original version) has a total of fourteen headings. Each of the heading is arranged to give an overview of the background, policy rationale, its goal and objectives, and implementation strategies. Resonating on the objectives of other polices and strategies, the NHIP carries forward the Government's aspiration to achieve universal coverage by reducing high out-of-pocket healthcare expenditures. The policy's descriptive analysis is presented in the following paragraphs based on the policy document itself (refer to annex 1).

Policy Context: The NHIP identifies the prevalence of inequity in healthcare utilization by population groups of different socio-economic status and geographical areas. The challenges to equitable healthcare utilization have been briefly mentioned in the document as a

separate heading. Weak financing function of the Nepalese health system, in terms of resource generation, pooling and purchasing of services comes as a prominent obstacle in the description. The limitation of various government-led interventions to provide protection to poor and marginalized population has been recognized. The document backs the policy rationale by Nepal's National Health Accounts from 2001 to 2009. These Accounts show high unregulated OOPs for healthcare, which exceed existing pre-payments arranged by both government and non-government organizations. The policy presents itself as the tool to effectively operationalize the efforts of the GoN to provide social health protection to its citizens, especially disadvantaged groups.

Goals, Objectives and Strategies: The policy constitutes of the long-term goal, the main objective and three specific objectives. The long-term goal of the NHIP is “to improve the overall health situation of the people of Nepal”, and the main objective is “to ensure universal health coverage by increasing access to, and utilization of, necessary quality health services”. The specific objectives of the Policy are in line with this main objective, encompassing the aspects of increasing financial protection, mobilizing financial resources and improving health service delivery.

The policy incorporates three broadly categorized strategies in line with three specific objectives. Strategy 1 speaks to specific objective 1 and intends to decrease out-of-pocket expenditure, pool and allocate funds equitably, increase community mobilization and improve health seeking behavior. Strategy 2 is related to promoting pre-payment mechanism through collection of sufficient funds and prioritizing the allocation for target groups. The final strategy intends to improve health services delivery by provider payment mechanism, integration of current social health protection programmes, stakeholders' engagement and probable risks reduction.

Governance Plan: The NHIP is envisaged to be operationalized by an autonomous entity, the National Health Insurance Fund, which is governed by the National Health Insurance Board. The National Health Insurance Fund is accountable to the Insurance Board and the Government. The Board is expected to work directly under MoHP and is responsible for regulating the programme. This Board would consist of representatives from –

- various government bodies like National Planning Commission, Ministry of Health and Population, Ministry of Finance, Ministry of Labor and Employment, Ministry of Federal Affairs and Local Development, Ministry of Cooperatives and Policy Alleviation.
- a representative from Health Insurance Board
- a representative from Social Security Fund
- representatives from non-governmental and professional bodies and consumers

Implementation Plan: The plan for implementation as per the insurance functions is described below-

- ✚ **Collection and pooling of the fund:** The National Health Insurance Fund is responsible for collection and pooling of funds. There are three main sources through which the funds are collected-
 - The households: funds collected as contributions/premiums, as set by the National Health Insurance Board
 - The government: funds provided for enrolling poor and target households, funds provided for implementing national health insurance programme and funds provided to existing social health protection interventions pooled into one programme
 - Other institutions, organizations, individuals and bodies
- ✚ **Purchasing and provision of health services:** The National Health Insurance Board is responsible for making contractual agreements with service providers to provide defined health services. Based on the pre-defined criteria, service providers (public or private) are enlisted or delisted as providers under the insurance programme. Although this policy document does not specifically provide purchasing mechanism, it writes “an effective and efficient payment mechanism shall be defined for making payments to service providers”. Furthermore, the document refers to the establishment of measures to maintain responsiveness by health facilities. Despite the policy’s intent to provide services to enrollees on the ‘cash-free’ basis, the document hints towards a possible co-payment system for referred cases.

Administrative and Legislative Arrangement: The NHIP is envisioned to be supported by a separate insurance Act. Those enrolled in the insurance programme are to be provided with electronic identity cards. Furthermore, an electronic system looks after the membership issues like registration, renewal, payments, and collection of contributions. The poor and members of target population are identified to ensure their participation. The policy also envisions the establishment of an integrated monitoring and evaluation framework. Finally, towards the final page, the NHIP document lists risks and assumptions. The risks range from low enrolment, issues relating to identification of the poor and moral hazard to the skewed flow of patients to private providers. Of the two assumptions, the first one is regarding the availability of budget to look after infrastructure needed by the insurance programme such as human resources and administrative costs. The second assumption relates to the assurance of uniformity in provision of quality services through mechanisms like accreditation and enlisting.

3.2.2. Efforts made so far

Four years after the policy was adopted in 2013, GoN has made continuous efforts for its implementation (36). Below are some notable efforts being made in the area so far-

- Formation of Social Health Security Development Committee on 9th February 2015 to “provide health security coverage and ensure access, utilization of quality health services at an affordable cost for all citizens of Nepal”. The Committee is chaired by the Secretary of MoHP.
- Formulation of Social Health Security Programme (health insurance) implementation guideline in 2015.
- Piloting of insurance programme in three districts (Kailalim Baglung and Ilam) in FY 2015/16.
- More districts selected to further scale up, in phase-wise manner (5 districts in every 3 months) for FY 2016/17.
- Rs. 2.5billion (≈US \$ 24million) had been earmarked by MoHP for implementing SHSP in FY 2016/17.
- Endorsement of the Health Insurance Act in 2017.
- Government interested to make the SHSP mandatory for civil servants and migrant workers
- SHSDC ended the previously arranged ‘co-payment’ system.

The salient features of ongoing Social Health Security Programme include (49, 50)-

- Voluntary-based
- Household-contribution based. A five membered family pays Rs. 2500 (≈US \$ 25) per year. For more than five members, additional Rs. 425 (≈US \$ 4.25) has to be paid. The family with five members will be able to make a claim of upto Rs. 50,000 per year while the one with more than five members are liable to Rs. 50,000 with additional Rs. 10,000 for each extra member. The definition of household has been given by the Health Insurance Act.
- Subsidies provided by the GoN for categories: ultra-poor (100%), poor (75%), vulnerable group (50%), female community health volunteers (50%)
- Conditions put on referral system to strengthen gatekeeping
- Use of technology like smart phones for enrolment.

3.2.3. Assessment of relevant literature on the policy and SHSP

The first ever piloting of SHSP in three districts resulted in considerably low participation. The initial assessment showed that there were 12,623 enrollees, representing just under one percent of the total population of these three districts (49). The general perception of services provided at public facilities being poor has contributed to the low enrolment. In addition, the analysis from this initial phase included challenges related to issuing identity

cards to the poor and target groups, integration of formal sector, reaching the informal sector and migrant population. Although the insurance policy aimed at integrating the existing social health security interventions into one national programme, this has been a challenge in the first round (36, 49). The assessment has also shown higher number of enrollees being female. No further examination of this finding has so far been done. As of January 2017, a total of 47, 734 people were enrolled in the SHSP in 8 piloted districts of Nepal, and 90% of the utilization had been on outpatient services. The challenges identified in earlier stage continued to extend to the later stage of SHSP implementation (50).

Considering the current governance and purchasing system of SHSDC, one study came up with recommendations for SHSDC on the very matter. These include making SHSDC an independent body, practicing strategic purchasing and integrating all the social health security funds into a single pool. The study further emphasized on the role of state to monitor the agency implementing SHI (51). Additionally, Mishra et al. highlighted the importance of inclusive and larger risk pooling, comprehensive benefit package and private sector engagement to help ensure access to healthcare (52). Furthermore, reflecting back on the previous experiences of Nepal with the implementation of CBHI schemes, another study stressed on the need to strengthen health system as a whole while the new insurance programme is being launched. This study clearly pointed out how the current health insurance programme was being rolled out without any strong financing measures both at supply and demand side, considering it as a 'risky approach'. The study further emphasized on the urgency of more debates and discussions on matters relating to the implementation of Nepal's health insurance policy to facilitate its operationalization (17).

3.3. Sub-chapter 2: Review of Literature from LLMICs

3.3.1. Analysis of the Effects

❖ Effectiveness

Effectiveness is directly related to the goal and objectives the policy intends to achieve. In the Morestin healthy policy analysis framework, effectiveness dimension refers to any effect resulting from the implementation of the policy. These effects could either be positive, neutral or negative. The Framework focuses on the use of intervention logic/logic model along with the serious consideration of the 'implementation context' in order to analyze the effectiveness of the policy being pursued (46). Theoretically, the health insurance programme achieves UHC through a series of anticipated effects such as increased health services utilization and reduced out-of-pocket expenditures (53). Following this logic, the degree of effectiveness of insurance programme is reflected through a number of variables, namely service utilization, financial protection and improved health status (10, 12). The forthcoming paragraphs highlight the results documented in LLMICs in these variables.

A systematic review of health insurance in developing countries showed that while most countries recorded increased utilization of health services, particularly hospital care, others did not follow this trend. Interestingly, some countries had conflicting results within themselves. For instance, few studies on Vietnam revealed increase in service use by the insured compared to uninsured, but some others showed that SHI did not affect service utilization (53). However, a recent systematic review from India found health insurance positively associated with increased use of healthcare services. The degree of increment varied from 12.3% up to 244% among insured HHs. Pent-up demands due to previous inaccessibility and genuine elimination of barriers to access care were two main reasons discussed, although the review indicated the absence of robust studies to make any association (54). Another study concluded that India's national health insurance programme, Rashtriya Swasthya Bima Yojana (RSBY) resulted in increased inpatient care utilization rate by 59%. The study pointed at the lack of strong evidence regarding factors contributing to this increased rate after introducing RSBY (55). The study on Indonesia's Jaminan Kesehatan Nasional (JKN) also showed increased service utilization due to increased willingness of people to use the services (56). Furthermore, a study from Tanzania found that the enrolled HHs were more likely to seek care and use services. The authors concluded that the provision of wide range of providers, reduction in financial barrier and insured HHs living closer to health facilities acted as enabling factors for positive health seeking behaviors (57).

Increased utilization rates due to National Health Insurance Scheme (NHIS) added extra workload and put pressure on the existing infrastructure in Ghana. This led to negative results such as illegal and informal payments, long waiting hours and health workers not adhering to standard operating procedures. Due to limited capacity of health system to capture the growing number of clients, both technical and perceived QoC degraded as a result of NHIS (58). The QoC was also challenged by ineffective gatekeeping system. Absence of any co-payment mechanism and incentives to check frivolous service use by clients resulted in 'provider shopping' and moral hazard in Ghana. Lack of technologically sound record keeping structures at Primary Health Care Centers further weakened Ghana's gatekeeping system (9). Bypassing primary healthcare facilities due to low QoC was also recorded in the Philippines' Philhealth programme (59). Moreover, studies from India and Tanzania found that the utilization by the insured HHs skewed towards private providers. In fact, of the total claims made under the RSBY, three quarters were from the use of services from private facilities. In light of the prevalence of dual practice in India, the study indicated towards the possible 'gaming' by private providers and providing unnecessary services (54). Similar to other LLMICs, the public in Tanzania perceived quality of services provided in private facilities to be better than the government-led facilities. As a result, those insured were more likely to choose private providers rather than public (57).

In a systematic review from India, 5 out of 8 studies revealed that the implementation of health insurance did not result in reduced OOPs. On contrary, the review showed increased

OOPPs and catastrophic health expenditures (54). Studies on Philhealth and JKN also showed increased out-of-pocket expenditures (56, 60). Interestingly another study concluded that although not entirely, Philhealth did reduce the overall size of OOPPs among insured households (59). In another study, five years long implementation of the Indian RSBY was neither associated with catastrophic health expenditure nor with impoverishment related to health spending. Unlike this finding, records from Ghana, Indonesia and Vietnam showed 4 to 6 % reductions in the overall OOPPs since the introduction of the financing reforms. A separate study from Ghana, further showed strong contribution of NHIS in providing financial protection. In fact, the findings showed that enrolling in insurance reduced OOPPs by 86%. The authors attribute to the generous benefit package and absence of co-payment in Ghanaian NHIS for this result (61). However, the well-off households in urban areas were seen to be benefiting from such prepayments rather than the poor. Notably, the presence of indirect costs (example travel and lodging costs), informal payments, limited benefit package and coverage, co-payments system and supplier induced demand were attributed to such a situation (53-55, 59, 60, 62).

With regard to the improved health status of insured population, the literature review reiterated that there is lack of robust studies to make any conclusive statement. Whilst there some studies found little contribution of insurance in improving the health status, others showed no effect in majority of outcome indicators. Nonetheless, a study from India positively associated health insurance with decreased mortality from the conditions insured by the scheme. Likewise, the women enrolled in Ghanaian health insurance programme were more likely to receive care during pregnancy, deliver in health institutions and have lesser pregnancy-related complications (53, 54, 63). However, considering the difficulty to establish causal relation between social health insurance and health outcomes, overall findings on this subject remain ambiguous.

❖ **Unintended Effects**

All policies are implemented in a dynamic environment, where complex interactions among different socio-political systems and stakeholders occur. These interactions in turn, may produce results unrelated to the objective of that policy, either be positive or negative. All those effects produced as the consequence of the policy's adoption but are not related to the objective of the policy, are categorized into 'unintended effects' under the Morestin's framework (46). As such, these effects occur outside the intervention logic of SHI. The literature review in general found that the studies concerned with direct analyses on such unintended effects is non-existent. Most of the effects recorded in the literature fall under the criteria of 'effectiveness' dimension and hence have been presented there. However, some of the impact studies do reflect on the consequences of implementing health insurance intervention which have been found to fit this dimension.

Both positive and negative unintended effects were recorded in some studies from Ghana and Tanzania. An experimental study from Ghana revealed that the households prioritized male members of the family to be enrolled in the health insurance programme, for example enrolment of sons over daughters. It showed that this gender-biased prioritization of household resources for health was associated with the general status of men in the Ghanaian society rather than their risk taking behaviors (64). Similarly, extreme political interference in the recruitment of staff for Ghanaian NHIS raised concern over the scheme becoming a “vehicle for rewarding party members” (9). The study from Tanzania showed that due to the initiation of national health insurance, extensive capacity building trainings were provided to the health workers of the country. Although the training was specifically meant for the personnel involved in the implementation of the programme, other staff also benefitted from it (65).

❖ Equity

With its theoretical roots in the principle of redistributive justice, health equity is defined as the “absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy” (66). Critically looking into the policy from the equity lens is considered crucial considering the fact that while most policies improve the health of population in general, some may have implications on specific segment of population. These implications may be positive or negative. Thus, in Morestin’s healthy policy analysis framework, the differential effects of the policy on different groups with different characteristics (such as age, gender, socio-economic status, sexual orientation, ethnicity, place of residence, etc.) are examined (46). One of the main focus of SHI in low and lower-middle-income nations has been to provide access of care to all their citizens, especially poor, marginalized and vulnerable groups (67). Unsurprisingly, most of the health insurance related studies done in these countries have incorporated the element of equity.

A systematic review from India showed that the enrolment of households in its publicly funded health insurance scheme as well as the utilization of health services were inversely related to one belonging to the socially disadvantaged population such as poor, and lower caste people. This meant that those groups actually targeted by such insurance programmes usually have inequitable enrolment and service utilization (54). This finding was further supported by another study done on India’s RSBY, which revealed only 12.7% of households in poorest quintile were enrolled in this national scheme, against 36.52% enrollees belonging to the richest quintile (55). Similar result was seen in another literature review done in low and middle-income countries and was further corroborated by the study from Ghana. These studies showed the richer households participated more in their national insurance programmes than the poor. In addition, enrolment of large unregulated informal sector prevailing in these countries have remained to be a challenge as is evident from bulk

of reviews (53, 62, 63, 68). In Nigeria, for instance, of the total 3% coverage of the NHIS, most were formal employees. More than 75% of the population who were engaged in informal economy were not yet covered by the Nigerian NHIS (69).

Administrative and technical challenges such as defining and identifying poor, distribution of cards to appropriate groups on time, fixing appropriate premium, collection of contributions, moral hazard and politicization of healthcare have hindered in including poor households and informal sector. Low level of understanding among general public regarding the concepts of pre-payment and its benefits was another issue observed in LLMICs, which led to low enrolment and retention of especially the vulnerable groups of rural areas (53, 70, 71). Interestingly, Vietnam persistently recorded greater enrolment from those belonging to the highest and the lowest income groups. As a result, the problem of 'missing middle' remained significant as the non/near-poor households from informal economy could not be captured by the country's SHI initiative (72). With regard to other demographic characteristics, the studies have found that the educated households, and those headed by elderly and by female were more likely to be enrolled in the insurance schemes (68). For example-the households headed by people aged more than 40 years were more enrolled in RSBY than those who were younger. Positive association of enrolment was also found with smaller family size. The studies attribute to women's likelihood of taking care of illness and increased cost for premium with larger family size for the higher number of enrolled households with female heads and small family size respectively (53, 55, 68).

However, the studies showed mixed results of households with chronic conditions being enrolled in the social health insurance. There were also considerable variations in coverage of SHI with regard to rural and urban areas, across and in between different states (63). While most studies showed lower rural coverage of insurance in general, some studies in Ghana and India have shown the opposite being true. The programme's pro-poor and decentralized approach have been attributed for such results. Unsurprisingly, it was found that the states in India with better administrative and institutional capacities to implement RSBY as well as stronger political commitment had significant higher coverage than other states despite being poor (55, 68). Contrary to the objective of health insurance programme, the evidences from LLMICs show unsatisfactory result with regard to improving health equity. In fact, the implementation of insurance in many LLMICs has further worsened the existing inequities in this part of the globe.

3.3.2. Analysis of Implementation Issues

❖ Cost

In Morestin's healthy policy analysis framework, the 'cost' dimension contains all the financial costs associated with implementation of the policy under study. The cost could either be in terms of gains or expenses, and also in terms of the cost incurred by the government or by any other actors involved in the implementation of the concerned policy directly or indirectly. Likewise, this dimension also looks at the distribution of cost over time and critically analyzes to what degree those costs are apparent (46). The cost for SHI not only constitutes administrative cost in terms of establishing an institution with qualified human resources, but also the cost incurred in purchasing services for the insured households. The following paragraphs include country examples of how the financial arrangements have been done, what have been the results and what are future projections. Studies examining the distribution of cost over time was not found during literature search.

Ever since the introduction of RSBY in 2008/2009, US\$587 million of collected tax amount had been invested by the Government of India for the programme's implementation(73). Despite the significant portion being allocated for the RSBY each year, economic estimation done in 2012 showed that the budget was insufficient to maintain already enrolled households in the programme, let alone be able to look after the new enrollees. In fact, the budgeted resources only covered one-third of total enrolment cost (74). Ghana funds its NHIS through various sources. But because of large informal sector and more than 60% of its population falling within the various exemption categories, the premium collection makes less than 5% of total NHIS income(58). Consequently, the NHIS is heavily dependent on tax-based revenue. In 2010, Ghanaian NHIS reached US\$1million deficit for claims payment. In absence of increased revenue and decreased cost in the future, many studies have raised concerns about the financial sustainability of Ghana's NHIS (9). Likewise, the premium collected contributes to only 6% of the total revenue of the Philippines' PhilHealth programme. This supports the fact that voluntary household contributions can share only a small portion of the overall revenue for SHI implementation (60).

Similarly, the Vietnamese SHI estimated that around 40% of total cost to be assumed by the government. In addition, it was projected that Vietnam would require to increase public spending in health by 0.6-0.8% of the GDP in order to expand the coverage to 70% of its population in 2015. There were also issues of high inefficiencies related to benefit packages, provider payment mechanisms, service delivery system etc. (72). The actuarial costing of universal insurance in Indonesia estimated that the country would require to spend 6.66% to 11.58% of the total public expenditure (or 1.17% to 2.03% of the GDP) for it to achieve universal coverage of health insurance by 2020 (75). A Kenyan study has also estimated that for the financial sustainability of the SHI, the contribution made by formal sector needs to increase from current 2.4% to 11% of gross income. Additionally, the study discussed on the

limitations of financial sustainability of Kenyan SHI over time and argued on tax-based system being more sustainable in long run (76).

❖ **Feasibility**

The feasibility dimension of Morestin's framework analyzes the implementation of healthy public policy in terms of its technical aspects. Some of the main factors that influence the technical feasibility of the policy include but are not limited to -adherence of the policy to the legal framework, availability of the human, material and technological resources, administrative capacities and the ability of different actors to oppose or support the policy under study. This dimension also considers the number of different actors involved in implementation of the policy and the degree to which these actors collaborate with each other (46). The next paragraphs are composed of the overall management experiences the LLMICs have in putting social health insurance into operation.

Ghana's NHIS has gone through various administrative, technical and governance challenges over the years. Fraudulent claims were rampant in the early stage. There were claims for 'caesarian operation on men' and reimbursements provided to 'non-existing providers'. Hence, the system of clinical audits was later established to check the abuse of NHIS (9). Besides, lack of effective monitoring structures and dissatisfaction of clients on the QoC has further threatened its operational and financial sustainability. Ghana thus started different kinds of client-centered initiatives such as biometric registration system, use of mobile technology and instant issuance of health insurance cards to the insurers to combat some implementation issues. Call centers were introduced to address the grievances from the insurers (58). However, the providers within NHIS were not well networked and there was no mechanism to ascertain which services clients used where and which medications were prescribed. Consequently, 'provider shopping' continues in Ghana (9). Another study from Ghana also reiterated that the challenges of implementing NHIS remained due to pre-existing health system shortcomings like inadequate staff and logistics and low managerial and technical capacities. The inequitable distribution of health facilities and human resources in the country significantly affected the operation of NHIS. The challenge was further aggravated by low recruitment and retention of medical staff, especially in rural regions of Ghana (77).

Furthermore, the LLMICs are characterized as having a large informal sector. Most countries have followed similar pattern of implementing SHI- mandating the programme for formal sector and making it voluntary to those in shadow economy (70). For example, Nigeria put the main focus of its health insurance programme on the population in formal economy due to administration challenge. But the enrolment of formal employees within the Nigerian NHIS is only 4% in 2013 even after years of its implementation (78). Similar findings were also documented in countries which targeted poor populations. Technical difficulty of identifying the poor and enrolling them in the SHI programme remained to be a challenging

task. For example, the analysis of Vietnamese SHI revealed the errors of inclusion and exclusion of the vulnerable groups. Lack of technical capacity of the personnel involved in recruiting insurers was one of the main factors contributing to such errors in Vietnam (72). In addition, many studies from LLMICs highlighted prolonged delays in distribution of insurance cards to vulnerable groups and reimbursement of insurance claims. The lack of sufficient technical and resources to administer and monitor the insurance claims was identified as the main reason for this (54, 58, 65, 77).

As presented in the previous 'cost' dimension, feasibility of social health insurance in financial terms was indicated in many studies from LLMICs. Besides the estimated budget being often insufficient, the national governments had not been able to raise adequate revenue base of SHI due to technical and managerial challenges. Furthermore, considerations on insurance coverage, services demand, technology and general economic growth of the country influence cost projections in LLMICs. Keeping up with such an additional economic burden pose a threat in the financial feasibility of the health insurance programmes in these countries (9, 58, 60, 72, 74, 76). Hence, in the context of existing inefficiencies in health sector in these countries, the evidences strongly point to the significant financial burden to their national governments as well as other parties like accreditation agencies, providers, insurers, members, etc. for SHI implementation (79).

❖ **Acceptability**

Acceptability, which includes stakeholders' opinions with regard to the policy, is the most intricate dimension in Morestin's framework. Here, stakeholders refer to people or groups of people who are concerned with the policy at hand. They form perceptions on the policy based on how they view other five dimensions as well as their own knowledge, experiences beliefs and values. Thus, acceptability is influenced by how stakeholders perceive intrinsic features of the policy as well as the extrinsic environment where the policy is being implemented. The acceptability dimension is dynamic, and changes over time, which means that the policy with lower acceptability during conception may have stronger acceptability during implementation phase and so on. Hence, this dimension captures the 'political feasibility' by analyzing the perspectives and position of various actors involved in the policy under study (46). The social health insurance policies in LLMICs are at different stages of development and have documented varying experiences on the matter concerning stakeholders.

Studies on the political journey of Ghana's NHIS reflected on how the policy had been constantly influenced by differences in the positions of multiple actors since its conceptualization. Despite the support from the government, there was resistance from some of the existing CHBIs which saw the new programme as a threat to their identity. However, the then main opposition party supported the key features of the proposed NHIS like decentralized approach and community participation. The professional bodies such as

Ghana Medical Association which were against the then 'cash and carry' system also hugely supported the new NHIS (80). Furthermore, the political atmosphere in Ghana resulted in constant interference with the operation of NHIS, particularly during its recruitment processes (9). Similar experiences were documented by Abuya et al while looking into the historical development of Kenya's NHIS. In Kenya, four main factors were identified for NHIS opposition- the associated cost with implementation, perceived fear on possible changes from private sectors, existing mistrust between the citizens and governments and the perceived mismatch in roles of some EDPs implementing vertical programmes in the country (81).

Nigeria's NHIS also went through opposition from different stakeholders. As a result, NHIS is adopted by only 3 of the 36 federal states. The resistance from other 33 states were primarily due to issues regarding transparency and accountability of NHIS, dissatisfaction with the design of scheme and inadequate local evidence on the impact of insurance schemes (78). The opposition mainly came from the labor unions and federal civil servants. Whilst this opposition directly affected the implementation of NHIS, it also affected its financial sustainability as the employees refused to make their prescribed share of contributions. The central coordinating role played by the Nigerian Health Minister and the then President became crucial in addressing some of the issues over time (82). Likewise, a feasibility study from Afghanistan showed that despite the majority of the stakeholders being positive, they stressed on country's existing political and health system context to be a challenge in introducing SHI. Political instability, poor healthcare services, low public awareness, willingness to pay and weak government commitment were the highlights made by stakeholders in this study (83). Furthermore, another study noted how Uganda's NHIS was largely shaped by the private sectors. Although there was strong resistance initially, negotiations between private sectors and the government in presence of the World Bank as a neutral party helped eliminate the grievances over the years (84).

CHAPTER IV: DISCUSSION

The LLMICs are at different stages of implementing their social health insurance. Nonetheless, the overall finding shows that they continue to face very similar challenges. Low enrolment at initial stage of SHI implementation and increment at later stages is often anticipated. Nepal's NHIP document too made this anticipation, and this indeed happened during the country's early implementation. However, the evidence from LLMICs reveals strong contradiction. The SHI in these countries persistently suffers from unsatisfactory enrolment rate even after years of implementation. Lack of awareness about the benefits of SHI and peoples' mistrust in public system are cited as two main reasons leading to this long standing problem. This shows that achieving universal coverage of SHI can be at snail's pace without adequate measures both at demand and supply side. The findings on service utilization are positive in all the LLMICs. But as most of the studies point out, the challenge remains with results showing skewness of service utilization towards hospital care and its adverse effects on QoC. As of yet, Nepal's situation on this front is not available. However, one cannot anticipate that Nepal's experience will be any different, when the country's current health system is afflicted with issues of inadequate resources such as skilled personnel, medicines and supplies.

The literature review shows that insured HHs seek care from private providers than from public. Perceived low QoC in public facilities and 'gaming' by private providers are the main contributors for this asymmetric result. In fact, dual practice is rampant, and gaming by providers is not a new phenomenon in this part of the world including Nepal where mixed health system is rapidly burgeoning (85). Without proper regulatory mechanisms in place, it is impossible to intervene this practice. Although NHIP well anticipates this situation, it fails to describe any mechanism to check supply-and demand-side behaviours. The current features of SHSP also present some benefits and risks. The conditions being put on referral cases may help strengthen the gatekeeping system if strictly followed. The mixture of public and private providers may foster competition as well as encourage new enrolment due to wide choice of providers. But in the Nepalese context where QoC in public facilities is perceived to be low, inclusion of such unregulated private sector may leave public sector underutilized and/or under-resourced. In the long run, SHSP may draw much of the public resources towards private sector. Furthermore, lack of strong provider network and co-payment in current SHSP may lead to moral hazard and provider shopping. In any case, increase in service utilization due to SHSP may not necessarily mean better access. On contrary, this may be a subtle hint of the presence of supplier induced demand and a threat to preventive care.

With studies indicative of SHI reinforcing gender inequality and becoming a "vehicle for rewarding party members", the insurance programme is not without unintended effects.

Such effects can also be in positive terms when initiating SHI becomes a reason for carrying out extensive capacity building of new as well as existing health workers. These experiences not only suggest that the effects of SHI sometimes go beyond health sector but also reiterate that the influence of country's political system on SHI is unavoidable. In Nepal's case, the policy lacks the analytical perspective on this subject and does not provide enough foresight. Regardless, Nepal needs to be mindful of how its SHI programme can have repercussions. The existence of a pooled fund may discourage Finance Ministry to prioritize tax amount for MoHP in the context where other competing sectors like education, labor, agriculture etc. are on the strongholds. At present, the SHSP is being scaled up with four different exemption categories. The ultra-poor and poor HHs are respectively entitled to free and highly subsidized healthcare services as long as they fit to these categories. Such an arrangement may have perverse incentives in the sense that this may discourage these HHs to get out of poverty in the fear of losing that entitlement. An in-depth investigation would help to anticipate unintended effects like these in Nepalese context and provide insights into preventing them.

The literature in general, is unsupportive of the popular belief that SHI prevents catastrophic health expenditures. While some LLMICs show 4-6% overall reductions, others report an increase in OOPs due to indirect costs, informal payments, limited benefit package and coverage, co-payment system and supplier induced demand. Nepal's NHIP document provides wide space in terms of determining the household contribution and benefit package. This flexibility allows SHSDC to come up with context-specific package and appropriate contribution. As such, a "comprehensive" benefit package was developed. However, with apparent epidemiological transition marked by 60% of NCDs prevalence, the current benefit package does not cater to large chunk of Nepalese population. This means even without co-payment, the insured HHs bear certain percentage of expenditure while using services which are beyond this package. In addition, two contextual factors may act against the goal of NHIP. First, the fact that the small drug vendors mushrooming in Nepal, which most people conveniently utilize are not listed in the SHSP. Secondly, the culture of informal payment and prevalence of high indirect costs are well documented in Nepal. Without a responsive and accountable healthcare system, these hidden costs may undermine the effectiveness of SHSP in preventing catastrophic expenditures.

Equity is at the heart of UHC reforms across the globe including Nepal. The SHI programme intends on exclusively targeting the poor, marginalized and vulnerable sections of the population. But as evidences unfold, reality is a far cry from the theoretical aspiration. The overall literature accentuates marked differences in enrolment and service utilization of HHs on the basis of economic status, education, gender, age, place of residence, position in the society, and employment sector. Even in targeted insurance schemes like India's RSBY, the error of exclusion and inclusion persists, with affluent households enjoying the subsidized scheme instead of the poor. And as the resources are unintentionally diverted towards well-off HHs, a further divide in equity is observed. The principle of equity is also challenged by

the persistent difficulty of SHI initiatives to capture the households from informal economy. Vietnam and Indonesia, for example, are currently facing the ‘missing middle’ problem. Whilst increasing inequity may not take too long, the process of mitigating such inequities and achieving UHC through social health insurance may take decades.

In Nepal, the prominent presence of health inequities set the stage for NHIP. The document firmly puts its emphasis on mobilizing resources equitably and reaching every HHs in the country. The ongoing SHSP takes off this policy rationale very well into creating different categories for effective provision of subsidies. But as the initial analysis shows administrative and technical difficulties in capturing target population, Nepal’s early experience mirrors the experiences of its fellow nations. In fact, many LLMICs still struggle to reach the poor, marginalized groups and large informal sector till date. With a quarter of its population below poverty line, growing out-migration rate and more than 70% of economically active population involved in informal sector, Nepal’s unique socio-economic features point towards a strenuous path to achieving equity. Surprisingly, the NHIP seems to disregard these circumstances and lack an effective oversight of the technicalities required for its operation. Without serious consideration of this situation, Nepal’s SHSP too may end up becoming what Adewole describes- a “pseudo-social health insurance”, subsidizing services for the privileged few (69). Besides, SHSP stands alongside other numerous social health security schemes. If not integrated, these schemes may fragment risk pools, limiting cross-subsidization. This may further exacerbate inequities in accessing healthcare.

The NHIP implementation has direct monetary implications, be it for the government, regulatory bodies or households. But reflecting on the experiences from LLMICs, the socio-economic context of Nepal may pose a threat to sustainable financing of NHIP in many ways. First, the presence of large informal sector in Nepal means that premium collection may be a daunting task. In this regard, most of the population may also fall within different exemption categories of insurance scheme. Secondly, the SHSP is voluntary. So whilst the revenue base solely based on voluntary HHs contribution may be small, the financial need to provide sufficient subsidies remains high. In this misbalanced scenario, government may wind up bearing huge portion of the SHI expenditure. Thirdly, Nepal extensively relies on donors and EDPs for funding its overall health sector. This means the fate of financial viability of NHIP is directly linked with that of aid from donors. Besides, the allocative and administrative inefficiencies in Nepalese health sector is high and the fiscal space for health is limited. WHO’s Taskforce for Innovative Financing for Health System estimates that a low-income country needs US\$ 44 per capita to provide adequate health services for all, which is much higher than what Nepal currently spends (33).

It is also important to note that the countries which achieved UHC launched the programme while there was a rapid economic growth during the transition phase (86). This means the revenue base for SHI in these countries grew substantially with their progressive economy. As such, the development in the country’s broader socio-economic structure is vital for

determining the pace progress towards UHC (10). But even with growing economies, NHIS of Ghana and India consistently faced millions of deficits. This reiterates that along with an enabling economic environment, an efficient financial strategy to support NHIP is a must. In spite of this, the current policy document only superficially outlines its economic arrangements. It puts government allocated fund as a major source of the financing health insurance programme without seriously considering the government's weak financial position. In fact, there is no circumspection regarding the long-term financial viability of the NHIP, and its operation solely rests on the assumption that there will be timely provision of sufficient budget throughout.

An apparent challenge emerging from the literature across the globe is technical feasibility of SHI. Greater human resources capacity, strong regulating ability of national governments, sound administrative support and proper legal arrangements are key to its success. Unsurprisingly, Nepal's NHIP document lays down the need of such pre-requisites for effectively carrying out the insurance functions. Building in on this notion, the SHSDC intends to gradually construct a technically sound health insurance programme for Nepal. The legal stage has successfully been set up with a recent adoption of insurance bill. In its nascent stage, Nepal is also making use of information technology like android phones to implement SHSP. But the country's present health system context puts forth dire circumstances with regard to the availability of adequate physical and intellectual infrastructures. Huge out-migration and growing shadow economy do challenge the capacity of the government and its health system to tap the target population. Stewardship is another crucial component of an accountable, transparent and effective SHI system, which the policy of Nepal vividly recognizes (86, 87). However, Nepal's socio-political scenario is infamous among general public for fraud, corruption and patronage. In absence of proper accountability checks and continuous efforts to strengthen overall health sector, the entire SHSP may fall apart.

The retrospective policy analyses from LLMICs corroborate the statement that the journey of health insurance is not always straight-forward. Expectations from stakeholders of diverse sectors add to the complexity of political feasibility of SHI. Whilst some countries are able to overcome the resistance faced in introducing NHIS, others struggle to come to agreeable terms for opposing parties even after months long negotiations. As is evident from the global experiences, the whole negotiation process can stall operation of programme for years, if overlooked. Continuous engagement of key stakeholders like community, EDPs, policy makers, professional bodies and other important institutions determines the effectiveness and smooth functioning of the insurance system. In addition, the acceptability of such relatively new initiatives also relies public's trust on their governments. In writing, the NHIP aims at ensuring adequate representation of stakeholders in the implementing board. In practice, the SHSDC currently restricts itself with seven members from ministries of health and finances. The district-level implementation committee though, ensures representation from local community and civil society organizations.

Furthermore, the NHIP envisages a well communicated health insurance programme. But the documents on in depth stakeholder analyses and consultations on Nepal's current SHSP are non-existent. It is also important to note the lack of strong community support is deemed responsible for the disappointing experience of Nepal with the CBHI. With an obvious information gap regarding the perceptions of local people on SHSP in Nepal, one cannot confirm what caused the unsatisfactory community participation recorded in the initial phase. Such small enrolments may result from low public awareness regarding SHSP but also from community's concern pertaining to the current features of the insurance programme. It is crucial to critically look into the factors which may have led to the existing situation rather than just make speculations. In addition, the Government has also shown strong interest in making the SHSP mandatory for formal employees and migrant workers, although the mechanism is yet to be made public. This means that Nepal's NHIP implementation is following on the footsteps of fellow low and lower-middle-income countries. But before jumping into decisions, it is extremely important to make sure that the opinions of these groups be seriously taken into account.

Limitations:

The analytical framework developed by Florence Morestin provides a comprehensive guide to healthy public policy analysis. During this study, the framework helped me critically analyze the literature from LLMICs from six different dimensions. The framework helped me understand how inter-connected these dimensions are and how they together determine the effective operationalization of the NHIP. The framework also guided me in giving a logical shape to the findings and discussion chapters. There was enough flexibility in the framework to be adopted as per the study need. The comprehensive nature of the framework, however, made it difficult to explore the dimensions in depth. The framework covers a wide range of elements of the policy analysis instead of concentrating into one. This meant that my research could not go into the much needed depths of any analytical dimension.

This policy analysis also has other shortcomings. Firstly, it could not present rigorous discussions on all analytical dimensions of Morestin's framework due to insufficient evidences. The NHIP is at nascent stage with virtually absent evidence to be able to strongly draw inferences. The Nepalese documents did not have all the required information on SHSP, especially on its financial aspects. It is unsure how the SHSDC calculated current premium rate. No official actuarial costing was available. Literature from LLMICs in accordance with the dimensions were also limited. Many studies did not provide sufficient reasoning on their findings except for mere speculations. Hence, some questions on each analytical dimension remained unanswered. Secondly, the use of broader term, national social health insurance in this research might overshadow the variations in schemes, which might raise concern about the internal validity of conclusions. Thirdly, some documents did not have officially translated copies. Direct translation of Nepali into English might affect analysis. Finally, critically appraising the solutions applied by LLMICs to mitigate the challenges emerged during SHI implementation is beyond the scope of this study.

CHAPTER V: CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

The National Health Insurance Policy 2013 of Nepal clearly lays down the foundation for achieving UHC through health insurance mechanism. The policy superficially addresses key administrative, institutional and legal arrangements and leaves sufficient flexibility for the SHSDC to draw the most suitable roadmap for implementation. The strategic focus of the policy incorporates the core principles of equity and good governance. Sufficiently outlined rationale and well perceived risks and assumption make the overall policy pragmatic. Nonetheless, the document is deficient of a strong strategic position with regard to financing the policy. It lacks critical perspectives on the country's socio-economic and wider health system context and on the repercussions of such an initiative within this implementation context. As such, the policy document falls short in providing an analytic foresight on its longer term application. The evidences from across the globe and Nepal's own staggering experience shed a light to a number of insightful remarks vis-à-vis achieving UHC through the country's national health insurance policy.

Firstly, the road to operationalizing the policy in the form of SHSP is not at all straightforward. Whilst health services utilization, in general, increases with the adoption of health insurance, the literature equivocally suggests mixed and inconclusive results with regard to its role in preventing catastrophic expenditures. Secondly, simply pushing forward SHI without enabling socio-economic and political environment, and adequate infrastructures can jeopardize the quality of care, equity and system efficiencies. Operationalizing NHIP is thus a huge undertaking and sufficient preparatory work is a must to ensure its feasibility. Nepal's policy document lacks these critical insights regarding broader situational factors central to its execution. And considering its feeble start, Nepal's aspiration to cover all 75 districts in the voluntary SHSP by 2020 may be deemed unrealistic. Rigorous debates and discourses on the subject is indispensable to facilitate such a transition. Nevertheless, Nepal's current endeavors to implement NHIP is commendable. Backed by the Social Health Insurance Act, the SHSDC has put forth clear operational and communication guidelines. The concrete end-results of the SHSP is yet to be seen, but it does hold a great amount of expectations from the Government and general public.

Thirdly, there are uncertainties about the technical and political feasibility of the SHSP because of the apparent gap in Nepalese evidence base. Regardless, the Government's growing interest in providing quality healthcare services and citizens' increasing awareness on the subject can create an avenue for mutual accountability and support to scale up such initiatives. Hence, the unique situation of Nepal presents substantial opportunities as much as threats on this front. Together with the lessons from other countries, these opportunities

at national level need further exploration such that NHIP bears progressive outcomes. Lastly, as the country muddles through the loopholes within the policy document devoid of sufficient local evidences, some central questions emerge- with Nepal's prevailing health system challenges and it lacking essential socio-economic preconditions, how far can SHSP be effective? If SHSP is continued without strengthening an overall health sector, what will the effects be? The financial implications of implementing NHIP is huge. Does the Government of Nepal have capacities to sustain SHSP and well manage private providers? How are stakeholders involved in the entire process? And with the public system in constant scrutiny for fraud, corruption and patronage, what are the measures for good governance within SHSDC?

5.2. Recommendations

The SHSP, on its own, may not be the 'magic formula'. Nepal needs to establish complementary mechanisms to strengthen its SHSP, it also needs to explore alternate interventions to achieve health system goals. Drawing upon the global evidences, following recommendations are relevant in Nepal's context-

5.2.1. To the Government

- ✚ The Government should realize the critical role of Nepal's socio-economic, political and health system context in successfully implementing the NHIP. It should strive towards strengthening the overall system (finance, human resources, infrastructures, technology) rather than only focusing on the scheme.
- ✚ The NHIP should be revised to incorporate missing elements and capture the rapid socio-political and health sector related transitions (such as increasing NCDs and informal economy) that Nepal is currently undergoing.
- ✚ The SHSDC has been established as a part of the Ministry of Health and Population. Pros and cons of such an arrangement should be explored and the one most suitable to Nepal's context should be adopted.
- ✚ Immediate measures should be taken to certify poor, ultra-poor and marginalized groups. This can prevent errors of exclusion and inclusion, and the principle of equity envisioned in NHIP can be materialized.

5.2.2. To the SHSDC

- ✚ The current evidence base for the insurance policy as well as the SHSP is weak. As the responsible implementing agency, the SHSDC should conduct an extensive review of available information and carry out critical analyses to bridge the knowledge gaps. The Committee should form a Research Wing within the institution to work on the matter.

- ✦ To ensure the availability of technically sound human resources (managers, technicians, volunteers, registration assistants) regular trainings and capacity building workshops should be in place. The trainings should incorporate the use of latest information technology and be provided to managers at top to field workers.
- ✦ There should be a strong and periodic accreditation and regulatory mechanisms to ensure that adequate QoC are being provided by the providers. Whilst clinical audits can prevent frauds and corruption, absence of structures for effective gatekeeping can still jeopardize QoC. Complementary appraisal system should be in place to incentivize the providers to ensure service quality, prevent supplier induced demand and encourage the use of preventive care. There should also be sufficient numbers of strongly networked providers to foster competition and prevent 'provider shopping'.
- ✦ System-wide efficiencies should be encouraged by preventing leakage of SHI funds as well as fragmentation. These can be achieved through strong stewardship to check fraudulent claims and control patronage. Integrating existing social health security initiatives into a single pool can prevent fragmentation. Engaging stakeholders can also build mutual accountability and ownership.
- ✦ The Committee should consider making SHSP mandatory. Mandatory insurance scheme can increase the revenue base, in addition to preventing 'free riding' behaviors and 'adverse selection'. This can further ensure the insurance pool to be diverse for effective cross-subsidization.
- ✦ Feasibility of SHI hinges on trust and understanding of pre-payment system by public. There should be extensive promotion of SHSP, both in rural and urban areas. Call centers can be established to address queries and grievances regarding insurance. This can be a way of building trust of people in the Committee and give a sense of ownership to the potential beneficiaries.

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ANNEXES

Annex 1: National Health Insurance Policy 2013 of Nepal

Source- Ministry of Health and Population

National Health Insurance Policy 2013

1. Background

The Interim Constitution of Nepal 2007 provides for free basic health care as a fundamental right of citizens. Accordingly, the Government of Nepal has made certain health care services free for all and is providing additional services to target groups. Although access to health care services has gradually improved, universal coverage has yet to be achieved and out-of-pocket expenditure by private households is high. This expenditure largely takes place in the private sector on pharmaceutical products. Moreover, the current health financing system in Nepal limits the Government's capacity to motivate health care providers to improve productivity, quality and efficiency.

A national health insurance programme is needed to ensure universal health coverage by capturing the unregulated out-of-pocket spending and facilitating the effective, efficient and accountable management of available resources. This 'National Health Insurance Policy 2013', has been prepared by the Government to give guidance to the implementation of a National Health Insurance Programme in Nepal, as per the Three Year Plan (2010/11–2012/13).

The National Health Insurance Policy will support the objective of the Nepal Health Sector Programme II (2010–2015), which is to increase access to effective health care services, particularly for members of disadvantaged population groups. This policy is an important reform agenda and is intended to improve the health status of the population through strengthening health systems. Importantly, the policy is in line with National Social Protection Framework. The forthcoming Health Financing Strategy will provide guidance on the inter-linkages between the different financing mechanisms in Nepal. Other forthcoming policy and legal documents on state and non-state partnerships in the health sector, including the urban health policy (draft available) and health institutions operation (draft available) will complement the National Health Insurance

Policy and contribute to the effective implementation of a national health insurance programme in Nepal.

2. Past efforts: Existing programmes

To fulfil its constitutional and international commitments, the Government of Nepal is currently implementing various health care programmes, mainly aimed at providing free health care services to the general public or target groups. These programmes include *Aama Suraksha*, the Uterine Prolapse Treatment Programme, the Free Health Care Programme and some additional free services for target groups. Substantial subsidies are also being provided for the treatment of heart disease, kidney problems, cancer and many other diseases.

Some community-based health insurance schemes have been piloted by the Government of Nepal since 2003; there have also been several non-governmental initiatives at the community level to improve financial protection by pooling funds for health. However, despite budget allocations for the last three years, a national health insurance programme has not been implemented because of a lack of proper policies, legislation and institutional framework.

3. Current situation

Although major progress has been achieved in improving access to health care services in Nepal, reaching the poor and marginalised remains a challenge. The various social health protection interventions in place are fragmented, often fail to provide the necessary financial protection against catastrophic spending and are not always based on medical need. According to the last three rounds of the National Health Accounts (2001–2009), unregulated out-of-pocket payments by private individuals when receiving health services exceed prepayments by governmental and non-governmental organisations. The need for such out-of-pocket payments prevents a substantial proportion of the population from accessing health care services and puts them at risk of impoverishment from catastrophic spending.

4. Major problems and challenges

The challenges and obstacles affecting equity and access to health care services in Nepal (and the effectiveness of the health sector in general) can be summarised as follows:

- 1) financial barriers, which prevent people from being able to use health care services;
- 2) the risk of impoverishment from high out-of-pocket payments at the time of service utilisation;
- 3) the current passive purchasing of health care services in the public sector, which limits the capacity of the government to improve the effectiveness, efficiency and accountability of the health care system;
- 4) the limited ability of the health financing system to identify and protect the poor and, hence, to address inequities;
- 5) the fragmented nature of the various social health protection programmes and interventions, which provide insufficient financial protection and often do not meet the target group's medical needs;
- 6) the fact that most out-of-pocket expenditure takes place in the private sector where the government's capacity to protect the public from unfair pricing and inappropriate or unnecessary delivery of services is weak;
- 7) the limited capacity of the Government of Nepal to generate more resources for the health sector on a substantial scale; and
- 8) the lack of an integrated approach to making health providers accountable to the public.

5. Policy rationale

As per the Three Year Plan (2010/11–2012/13) and the Health Sector Programme II (2010–2015), a National Health Insurance Policy is needed to improve the health situation of the people of Nepal. Specifically, this policy is needed to:

- 1) increase accessibility to, and equity in, the provision of health care services by removing financial barriers to the use of health care services, focusing on the poor and marginalised;
- 2) promote pre-payment and risk pooling mechanisms by establishing a national health insurance programme to mobilise financial resources for health in an equitable manner;
- 3) encourage output-oriented expenditure in the health sector and improve the effectiveness, efficiency, accountability and quality of care in the delivery of health care services;
- 4) strengthen health systems in an integrated manner; and
- 5) improve the health seeking behaviour of the public through clear entitlement procedures, awareness raising and behaviour change communication.

6. Long-term goal and main objectives

6.1 Long-term goal

The long-term goal of this policy is to improve the overall health situation of the people of Nepal.

6.2 Main objective

The main objective of this policy is to ensure universal health coverage by increasing access to, and utilisation of, necessary quality health services.

6.3 Specific objectives

The specific objectives of this policy are to:

- 1) increase the financial protection of the public by promoting pre-payment and risk pooling in the health sector;
- 2) mobilise financial resources in an equitable manner; and
- 3) improve the effectiveness, efficiency, accountability and quality of care in the delivery of health care services.

7. Strategies

7.1 Strategy 1

To meet the first objective (increase financial protection) the National Health Insurance Programme will:

- 1) reduce out-of-pocket expenditure at the time of health service use;
- 2) pool and allocate funds in an equitable manner;
- 3) mobilise local community groups to increase the participation of the general public in the programme;
- 4) implement various interventions and activities to gradually improve the health seeking behaviour of the people; and
- 5) be gradually implemented to cover whole the country.

7.2 Strategy 2

To meet the second objective (mobilise financial resources in an equitable manner) the National Health Insurance Programme will:

- 1) promote prepayment by collecting contributions from households;
- 2) receive specific funding to ensure the participation of poor and target population groups;
- 3) receive additional resources to enable it to be initiated and implemented in a sustainable manner; and
- 4) cover every household in Nepal.

7.3 Strategy 3

To meet the third objective (improve the effectiveness, efficiency, accountability and quality of care in the delivery of health care services) the National Health Insurance Programme will:

- 1) introduce provider payment mechanisms;
- 2) integrate existing social health protection interventions and programmes into the National Health Insurance Programme, as feasible
- 3) develop a national framework to integrate government supported health insurance initiatives and promote complementarity with other private insurance schemes;

- 4) promote the participation of governmental, non-governmental and community organisations, and public-private-partnerships in the implementation of the National Health Insurance Programme;
- 5) motivate health workers and facilities to provide quality health services
- 6) develop a system to control moral hazard and other risks that may arise in relation to service providers and service consumers; and
- 7) promote output-oriented expenses.

Ministry of Health and Population shall continue existing health care services not covered by the NHIP.

8. Institutional arrangements

8.1 Organisational setup

- 1) An autonomous entity called the National Health Insurance Fund shall be established to operate the National Health Insurance Programme.
- 2) The National Health Insurance Fund shall be governed by a board, called the National Health Insurance Board.
- 3) The National Health Insurance Board shall be composed of an equal number of representatives from government bodies (the National Planning Commission member responsible for health; at least joint secretary-level nominees from the Ministry of Health and Population, Ministry of Finance, Ministry of Labour and Employment, Ministry of Federal Affairs and Local Development, Ministry of Cooperatives and Poverty Alleviation; a representative from the Health Insurance Board; and a representative from the Social Security Fund), non-governmental and professional bodies, and consumers.

8.2 Roles and responsibilities

- 1) The National Health Insurance Fund shall be responsible for pooling funds and contractual arrangements with health facilities.

- 2) The National Health Insurance Board shall be responsible for defining the benefit package, setting the contribution rate, approving the annual business plan of the Fund, and formulating and amending regulations.
- 3) The National Health Insurance Board shall report to the Ministry of Health and Population.
- 4) The National Health Insurance Board shall appoint a chief executive officer who shall function as the member secretary of the Board;
- 5) The National Health Insurance Fund will mobilise committees to support the operation of the National Health Insurance Programme.
- 6) The National Health Insurance Fund may contract non-governmental organisations, cooperatives and private insurance companies to undertake specific work.
- 7) The Ministry of Health and Population will be contact ministry for the National Health Insurance Fund.

9. Legal arrangements

- 1) A separate Act shall be formulated to govern the National Health Insurance Programme.
- 2) Until this legislation is enacted, the National Health Insurance Board and its Rules will be formulated under the Development Board Act 2013.
- 3) The Ministry of Health and Population shall initiate the implementation of the National Health Insurance Programme.
- 4) After the legal and institutional mechanisms are in place, the Programme will be implemented through the National Health Insurance Fund.

10. Financial arrangements

10.1 Resource collection

The National Health Insurance Fund will collect and pool the following resources:

- 1) contributions collected from enrolled households;

- 2) funds provided by the government for the enrolment of poor and target households in the health insurance programme;
- 3) funds provided by the government to initiate and implement the National Health Insurance Programme;
- 4) support received from other institutions, organisations, individuals and bodies; and
- 5) funds from the Government of Nepal's budget currently allocated to various social health protection programmes and interventions, where feasible and appropriate.

10.2 Household contribution

- 1) The household will be the unit for enrolment.
- 2) An appropriate method will be applied to determine the household contribution.

10.3 Service purchase and payment system

- 1) Contractual arrangements will be made with service providers to provide defined health care services.
- 2) An efficient and effective payment mechanism shall be defined for making payments to service providers.
- 3) Measures shall be adopted to make health facilities more responsive to the health needs of the people.

11. Health service providers and benefit package

11.1 Health service providers

- 1) Arrangements shall be made to standardise the health care services covered in the benefit package provided by the National Health Insurance Programme.
- 2) Arrangements shall be made to enlist and delist governmental, non-governmental, community, cooperative and private health service providers to provide the services in the benefit package according to predefined criteria and performance.
- 3) Providers will be required to ensure the availability of defined drugs; the list of defined drugs may vary according to the level and type of health facility.

11.2 Benefit package

- 1) The benefit package shall include health care services and other benefits, as prescribed.
- 2) Equity and efficiency shall be taken into consideration when defining the services included in the benefit package.
- 3) Health care services shall be provided on a cash free basis for members enrolled in the National Health Insurance Programme.
- 4) A ceiling may be applied to the services in the benefit package (per household per year).
- 5) Co-payments may be required from households for cases involving referral.
- 6) Arrangements shall be made for insured household members to access defined health care services from listed health facilities.

12. Good governance and accountability

- 1) The National Health Insurance Fund will be accountable to the National Health Insurance Board, its members and to the Government of Nepal.
- 2) A guideline shall be formulated to implement the National Health Insurance Programme.
- 3) Electronic identity cards shall be provided to enrolled members.
- 4) Arrangements shall be made for internal control as well as internal and external audits.
- 5) An electronic system shall be adopted for membership registration and renewal, the collection of contributions, payments and reimbursements, and reporting.
- 6) An integrated health insurance information system shall be created and linked with other information systems functioning within the health sector.
- 7) A mechanism shall be developed to identify poor and members of target groups.
- 8) A mechanism shall be prepared to handle and address grievances and complaints.

13. Monitoring and evaluation

- 1) A monitoring and evaluation framework shall be prepared and integrated with the national monitoring and evaluation framework.
- 2) The monitoring and evaluation of the programme shall be conducted in coordination with the regional health directorates and other line agencies.
- 3) Arrangements shall be made to review the National Health Insurance Programme periodically.
- 4) The National Health Insurance Programme shall also be evaluated through clinical auditing, social auditing and performance auditing.

14. Risks and assumptions

14.2 Risks

The risks include:

- 1) low enrolment in an initial phase;
- 2) problems in the identification of the poor and members of target groups;
- 3) problems in the effective and efficient use of information technology;
- 4) risks and moral hazard arising in relation to service providers and insured members;
- 5) shifts in patient flow from public to private sector health facilities; and
- 6) late release of budget for subsidies by the Government of Nepal to the National Health Insurance Fund.

14.2 Assumptions

The assumptions include:

- 1) special provision of budget funds for the infrastructural, human resources, and administrative costs of the National Health Insurance Programme during the initial phase; and
- 2) that uniformity can be ensured in the provision of quality services through the accreditation and enlisting of service providers.

Annex 2: Status of Universal Health Coverage

(Source- The World Bank, 2014)

Aspects	Group 1	Group 2	Group 3	Group 4
Status of UHC policies and programs	Agenda setting; piloting new programs and developing new systems	Initial programs and systems in place, implementation in progress; need for further systems development and capacity building to address remaining uncovered population.	Strong political leadership and citizen demand lead to new investments and UHC policy reforms; systems and programs develop to meet new demands.	Mature systems and programs: adaptive systems enable continuous adjustments to meet changing demands.
Status of health coverage	Low population coverage; at the early stage of UHC. Example: Nepal	Significant share of population gain access to services with financial protection, but population coverage is not yet universal and coverage gaps in access to services and financial protection remain. Example: Ghana	Universal population coverage achieved but countries are focusing on improving financial protection and quality of services. Example: Thailand	Universal coverage sustained with comprehensive access to health services and effective financial protection. Example: Japan

Annex 3: Table of literature from the low and lower-middle-income countries

S. No.	Title (Year of publication)	Author/s	Country	Methodology	Analytical dimension/s covered (Effectiveness, Unintended effects, Equity, Cost, Feasibility, Acceptability)
1	Impact of national health insurance for the poor and the informal sector in low and middle income countries (2012)	Arnab Acharya, Sukumar Vellakkal, Fiona Taylor, Edoardo Masset, Ambika Satija, Margaret Burke, Shah Ebrahim	Multiple	Systematic review	Effectiveness, Equity, Feasibility
2	Impact of Publicly Financed Health Insurance Schemes on Healthcare Utilization and Financial Risk Protection in India: A Systematic Review (2017)	Shankar Prinja, Akashdeep Singh Chauhan, Anup Karan, Gunjeet Kaur, Rajesh Kumar	India	Systematic review	Effectiveness, Unintended Effects, Equity, Cost, Feasibility,
3	Targeting and Effects of Rashtriya Swasthya Bima Yojana on Access to Care and Financial Protection (2017)	Soumitra Ghosh, Nabanita Datta Gupta	India	Impact evaluation using National Sample Survey (NSS) data	Effectiveness, Unintended Effects, Equity,
4	Health care seeking behaviour and utilisation in a multiple health insurance system: does insurance affiliation matter? (2014)	Eunice Nahyuha Chomi, Phares GM Mujinja, Ulrika Enemark, Kristian Hansen and Angwara Dennis Kiwara	Tanzania	Household Survey	Effectiveness, Unintended Effects, Feasibility
5	A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects? (2016)	Robert Kaba Alhassan, Edward Nketiah-Amponsah, Daniel Kojo Arhinful	Ghana	Review of literature	Effectiveness, Feasibility
6	Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia (2012)	<i>Gina Lagomarsino, Alice Garabrant, Atikah Adyas, Richard Muga, Nathaniel Otoo</i>	Multiple	Literature review supplemented with interviews done with policy makers	Effectiveness, Cost

7	Inequalities in Universal Health Coverage: Evidence from Vietnam	Michael G. Palmer	Vietnam	Impact analysis using the 2006 Vietnam Household Living Standards Survey (VHLSS) data	Effectiveness, Equity
8	Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis (2013)	Isaac AO Odeyemi and John Nixon	Nigeria Ghana	Literature review based comparative analysis	Effectiveness, Equity
9	Getting the Poor to Enroll in Health Insurance, and Its Effects on Their Health: Evidence from a Field Experiment in Ghana (2013)	Patrick O. Asuming	Ghana	Experimental study	Unintended Effects
10	Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why? (2011)	Caroline Jehu-Appiah, Genevieve Aryeetey, Ernst Spaan, Thomas de Hoop, Irene Agyepong, Rob Baltussen	Ghana	Household survey	Equity
11	Nigeria National Health Insurance Scheme: A Highly Subsidized Health Care Program for a Privileged Few (2016)	David A. Adewole and Kayode O. Osungbade	Nigeria	Analysis of secondary quantitative data	Equity, Acceptability
12	National health insurance fund (NHIF) in Tanzania as a tool for improving universal coverage and accessibility to health care services (2015)	PN Kumburu	Tanzania	Mixed-method cross-sectional study	Feasibility, Unintended effects
13	Does Indonesian National Health Insurance serve a potential for improving health equity in favor of workers in informal economy? (2015)	Dwintha Maya Kartika	Indonesia	Review of literature	Equity

14	Is RSBY India's platform to implementing universal hospital insurance? (2012)	David M. Dror and Sukumar Vellakkal	India	Cost analysis using data on below-poverty level population estimates and national average premiums	Cost
15	The Politico-Economic Challenges of Ghana's National Health Insurance Scheme Implementation (2016)	Adam Fusheini	Ghana	Exploratory qualitative study (33 participants)	Cost, Acceptability
16	Moving toward Universal Coverage of Social Health Insurance in Vietnam: Assessment and Options (2014)	Aparnaa Somanathan, Ajay Tandon, Huong Lan Dao, Kari L. Hurt, and Hernan L. Fuenzalida-Puelma	Vietnam	Qualitative research method with literature review	Cost, Feasibility
17	Actuarial Costing of Universal Health Coverage in Indonesia: Options and Preliminary Results (2011)	Yves Guerard, Mitch Wiener, Claudia Rokx, George Schieber, Pandu Harimurti, Eko Pambudi and Ajay Tandon	Indonesia	Actuarial costing analysis	Cost
18	The cost of free health care for all Kenyans: assessing the financial sustainability of contributory and non-contributory financing mechanisms (2017)	Vincent Okungu, Jane Chuma and Di McIntyre	Kenya	Feasibility and financial estimate analysis using Simulation Insurance (SimIns) modelling. Review of literature done to obtain data	Cost
19	Towards universal coverage: a policy analysis of the development of the National Health Insurance Scheme in Nigeria (2015)	Chima A Onoka, Kara Hanson and Johanna Hanefeld	Nigeria	Qualitative study (stakeholders analysis approach)	Acceptability
20	Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria (2013)	Chima A Onoka, Obinna E Onwujekwe, Benjamin S Uzochukwu and Nkoli N Ezumah	Nigeria	Comparative study of two states of Nigeria using qualitative research method	Acceptability
21	Stakeholders Perspectives on the Success Drivers in Ghana's National Health Insurance Scheme -	Adam Fusheini, Gordon Marnoch, Ann Marie Gray	Ghana	Qualitative study	Acceptability

	Identifying Policy Translation Issues (2017)				
22	Historical account of the national health insurance formulation in Kenya: experiences from the past decade (2015)	Timothy Abuya, Thomas Maina and Jane Chuma	Kenya	Retrospective policy analysis	Acceptability
23	Players and processes behind the national health insurance scheme: a case study of Uganda (2013)	Robert K Basaza, Thomas S O'Connell and Ivana Chapčáková	Uganda	Retrospective stakeholder analysis	Acceptability
24	Assessing the feasibility of introducing health insurance in Afghanistan: a qualitative stakeholder analysis (2017)	Wu Zeng, Christine Kim, Lauren Archer, Omarzaman Sayedi, Mohammad Yousuf Jabarkhil and Kathleen Sears	Afghanistan	Qualitative study	Acceptability
25	Can health insurance protect against out-of-pocket and catastrophic expenditures and also support poverty reduction? Evidence from Ghana's National Health Insurance Scheme (2016)	Genevieve Cecilia Aryeetey, Judith Westeneng, Ernst Spaan, Caroline Jehu-Appiah, Irene Akua Agyepong and Rob Baltussen	Ghana	Household survey	Effectiveness
26	Implementation Challenges of the National Health Insurance Scheme in Selected Districts in Ghana: Evidence from the Field (2017)	Adam Fusheini, Gordon Marnoch & Ann Marie Gray	Ghana	Field survey	Feasibility
27	Out-of-pocket medical expenses for inpatient care among beneficiaries of the National Health Insurance Program in the Philippines (2012)	Makoto Tobe, Andrew Stickley, Rodolfo B del Rosario Jr and Kenji Shibuya	The Philippines	Analysis of insurance claims	Effectiveness
28	The Impact of National Health Insurance Program on Household Health Expenditure and Utilization of Health Services in Indonesia	BA Suryanto, B Setiohadji, YF Syukriani	Indonesia	Analysis of data from Indonesian Family Life Survey 2007 and 2014	Effectiveness

Annex 4: Table of literature from Nepal

S. No.	Title (Year of publication)	Author/s	Literature type
1	National Health Insurance Policy 2013	Ministry of Health and Population	Official policy document
2	Governance and Purchasing Function under Social Health Insurance in Nepal: Looking Back and Moving Forward (2017)	Vishnu Prasad Sapkota, Umesh Prasad Bhusal	A commentary published in the Journal of Nepal Health Research Council
3	Annual Progress Report (2016/17)	Social Health Security Development Committee	The first annual report from the SHSDC
4	Annual Health Report (2015/16)	Department of Health Services, Ministry of Health	The official annual health report from the Ministry
5	Nepal's Quest for Universal Health Coverage (2016)	Shiva Raj Mishra, Pratik Khanal, Meghnath Dhimal	An editorial published in the Journal of Pharmacy Practice and Community Medicine
6	Social Health Security Programme (Health Insurance) 2016	Social Health Security Development Committee	A descriptive brief on SHSP from the Committee
7	National health insurance policy in Nepal: Challenges for implementation (2015)	Shiva Raj Mishra, Pratik Khanal, Deepak Kumar Karki, Per Kallestrup, Ulrika Enemark	A commentary published in the Journal of Global Health Action