



# Providing Health Care Benefits in Nepal

Views of Opinion Leaders and Practices of Establishments

gtz



Health Sector Support Programme (HSSP)  
Ministry of Health and Population (MoHP) – Nepal  
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)



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# Imprint

Published by

GTZ/GFA Consulting Group GmbH



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Print

Hillside Press

Kathmandu, December 2009

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31 December 2009

The Ministry of Health and Population (MoHP), Government of Nepal, is committed to strengthen social inclusion in the health sector. Two major pro-poor programs have been implemented to date. The first one is a program of free essential health care services targeted to the poor and vulnerable people at the district hospitals. The second one is a universal program of free essential health services for all citizens at health posts / sub-health posts and primary health care centers which commenced in January 2008 and 2009 respectively. A major issue, however, is the financial stability and sustainability of these programs. At present, the government has limited fiscal space. In addition, out-of-pocket expenditures remain very high and are a major contributing factor in impoverishing people and threatening their economic basis.

For this reason, the MoHP intends to study in more depth innovative and equitable forms of financing health care in order to provide social health protection consistent with the thrust of the present administration of providing free health care to all. A workshop on Social Health Protection was conducted on 17-18 February 2009 in Dhulikhel in order to gain better understanding of the concepts of social health protection and learn from experiences of other countries as well as to develop a process to explore sustainable health financing options for Nepal. The Dhulikhel workshop identified preparatory activities contributing to the capacities of the MoHP to lead the political and technical processes of moving the social health protection agenda forward.

In this context, study on “the current legal framework on health care financing and social health protection in Nepal” has been conducted, and its outcomes have already been disseminated on 23 November 2009. Similarly, MoHP would like to

conduct a thorough and comprehensive survey of the views / opinion of leaders on social health protection. The study is intended to review current practices of public and private establishments in providing medical / health benefits to their employees, and assess the views or opinion of leaders on the financing of health care. It provides insights for the political advocacy efforts in moving the agenda of social health protection forward.

The MoHP would like to appreciate the technical and financial support provided by GTZ/GFA Consulting Group GmbH, and acknowledges the inputs of the Thematic Task Team members (Dr. Baburam Marasini, Mr. Yogendra Gauchan, Mr. Giri Raj Subedi, Mr. Parashu Ram Shrestha, and Dr. Rajendra Kumar BC) to steer the whole process. The study greatly benefited from the guidance and cooperation of Dr. Friedeger Stierle, Dr. Susanne Grimm, Professor Dr. Konrad Obermann, Mr. Christian Caspar, and Professor Dr. Detlef Schwefel. The MoHP would like to recognize and appreciate the work of Ms. Deborah Carmina B. Sarmiento, International Consultant for her painstaking efforts to complete the study. Special thank goes to her. Last but not the least; MoHP would like to thank Prof. Ramji Pathak, Dr. Shiba Bahadur Karkee, Mr. Bishnu Prasad Paudel, Mr. Krishna Mani Parajuli and all others involved in these processes.

**Dr. Laxmi Raj Pathak**

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# Abbreviations

CHI	Community Health Insurance
DH	District Hospital
DoHS	Department of Health Services
EDPs	External Development Partners
EHCS	Essential Health Care Services
EPF	Employee Provident Fund
FCHV	Female Community Health Volunteer
FHCP	Free Health Care Policy
FHCS	Free Health Care Services
FNCCI	Federation of Nepalese Chamber of Commerce and Industry
GoN	Government of Nepal
HEFU	Health Economics and Finance Unit
HFMC	Health Facility Management Committee
HP	Health Post
HSSP	Health Sector Support Programme
MCH	Maternal and Child Healthcare
MoHP	Ministry of Health and Population
NGOs	Non-Government Organizations
OOP	Out-Of-Pocket
PHCC	Primary Health Care Center
SHI	Social Health Insurance
SHP	Sub-Health Post
SHPr	Social Health Protection

# Executive Summary

The Government of Nepal (GoN) through the Ministry of Health and Population (MoHP) implemented two pro-poor programs in its efforts to strengthen social inclusion in the health sector. The sustainability of these programs largely hinge on the financial capacity of government, which is believed to have a limited fiscal space. For this reason, the MoHP intends to study in more depth innovative and equitable forms of financing health care in order to provide social health protection (SHPr).

The study reviewed current practices of public and private establishments in providing medical / health benefits to its employees, and survey the views of opinion leaders on the financing of health care. The results of these two surveys provided insights for the political advocacy efforts in moving the agenda of SHPr forward.

A total of 181 establishments were interviewed through telephone and/or face-to-face for the stocktaking survey. These establishments consisted of government and private companies and professional associations. Of the 181 establishments, 51 percent were interviewed through the telephone only. The telephone interviewed was meant to identify establishments that provide health insurance benefits to its employees / workers. The employers and/or employees of 89 establishments were interviewed face-to-face. In 54 percent of the

establishments, only the employers were interviewed while only employees / workers were interviewed in 40 percent of the companies. In six percent of the companies, the employers and the employees / workers were interviewed. The interviews were conducted from July– September 2009 by trade union representatives and senior experts. For the opinion survey, a total of 83 opinion leaders representing key stakeholder groups, namely: politicians, administrators, social partners, NGOs / civil society, health providers and external development partners (EDPs) and academics were interviewed. Seventy-one percent of those interviewed were from Kathmandu valley while rest from different regions representing the different ecological region of the country. The interviews were conducted from April – September 2009.

## Practices of Establishments in Providing Health Benefits

The legal framework of Nepal provides for free essential health care services (EHCS) at the health posts (HP), sub-health post (SHP) and primary health care center (PHCC) for all Nepali citizens and free health care services at the district hospital (DH) level for the targeted group comprised of ultra poor, poor, senior citizens, disable people, helpless, and female community health volunteer (FCHV). In



addition, Nepal laws provide health benefits to workers and employees in the government and the private sector. However, there are no laws providing additional health benefits (apart from the free health care policy) to those employed in the agriculture sector, which comprised about 70 percent of the employed sector and overseas workers, the unemployed and those outside of the labor force (except for the retired army, police and armed police who are granted health benefits under the army welfare fund).

Most of the companies interviewed (94%) provided one or more forms of health benefits to their employees / workers in the form of accident insurance (70%), health benefits related to illness in cash or kind (56%), medical allowance (51%) and health insurance (27%). The companies reportedly not providing any health benefit employ about one percent of all workers / employees of the establishments covered by the interviews.

The features of the accident and health insurance were very similar. The costs of contribution for both accident and health insurance were generally borne by the employer. In majority of the companies, health and accident insurance were provided to all employees while in some companies, only the permanent employees / workers were covered. Health insurance in a number of companies was made available to family members although in some cases, employees paid for the contribution for their family members. Similar package of benefits (e.g. hospitalization, drugs) were provided by accident and health insurance. In most cases, the patient paid the medical care costs first and was then reimbursed by the insurance company. Most insurance companies defined a ceiling for reimbursable health expenses or reimburse a certain percentage of the medical care costs. Co-payment was reported by companies. A number of insurance-related administrative tasks were reportedly performed by the

establishments such as registration, contribution collection and processing of claims.

Most employers and employees / workers were satisfied with all the schemes, but more employers and employees / workers were satisfied with health insurance. The satisfaction levels depended on (a) the level of financial protection especially for risky occupation, (b) variation of benefits provided within the company, (c) coverage of employees and family members, (d) quality of care, and (e) health insurance services specifically the reimbursement system.

## Views of Opinion Leaders on Health Care Financing

The opinion leaders are divided on their views on the benefits and the capacity of the government to sustain the financing of the free health care policy (FHCP). Thus, while majority believed that people should also pay for their health care needs, they expressed the concern for the protection of the poor.

The concept of health insurance appealed to the opinion leaders since they viewed health insurance as an instrument that could substantially cover the costs of care and eventually reduce household expenditures on health particularly in catastrophic cases and after retirement. Since the poor did not have the capacity to contribute, they thought government should contribute for the poor. However, most opinion leaders believed that it is not - but should be - on the political agenda.

The health insurance preferred by the opinion leader was characterized by the following: (a) It should cover the formal sector first and foremost, (b) It should cover the poor without paying any contribution, (c) It should provide coverage for complex and expensive care, (d) It should be done with the MoHP or an autonomous organization as the leading agent, and (e) It should be operated with the concept of decentralization.

Measures that may be considered in moving the SHPr agenda forward are: (a) Formulating a health financing strategy which identify the level of financial protection that the country wants to achieve, and the financing mix & strategy that will best achieve the set goals, (b) In the event that country would decide to implement a social health insurance (SHI), an option it may consider is to target at the onset

universal coverage and provide benefits that people are entitled within the FHCP as the minimum benefit package, (c) Carefully study the possible effects of the health financing strategy and the legal framework on the behavior of health providers and of the people, specifically on the issue of quality, access, equity and rational use of care.

# Introduction

Government of Nepal (GoN) through the Ministry of Health and Population (MoHP) implemented two pro-poor programs in its efforts to strengthen social inclusion in the health sector. These programs provide free essential health care services (EHCS) to the ultra poor, poor, senior citizens, disable people, helpless, and FCHV at the district hospital (DH), and free EHCS for all citizens at sub-health post (SHP), health post (HP) and primary health care center (PHCC). The government intends to expand universal free health care beyond SHP, HP and PHCC to DH in 2010, thereby providing free EHCS to all citizens at all facilities up to the district level.

In addition to the Free Health Care Policy (FHCP), the current legal framework of Nepal also mandates public and private establishments to provide health benefits to workers and employees in the formal and informal sector. The benefits that these laws extend to the employed sector vary depending on a number of factors such as employment status, period of employment and position (Badal R, 2009). However, a vast majority of the employed such as the agriculture workers (which comprise about 70% of the employed), the overseas workers, the contractual, daily wage earners and non-permanent employees in the government sector were not covered by any health benefits other than the FHCP. Except for the retired personnel of the army, armed police, police and their dependents, the

unemployed and the retirees did not enjoy health benefits in addition to the FHCP.

Under this set-up of health benefit provision, the GoN is estimated to have spent 10.4 percent of total government expenditures on health in 2007. This represents about 36 percent of total health expenditure of the country. The remaining 64 percent of the total health expenditures were financed through private sources consisting of out-of-pocket (OOP) spending of households (84% of private health expenditures or about 54 percent of total health expenditures), pre-paid/risk pooling plans (0.4%), non-government organizations (NGOs) and firms ([www.who.int/nha/country/npl.pdf](http://www.who.int/nha/country/npl.pdf)).

The high OOP expenditure and the limited financial capacity of government make it imperative to discuss and explore health financing options that are sustainable and compatible with the socio-economic context of the country. For this reason, the MoHP intends to study in more depth innovative and equitable forms of financing health care in order to provide social health protection (SHPr) consistent with the thrust of the present administration of providing free health care to all. To guide the work in identifying strategic options in financing health care, preparatory studies were commissioned to take stock of the current situation in the country that can provide a better perspective of the legal framework, current practices and views on health financing.

Table 1. Summary of Workers/Persons Covered by Health Benefit Schemes

Sectors	Workers / Persons Covered	Benefits Provided	Not Covered
Government	Permanent	Medical expenses depending on the type of government service, position, length of service, and/or status of employment	Contractual daily wage earners, Non-permanent employees
Private Formal	<ul style="list-style-type: none"> <li>Permanent</li> <li>Probationary</li> <li>Non-permanent employees</li> </ul>	<ul style="list-style-type: none"> <li>Compulsory health check-ups for health-risky enterprises,</li> <li>Medical expenses for injuries while discharging duties assigned by employers</li> </ul>	<ul style="list-style-type: none"> <li>Occupational disease,</li> <li>Mental disability,</li> <li>Medical expenses for injuries not related to the duties assigned by employers</li> </ul>
Informal Sector	<ul style="list-style-type: none"> <li>Establishments with less than 10 workers,</li> <li>Transport workers,</li> <li>Workers in rafting, adventure, mountaineering and travel and trekking agency</li> </ul>	Treatment for work injury	<ul style="list-style-type: none"> <li>Agriculture workers,</li> <li>Overseas workers</li> </ul>
Others	<ul style="list-style-type: none"> <li>Retired army, police, armed police and their dependents</li> </ul>	Treatment only for retired army	<ul style="list-style-type: none"> <li>Unemployed population,</li> <li>Outside the labour force including retired personnel of private sectors and some of governmental services</li> </ul>

Source: The Current Legal Framework on Health Financing and Social Health Protection in Nepal, 2009

## Objectives

The study was intended to:

- Review current practices of public and private establishments in providing medical / health benefits to their employees, and
- Assess the views or opinion of leaders on the financing of health care.

The results of these two objectives provided insights for the political advocacy efforts in moving the agenda of SHPr forward.

## Methodology

Cross-sectional descriptive study was conducted. Qualitative information was collected from the variety of leaders involved in health care financing, while quantitative and qualitative information was collected from the employers and employees of public and private establishments that provides medical / health benefit to their employees.

This information ultimately gave the flavor of opinion and stock taking survey on SHPr.

### Stocktaking Survey

**Objective and Data Generated:** The objective of the survey was to get an overview of the current practices of public and private establishments in providing medical / health benefits as well as identify key features of the health benefit schemes provided by the establishments, especially the health insurance benefits. The survey generated data on medical / health schemes implemented by companies, key features of the schemes and the satisfaction of both the employers and the employees with such schemes.

**Interviewees:** Since there is no updated and complete list of companies (with employment data), the companies interviewed were selected from the list of member or affiliated companies of the Federation of Nepalese Chamber of Commerce and Industry (FNCCI), the stock market and those provided by the trade unions. A total of 181 establishments were

interviewed through telephone and/or face-to-face interview technique. These establishments consisted of government and private companies and professional associations. Of the 181 establishments, 92 (51%) were interviewed through the telephone only. The telephone interviewed was meant to identify establishments that provide health insurance benefits to its employees / workers. Employers and/or employees of 89 companies representing about 50 percent of the companies were interviewed face-to-face. In 48 companies, only the employers were interviewed while only employees / workers were interviewed in 36 of the companies. In five of the companies, both the employees / workers were interviewed. Face-to-face interviews were conducted for large and essential companies refer to establishments that are vital to the functioning of the economy such as power, electric, telecommunication companies, those providing health insurance to its workers and companies that are located in districts where industries are concentrated such as Makawanpur (Hetauda), Morang (Biratnagar), Kaski (Pokhara), Jhapa (Ilam), Banke (Nepalgunj), Rupendehi (Butwal), and Parsa (Birgunj). The MoHP, Employers' Council and the trade unions were consulted in the selection of the districts that will be covered by the survey.

**Questionnaire:** The three sets of questionnaires used in the interviews were patterned using the InfoSure instrument (Hohmann et al

2001) to assess community-based health insurance schemes. While a different questionnaire was used for the interview of employers, employees and professional associations, the questionnaires were formulated very similarly for comparability. The survey instrument was pre-tested and translated into the Nepali language.

The interviews were conducted from July–September 2009 by trade union representatives and senior experts.

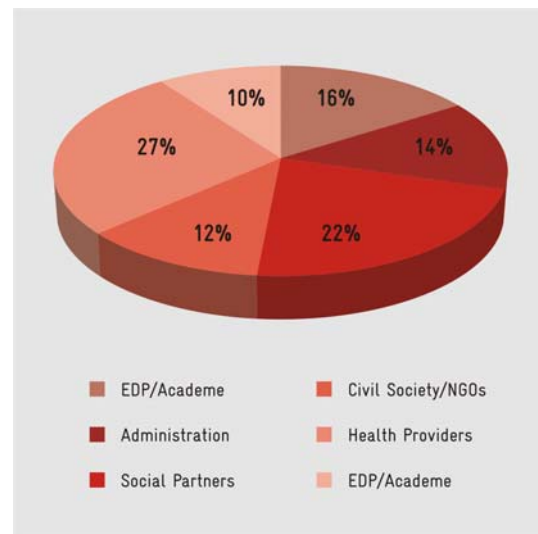
## Opinion Survey

**Objective and Data Generated:** The objective of the opinion survey was to assess the views of opinion leaders on financing mechanisms in Nepal, specifically: the FHCP, user fees, informal payments as well as their views on social health insurance (SHI). The opinion survey provided insights on handling the political process in moving the health financing agenda forward.

**Interviewees:** A total of 83 opinion leaders representing key stakeholder groups, namely: politicians, administrators, social partners, NGOs / Civil Society, Health Providers and External Development Partners (EDP) and academics were interviewed. The distribution of the opinion leader per stakeholder group is in Figure 1. The selection of the opinion leaders was purposively done based on discussions with the MoHP.

Seventy-one percent (71%) of those interviewed were from Kathmandu and rest from the different eco-development regions of the country: the Tarai, Hill and Mountain area.

**Figure 1. Distribution of Opinion Leaders Interviewed per Stakeholder Groups**

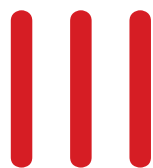


83 opinion leaders interviewed

Opinion leaders interviewed outside of Kathmandu valley were from Kaski (Pokhara), Morang (Biratnagar), Pyuthan, Kailali (Dhangadi) and Rasuwa districts.

**Questionnaire:** The 39-questions instrument used in the survey was based on the instrument used in Yemen. The questionnaire was pre-tested and adjusted accordingly in April 2009. All issues raised in the pre-test were considered in the final design of the questionnaire except comments pertaining to the length of the questionnaire and the timing of the survey, which was conducted at a time the government and the constitution were in transition. The Nepali version of the questionnaire was used in the interview.

The interviews were conducted from April – September 2009 by senior Nepali experts.



## Current Practices in Providing Health Benefits in Establishments

### Health Benefits Provided by All Establishments Interviewed

The 181 establishments that were interviewed either through the telephone or a face-to-face interview included private companies, semi-government establishments and the police force. These establishments were in the banking and finance, transport, food, tourism, pharmaceuticals, gas, electricity / hydropower, wood, metal and cement sectors, and employ 141,651 people. If we exclude the police which employ 56,000, the average employment size of these 181 establishments was 473 workers. Employment size ranges from 11 to 10,550. Majority of these establishments have offices in Kathmandu (65%) and about 57 percent have offices, factories outside of the country's capital.

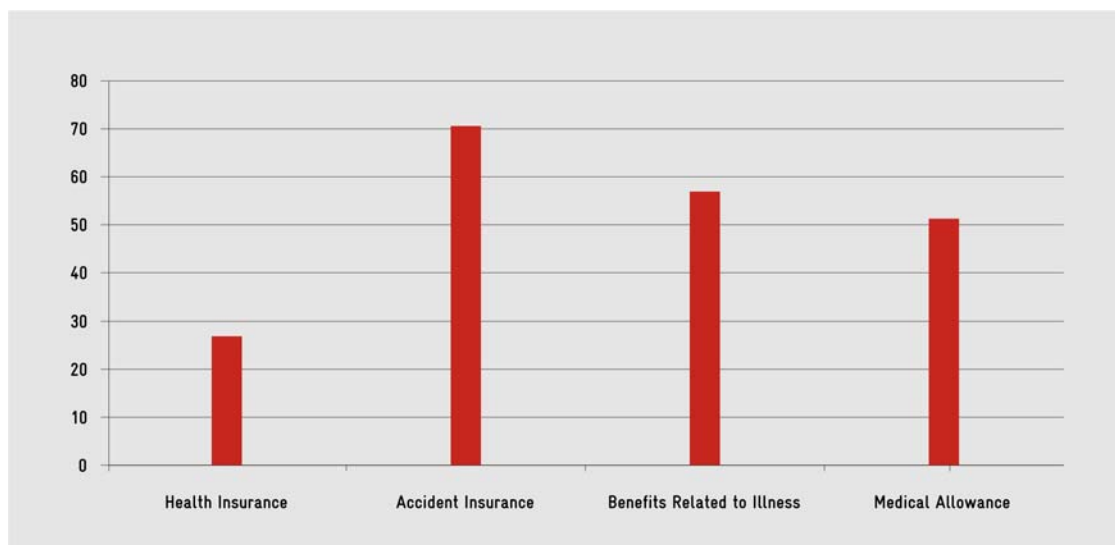
#### **Most Establishments Provide Health**

**Benefits.** Of the 181 companies interviewed, 94 percent (171) of the companies provided at least one type of health benefit. Six percent of the companies reported that they were not giving any health benefit scheme to their employees. Figure 2 shows the distribution of the companies providing each type of health benefits.

- **Medical allowance:** About half (92 companies or 51%) of the establishments pay medical allowance, which were benefits given in cash as a kind of regular salary and given even if the employee is not ill.
- **Health benefits in cash or in kind:** Fifty six percent (102) of the companies provided health benefits in cash or kind. These were benefits related to illness and were enjoyed by an employee when he / she or his / her family members were ill. The benefits were provided either in cash such as through reimbursement of medical / health expenses or in kind such as by hiring a company doctor, provision of medicines, agreements with a health provider or hospital.
- **Enrollment to a health insurance:** Only 27 percent (48) of the companies enrolled their employees to a health insurance scheme. This benefit refers to a scheme where the company pays wholly or partially the contribution to a health insurance scheme. The costs of illness (covered by the health insurance) of its employees and/or their family are wholly or partly paid for by the health insurance scheme.
- **Accident or work injury insurance:** Seventy percent (127) of the establishments reported that they provided health benefits to its employees / workers in the form of accident insurance. This benefit refers to a scheme where the company pays wholly or partially the contribution to an accident or work injuries insurance scheme so that the medical costs resulting from work injury or accidents are wholly or partly paid for by the insurance scheme. An accident at work is defined as an external, sudden, unex-



Figure 2. Distribution of Companies Interviewed (face-to-face and by telephone) by Health Benefits Provided



pected, unintended, and violent event, during the execution of work or arising out of it, which causes damage to the health of or loss of the life of the employee (the insured).

The companies reportedly providing health benefits employ about 99 percent of all workers / employees of the establishments covered by the interviews.

### Health Benefits Provided by Establishments Interviewed Face-To-Face

**More Establishments Provide Work Injury Insurance Benefits.** Eighty nine establishments that were interviewed face-to-face (excluding those interviewed by telephone) provided at least one health benefit scheme. These 89 companies had an employment size of 126,561. Figure 3 shows the distribution of the companies providing each type of health benefits and the percentage of their employees that were covered by a particular health benefit. There was no data on the percentage of employees covered by medical allowance and health benefits related to illness.

The employees covered by each of these schemes were as follows:

- Medical allowance:** Sixty-nine percent (61) of the companies provided medical allowance. These companies had a workforce of 107,821 workers, which represented 74 percent of the total workforce of the surveyed establishments. On an average, medical allowance represented nearly nine percent of the gross income of the employees in the companies that provided such benefit.
- Health Benefits related to Illness given in Cash or in Kind:** This health benefit scheme is provided by 48 percent (43 companies) of the establishments. These companies employed 89 employees / workers (nearly 62% of the workforce of the companies surveyed). The health benefits were provided mostly only to the employees / workers in 84 percent (36) of the companies, although some establishments (14% or 6 companies) extended the benefit to family members. Employees of most companies (63% or 27 companies) did not co-pay to receive the benefits.



In the 16 companies providing health benefits related to illness where the employers were interviewed, 75 percent (12) of these establishments provided the benefits through reimbursements of claims, while one-third (5) of the companies provided drugs to their employees and another one-third (5) employed the services of medical doctors. About half (56% or 9) of the companies reimbursed the cost or provide medical services / drugs for all types of illnesses while 31 percent (5) reimbursed or provided health care services for only work-related illnesses.

- **Accident Insurance:** Accident or work injury insurance was provided by 80 percent (71 companies) of the establishments surveyed to 56,135 employees / worker representing 39 percent of the total workforce of all the companies interviewed (face-to-face). In 65 percent (46) of these companies, all employees were covered by the work injury insurance coverage while only permanent workers were protected in 34 percent (24) of these companies.
- **Health Insurance:** Twenty-six percent of the companies (23) enrolled 21,650 of their employees / workers to health

insurance. These enrolled workers / employees comprised 15 percent of the total workforce of all the establishments interviewed. Among the establishments enrolling their workforce in health insurance, 52 percent (12 companies) extended this benefit to all its employees while 48 percent (11 companies) enrolled only permanent employees. In most companies (96% or 22 companies), the family members, specifically the spouse (in 21 companies) were also protected.

#### Features of Health Insurance and Work Injury Insurance were Similar.

- **Payment of Contribution:** In majority of the establishments interviewed, the employers paid the contribution to the insurance scheme. In the 47 companies providing work injury insurance where the employers were interviewed, the employers shouldered the costs of contribution in 89 percent (42) of the companies while in the case of health insurance, cent percent companies paid the contribution to health insurance. Employees of nearly 8 percent (2) of the companies paid the contribution for their family members.

Figure 3. Distribution of Companies Providing Each Type of Health Benefits and Employees Covered

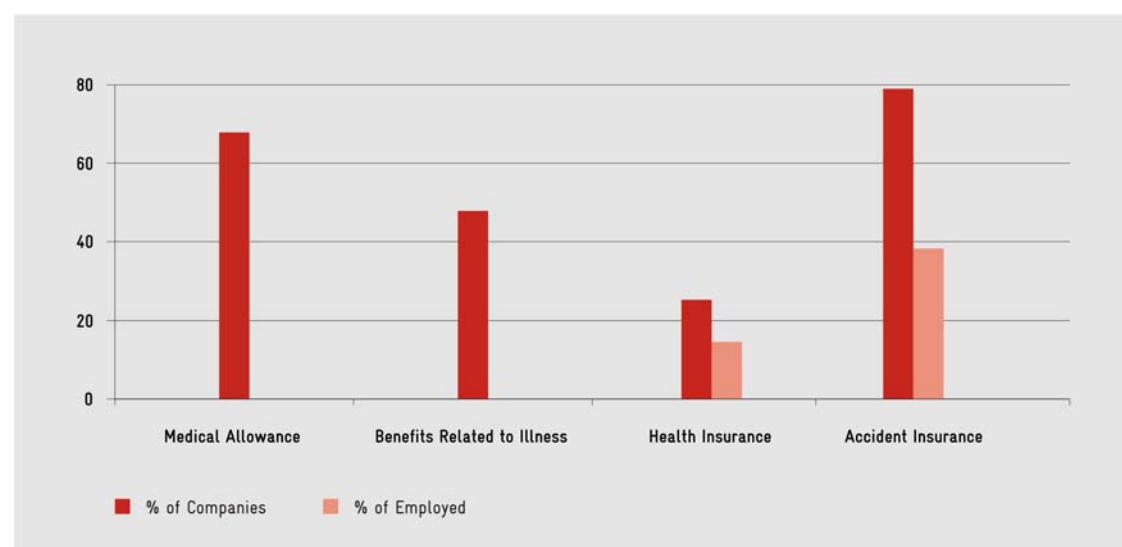
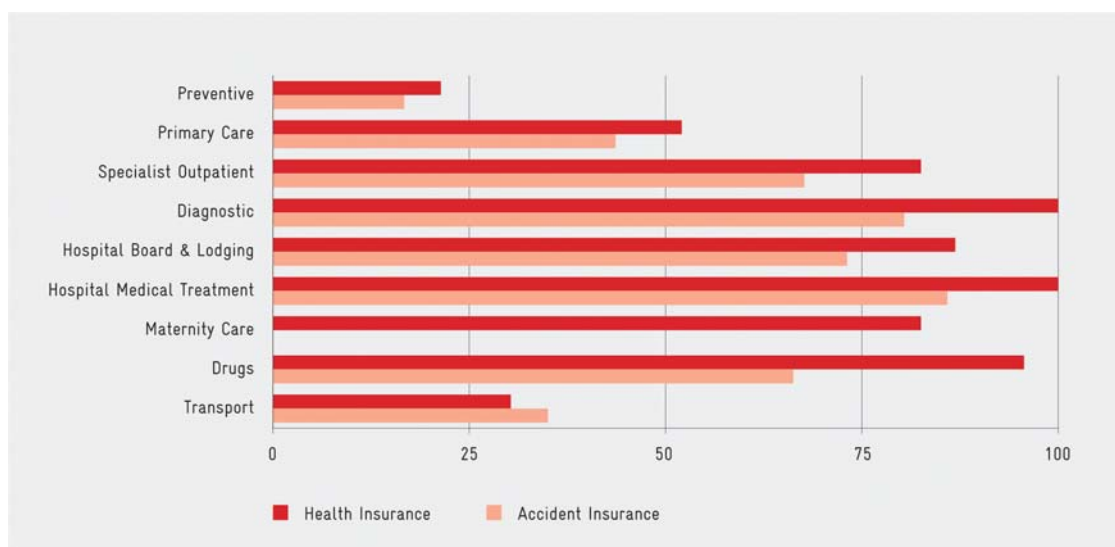


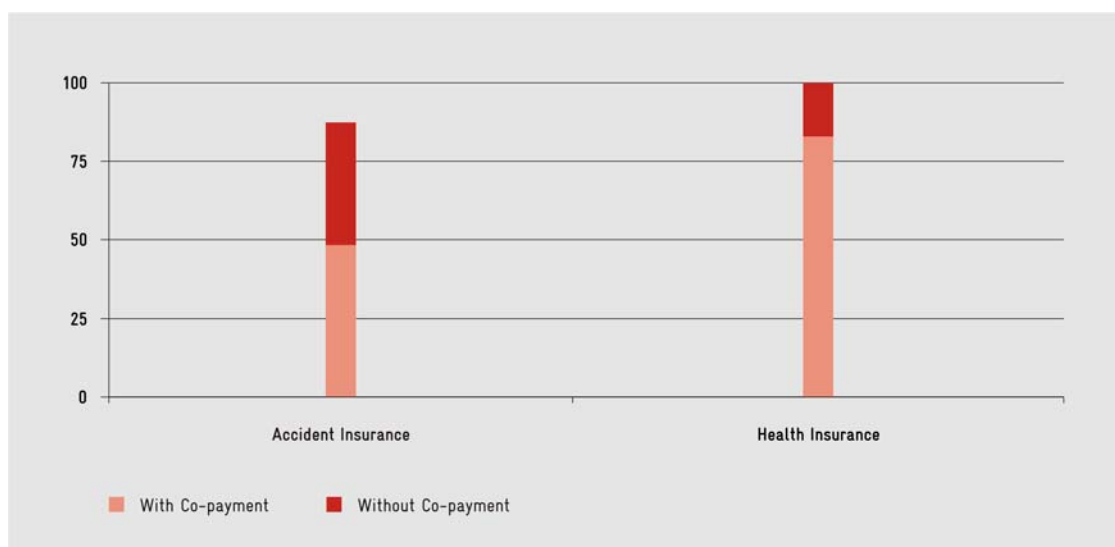
Figure 4. Distribution of the Benefits Received by Employees from Health and Accident Insurance



- Benefits Provided:** Figure 4 presents the distribution of the benefits provided by the health and work injury insurance. The work injury insurance mostly covered the hospital in-patient care (86% or 61 companies), diagnostics (80% or 57 establishments), specialized outpatient services (68% or 48 establishments) and drugs (66% or 47 establishments), which can be

availed of by the insured from any provider (59% or 42 establishments). In the case of health Insurance, most employees / workers can avail of medical treatment for in-patient care (100% or 23 establishments), diagnostic services (100% or 23 establishments), drugs (96% or 22 establishments), board and lodging for in-patient care (87% or 29 establishments), maternity benefits

Figure 5. Distribution of Companies Providing Accident and Health Insurance by Co-payment



(83% or 19 establishments) and specialized out-patient (83% or 19 establishments) in any health facilities (87% or 20 companies). Except for maternity benefits, the benefits provided by the health and work injury insurance were similar, although more companies enrolled in health insurance report that their employees were protected by each of the benefits enumerated above.

The insured are co-paying in both health and work injury insurance, although there were more companies enrolled in health insurance that reported co-payment. Eighty-three percent (83% or 19 establishments) of the companies providing health insurance benefits reported that they co-pay for their health care costs while co-payment was reported by only 48 percent (34) of the companies providing work injury insurance (Figure 5).

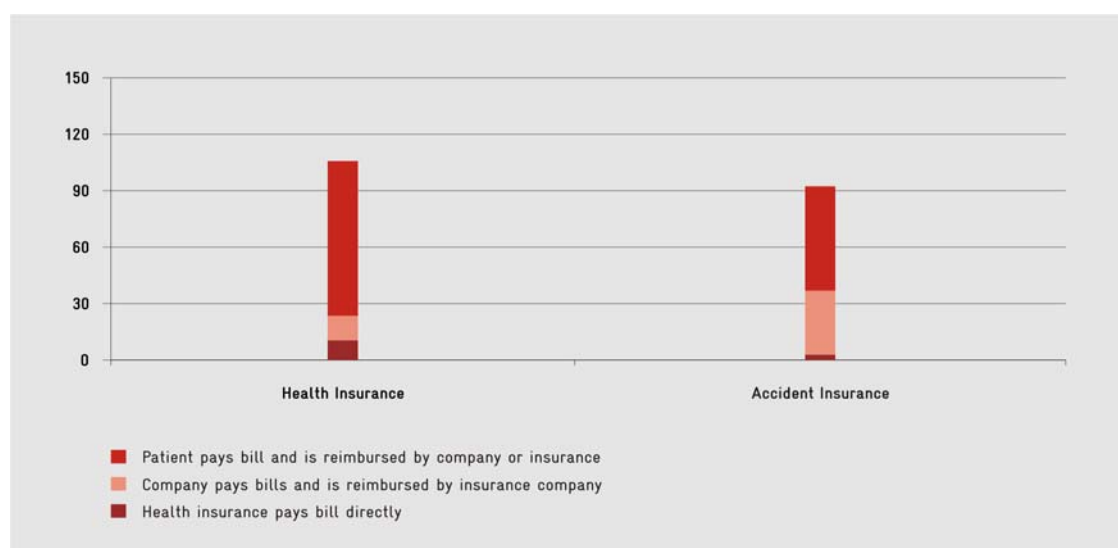
Based on interviews of employers providing work injury and health insurance (47 and 20 establishments, respectively), the common practice was for the patient to pay the health care costs and submit the bill for reimbursement (55% or 26 establishments and 82 percent or 18 establishments providing work injury insurance and health insurance, respec-

tively). In other cases, the employer (34% or 16 companies and 14% or 3 establishments for work injury and health insurance, respectively) paid the medical care costs first and was then reimbursed by the work insurance and Health Insurance Company.

Only in very few cases that the accident and health insurance company paid the bill directly to the provider (1 company or 2 percent in the case of work injury insurance and 2 establishments or 9 percent in health insurance (Figure 6).

The maximum reimbursable benefits in a health or work injury insurance were limited by a ceiling (68% or 15 companies and 45 percent or 21 companies providing health and work injury insurance, respectively). The second most common approach in defining the benefit ceiling was reimbursement of a certain percentage of the total costs in the case of health insurance (36% or 8 companies) and reimbursement of the total medical costs (36% or 17 companies) in the case of work injury insurance. In some companies, both methods – percentage of health care costs and ceiling – were applied. The total medical bill was paid in full by health insurance in 18 percent (4) of the companies.

**Figure 6. Distribution of Companies Providing Accident and Health Insurance by Payment of Health Care Providers**



- **Payment of Health Care Providers:** The employers interviewed reported that the health and work injury insurance companies did not limit the fees of the health providers through a fee schedule (64% or 14 establishments providing health insurance and 64 percent or 30 establishments enrolled in work injury insurance) and the insurance companies did not own nor enter into contract with health providers (85% or 40 establishments and 55 percent or 26 establishments enrolled in work injury insurance, respectively, and 91 percent or 20 establishments and 77 percent or 17 establishments enrolled in health insurance, respectively). The employers also reported that their health insurance did not adopt risk management measures (91% or 20 companies) that would reduce the potential of loss of the health insurance company by balancing the healthy and sick members (or risk mix).
- **Administrative Task:** A number of administrative tasks related to the provision of insurance were reportedly performed by the establishments. These tasks included the registration of the insured (79% or 37 establishments for work injury insurance

and 73 percent or 16 establishments for health insurance), contribution collection (81% or 38 establishments for work injury insurance and 85% or 19 establishments for health insurance), processing of claims (79% or 37 establishments for work injury insurance and 86 percent or 19 establishments for health insurance), statistics (74% or 35 establishments for work injury insurance and 64 percent or 14 establishments for health insurance), bookkeeping (72% or 34 establishments for work injury insurance and 68 percent or 15 establishments for health insurance) and controlling (70% or 33 establishments for work injury insurance and 59 percent or 13 establishments for health insurance) (Figure 7).

**Employers and employees were satisfied with all the schemes, but more employers, employees / workers are satisfied with health insurance (Figure 8).**

- **Medical Allowance:** The employers (89% or 25 employers) were satisfied with the medical allowance. However, the employees / workers were divided in their opinion; 49 percent (32 employees / workers) were satisfied while 46 percent (30 employees /

**Figure 7. Distribution of Companies Performing the Administrative Tasks Related to Insurance**

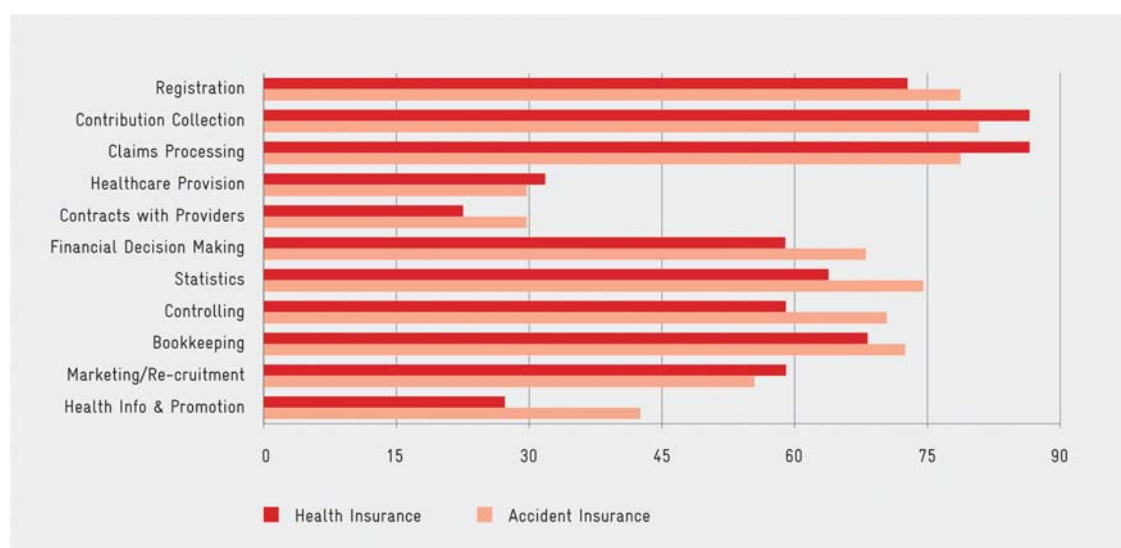
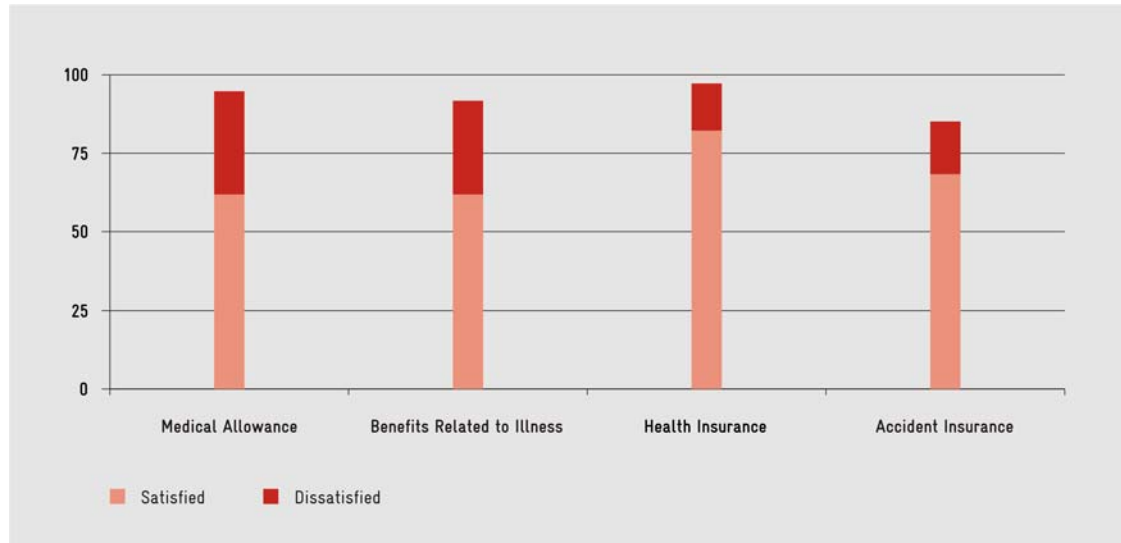


Figure 8. Distribution of Companies by Satisfaction with Health Benefits Schemes



workers) were not. Overall, 61 percent (57 employers and employees / workers) were satisfied with medical allowance. There seems to be a consensus among the employers and the employees / workers that the amount of the medical allowance was not sufficient given the costs of healthcare. Employers and employees / workers were aware that the financial capacity of the company defined the amount of the medical allowance. However, setting the amount of medical allowance according to the position of the staff was deemed inequitable causing dissatisfaction among some employees / workers. Those who were satisfied with medical allowance saw such benefit as supplementary to other health benefits that the company provided. Medical allowance covered the health needs that did not require hospitalization or those outside of the scope / coverage of the other health benefits provided by the company such as the health needs of family members. It, therefore, lowers the OOP expenditure of the employees / workers, and also, medical allowance could be used for purposes other than health.

● **Health Benefits related to Illness in Cash and/or in Kind:**

Just like in the case of medical allowance, 61 percent (43 employers and employees / workers) of the employers and employees were satisfied with this scheme. Readily available health service provided employers and employees with a feeling of security. Satisfaction was also brought about by some companies shouldering the full costs of care or advancing the money to pay for health services. Those who were dissatisfied raised the following concerns:

- Low quality of care such as the case of the not-so-well functioning hospital for the police force,
- Limited benefits provided. In some cases, this covered only work-related illness, while in other cases, family members were not entitled to get the benefits and in still other cases, the benefits were only available at the head office of the company,
- Variation in the benefits provided to the employees / workers within a company, and

- Insufficient financial benefits to cover the full cost of care.
- **Accident Insurance:** Sixty-eight percent (63) of the employers and employees interviewed were satisfied with accident insurance. Most of the employers (79% or 37 employers) and employees / workers (57% or 26 employees / workers) were satisfied with work injury insurance. The employers and employees / workers were satisfied with accident insurance because of the protection from the high costs of care and the quality and timely services of the insurance companies particularly as regards reimbursement of claims. These reasons were also the reasons cited by the employers for their company's decision to enroll in an accident insurance. Seventy-seven percent (36 employers) and 11 percent (5 employees) of the companies cited financial protection of workers and quality services of the insurance companies, respectively as the main considerations of the company in extending such benefits to its staff. The employer's plan to continue (77% or 36 companies) enrolling in accident insurance, although some may introduced some modifications in terms of the benefits.

The dissatisfaction with the scheme was due to the amount of the benefits, the employees covered and the reimbursement system. The amount of benefits was deemed limited particularly for risky occupation resulting to some employees / workers shouldering a portion of the costs of care. Also, the benefits did not cover occupational hazards and transportation costs incidental to medical care. Some companies did not enroll all of its employees / workers to the accident insurance. The workers / employers wanted coverage for their family members. The late releases of the claims, the screening of the claims filed and the documentation required for claims caused dissatisfaction among

employees / workers. Employees / workers preferred a scheme where the money was readily available at the time of accident instead of requiring them to advance the money to pay the health providers.

- **Health Insurance:** There are more employers and employees who are satisfied with health insurance compared with the different health benefit schemes mentioned above. About 82 percent (27) of employers and employees were satisfied with health insurance compared with the 61-68 percent satisfied with medical allowance, health benefit related to illness given in cash and/or in kind and accident insurance.

Dissatisfaction was expressed by 15 percent (5) of the employers and employees. The reasons cited for satisfaction with health insurance were financial protection and the services of the insurance company, particularly the timeliness of reimbursement and the helpfulness of the health insurance staff. Health insurance was considered as a motivation factor for employees. The employees also recognized that their health insurance coverage was anchored on the financial capacity of their company.

Issues raised by dissatisfied as well as satisfied employers and employees included the low benefit ceiling of the health insurance, the non-inclusion of parents among those covered by the insurance benefit, delayed in claims processing, disallowance in the claims for reimbursements and the practice where patients paid the bills first and were reimbursed later by the health insurance. Financial protection and services of the health insurance companies were the reasons cited by the employers for enrolling their employees / workers in health insurance (77% or 17 companies and 23% or 5 companies, respectively). Ninety-one percent (20 companies) planned to continue providing such benefits to their workers / employees.

## IV Views of Opinion Leaders on Health Financing

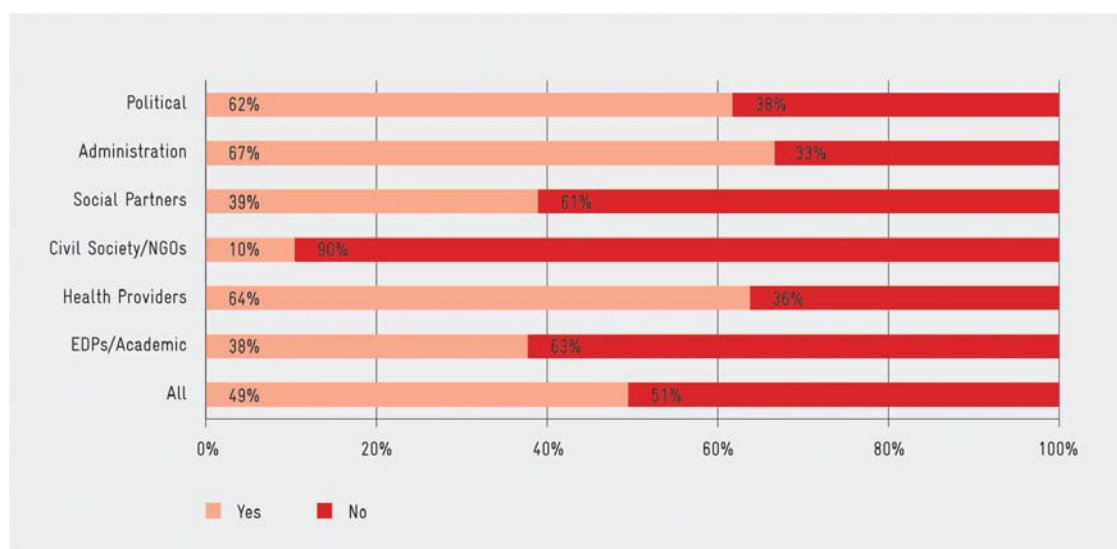
### Opinion leaders are divided on their views on the benefits and financing of the FHCP.

There were different views put forwarded by the opinion leaders on the benefits and capacity of government to finance entirely the implementation of the FHCP.

Forty-nine percent (41) of the opinion leaders mostly residing outside of Katmandu and representing the health providers, the administration and politicians were of the view that to some extent the people, especially the poor living in rural / remote areas, benefited from the FHCP since health service utilization increased and the people got the services for free (Figure 9).

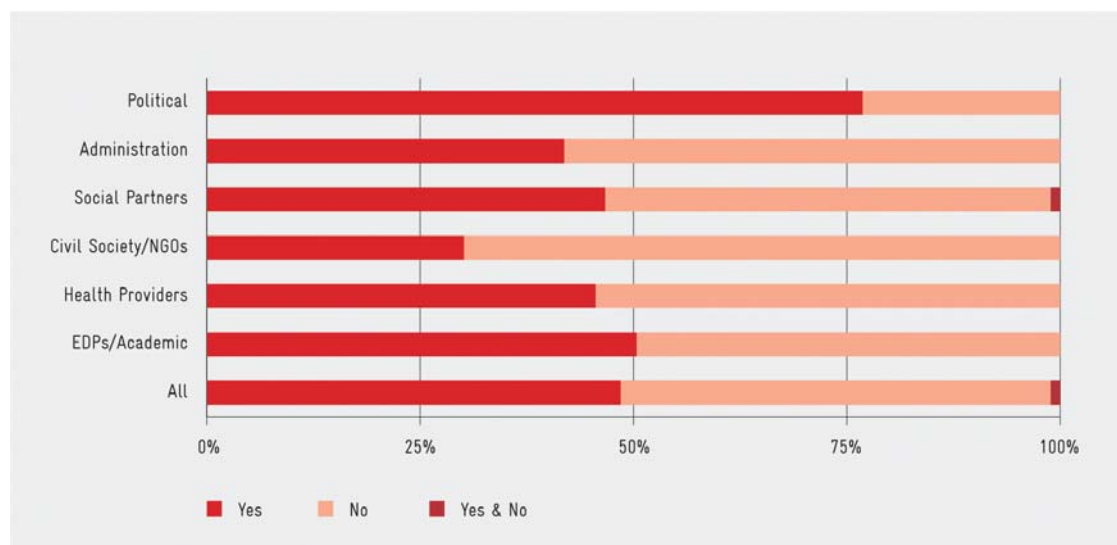
The remaining 51 percent (42) of the opinion leaders mostly those residing in Kathmandu and representing civil society, social partners, EDP / academics (Figure 9) identified access, quality and governance issues that prevented people from benefiting of FHCP. Issues on quality that prevented the people from benefiting from the FHCP were the inadequacy of trained human resources, inadequate availability of medicines, medical equipments, laboratory facilities and basic infrastructure as well as non-uniformity of treatment methods and the long waiting of patients. They attributed this situation to corruption, and inadequate rules and regulation, supervision and problems with transparency and accountability added to have

Figure 9. Distribution of Responses on Whether or Not People are Benefiting from Free Health Care Services





**Figure 10. Distribution of Responses on Whether or Not Government can Entirely Finance Free Health Care Services**



situation like this. Looking at the demand side, some opinion leaders claimed that the patients did not know what services are available for free and where they can get these services. The policy raised expectations of the people but there was inadequate preparation for its implementation.

Forty-eight percent (48% or 40) of the opinion leaders believed that the government could finance entirely the FHCS (Figure 10). There were more political leaders (77% or 10) and opinion leaders based outside of Kathmandu (58% or 14) who believed that government can finance FHCS. Their opinion emanated from their belief that the provision of FHCS is an obligation and commitment of the government – what the government needs is the will-power to implement the policies. The opinion leaders believed that resources could be generated from contributions of EDPs, imposition of taxes such as on tobacco and by introducing a health insurance. Additional resources can be made available by improving efficiency such as by reducing support to non-essential sectors, reducing wastage, and better coordination.

Fifty-one percent (51% or 42) of the opinion leaders thought that government cannot finance free health care in the long run because resources needed to put in place, the needed infrastructure and improve the quality of services, are huge compared with the resources of government. They thought that government might not be able to mobilize additional resources adequately to provide for competing priorities. Some opinion leaders believed that the people should be required to pay even a small amount in order to avoid unnecessary and over utilization of health services, and to increase the value of the health services to the people.

**Majority of the leaders believed in user fees but they express concern for the protection of the poor.** Majority of the opinion leaders (65% or 54) believed that not all services should be provided for free to the people (Figure 11). This result is consistent with the discussion in the above-mentioned section, where the opinion leaders cited the importance of imposing fees, though small, in order to avoid over-utilization of services and to increase the value of the service to the people.



Figure 11. Distribution of Responses on Whether or Not All Services should be Free

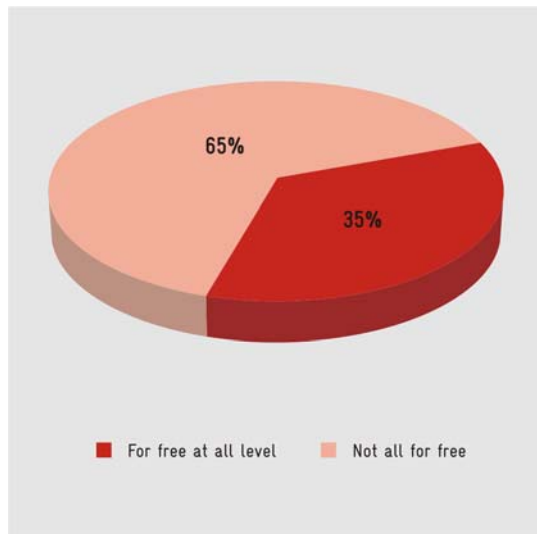
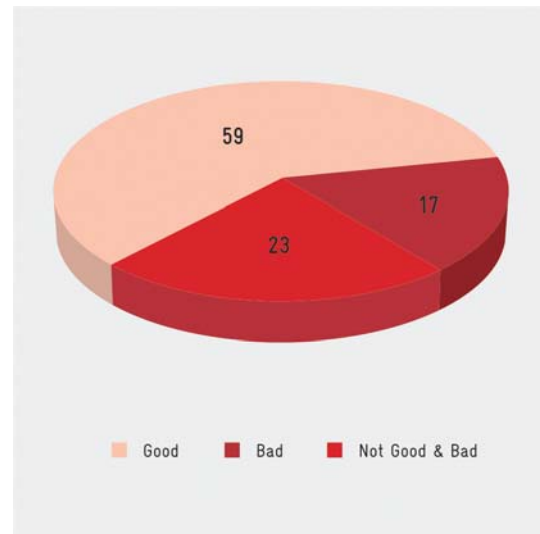


Figure 12. Distribution of Responses on Whether or Not User Fees are Good



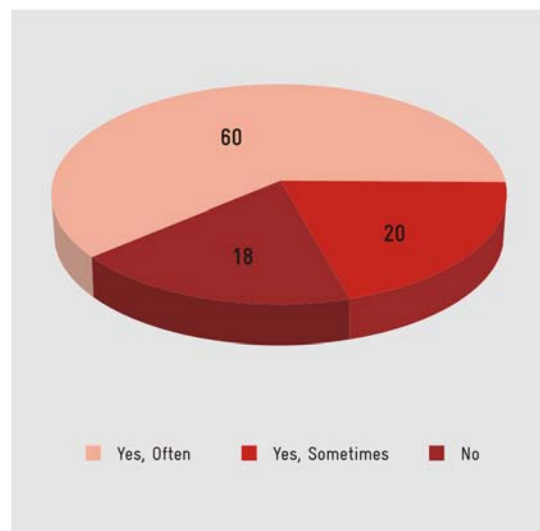
This position is further reinforced by their opinion on user fees. Majority (59% or 49) of the opinion leaders (Figure 12) believed that user fees are good for reasons cited above. Seventeen percent (14) did not agree with user fees because of the inability of the poor to pay. Figure 13 shows that 80 percent (67) of the opinion leaders believed that the poor postpone treatment, either sometimes or oftentimes, due to in-affordability to pay the user charges.

Close to a quarter (23% or 19) of the opinion leaders thought that using user fee concept could be viewed as good or bad. For them, it is important that the amount of user fees will vary across geographic location and socio-economic status of the patients.

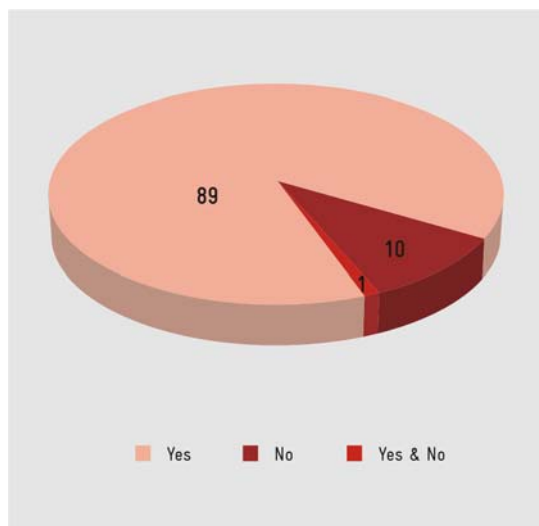
**Majority of the opinion leaders believed that some form of health insurance is needed now in Nepal.** Consistent with their views that people should contribute for their health care needs, majority of the opinion leaders (89% or 74) (Figure 14) found the concept of mandating people to make pre-payments for future health needs acceptable in view of the inability of government to finance

all the health needs and the rising costs of health care. The concept of health insurance appeals to the opinion leaders since they viewed health insurance as an instrument that can substantially cover the costs of care and eventually reduce household expenditures on health particularly in catastrophic cases and after retirement. Since the poor do not have

Figure 13. Distribution of Responses on Whether or Not the Poor Postpone Treatment because of User Fees



**Figure 14. Distribution of Responses on Whether or Not it is Good to Mandate People to Make Pre-payment for Health Future Health Needs**



the capacity to contribute, they thought government should contribute for the poor.

Those (10% or 8) who were not in favor thought that health insurance should not be mandatory, rather it should be voluntary and people should be made aware so they can make an informed choice. Concerns were raised on the ability of the poor, the unemployed and those in the rural areas to pay the contribution.

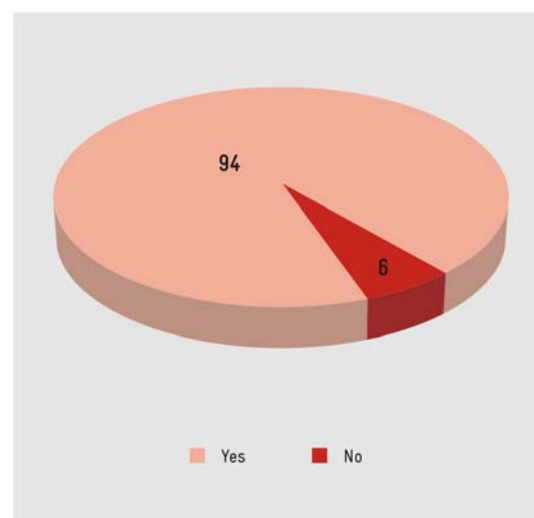
Majority of the opinion leaders (94% or 78) believed that SHI is needed now in Nepal (Figure 15). Under the Interim constitution of Nepal, health is defined as a fundamental right. With the increasing costs of care and the inability of both the people and government to singly pay the costs of care, reforms are needed in the existing system to improve access and utilization of care. Health insurance is deemed as the only viable mechanism to finance health care that will financial protect the people.

Those (6% or 5) who do not believe that health insurance is needed now in Nepal cited the current state of the health infrastructure,

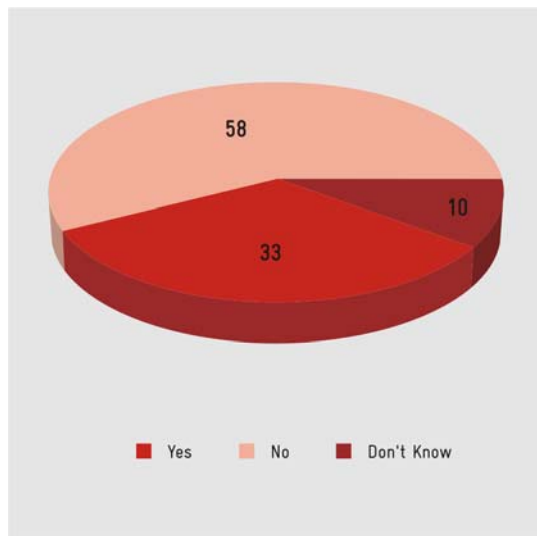
the awareness of the people and the FHCP as reasons. Social health insurance is deemed to be not feasible because of the weakness of the preventive health system, which will result to an increase in the demand for curative care services. A modification of the FHCP in order to address the service delivery issues is believed to be a more feasible option. Other leaders suggested a phased approach in implementing SHI. Rather than immediate full-scale implementation, health insurance can be pilot-tested first in order to improve the infrastructure and service delivery mechanism as well as increase the awareness of the people.

**Majority of the opinion leaders believed that health insurance should be in the political agenda.** The opinion leaders were asked on whether or not SHI is on the political agenda. Majority (58% or 48) believed that it is not on the political agenda while 32.5 percent (27) thought that the current political agenda included SHI. There were more opinion leaders belonging to the social partners (44% or 8) and the EDPs / Academics (62% or 5) groups who believed that the political agenda covered SHI. Majority of the

**Figure 15. Distribution of Responses on Whether or Not Social Health Insurance is Needed**



**Figure 16. Distribution of Responses on Whether or Not Social Health Insurance is on the Political Agenda**



political leaders belonging to the other categories that are the politicians, administration, health providers and the civil society/NGO groups believed that SHI is not on the political agenda (Figure 16).

Majority of the opinion leaders thought that the issues that were given more focus during the time of the survey were the political stability of the country, peace, law and order. There is less attention paid to SHI because of the FHCP, and also the politicians have limited understanding and awareness of the benefits of SHI. Some opinion leaders claimed that Nepal has no political agenda on SHI, which was included in the manifesto only during election campaign.

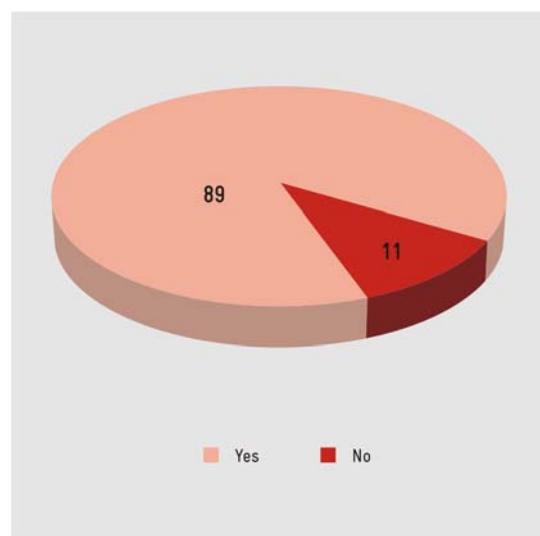
Some opinion leaders believed that SHI is in the political agenda because health is viewed as a fundamental basic human right in Nepal and the government is responsible for the protection and promotion of the health of the people. The government introduced improvements in the health care delivery system such as the community drug schemes, community health insurance (CHI) and the FHCP. It was

also believed that the government realized that it could not shoulder the entire cost of health services and that it needs to initiate reforms to adequately finance the provision of quality health care. While there were discussions on social security and the protection of the poor and the disadvantaged, there is still no policy, program, nor implementation plan for SHI.

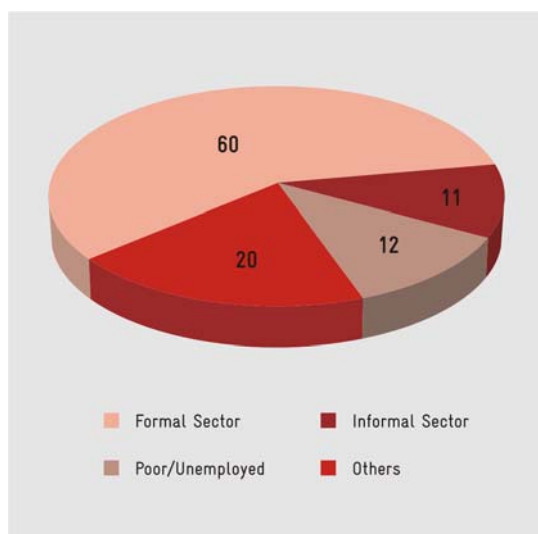
Since most opinion leaders believed that the concept of SHI is good and needed now in Nepal, 89 percent leaders (74) advocated that SHI should be in the political agenda in order to formulate policies that will reduce the financial burden of the government and improve access, utilization and quality of health care services (Figure 17).

Those who responded negatively to the question on whether or not SHI should be in the political agenda argued that health care financing is a common problem and should be included in the common agenda rather than merely included in the political agenda. The frequency of changes in government supports the argument that health financing should be a social agenda.

**Figure 17. Distribution of Responses on Whether or Not Social Health Insurance should be on the Political Agenda**



**Figure 18. Distribution of Responses on the Groups that should be Covered First and Foremost by Health Insurance**



**Majority of opinion leaders preferred a health insurance that enrolls at the onset the formal sector and covers the poor without paying any contribution.**

Majority of the opinion leader (60% or 50) thought that the formal sector should first be covered by health insurance (Figure 18). The formal sector has the capacity to pay the contribution and is relatively easier to enroll in the scheme compared to the poor / unemployed and the informal sector. Twelve percent

(10) and eleven percent (9) of the opinion leaders preferred to enroll the poor / unemployed and the informal sector first presumably because these group of people are in need of medical assistance. Others that were cited are the senior citizens and those belonging to certain geographic areas.

Most opinion leaders (95% or 79) thought that the poor should be the members of the health insurance without paying any contribution (Figure 19). Twenty-two percent (18) also believed that the unemployed should not pay any contribution to the health insurance.

Most opinion leaders thought that everyone should contribute to the health insurance, except the poor whose contribution will be paid by government (Figure 20). It is believed that contribution from all sectors would make the system participatory and create feelings of ownership, which is important in making the system sustainable. While all sectors will contribute, opinion leaders were of the view that the contribution of the people should be low and the government should provide higher contribution. This is because of the obligation of the national and local governments in providing health care, which is one of the basic rights of the people. Others were of the view that

**Figure 19. Distribution of Responses on the Group which should be Included in the Health Insurance without Paying Contribution**

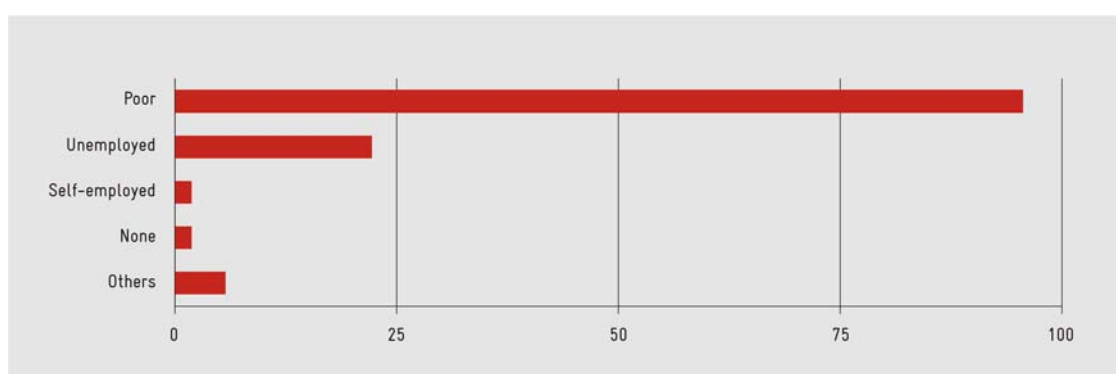
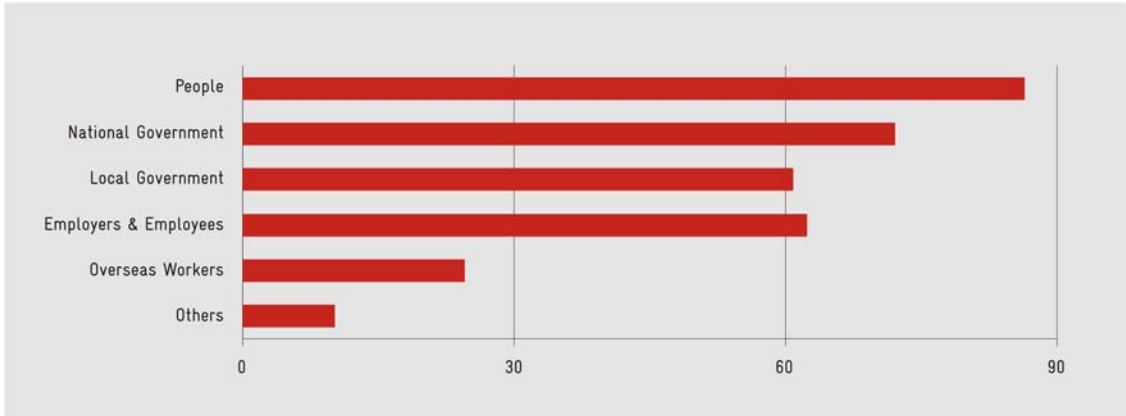


Figure 20. Distribution of Responses on who should Pay Contribution to the Health Insurance



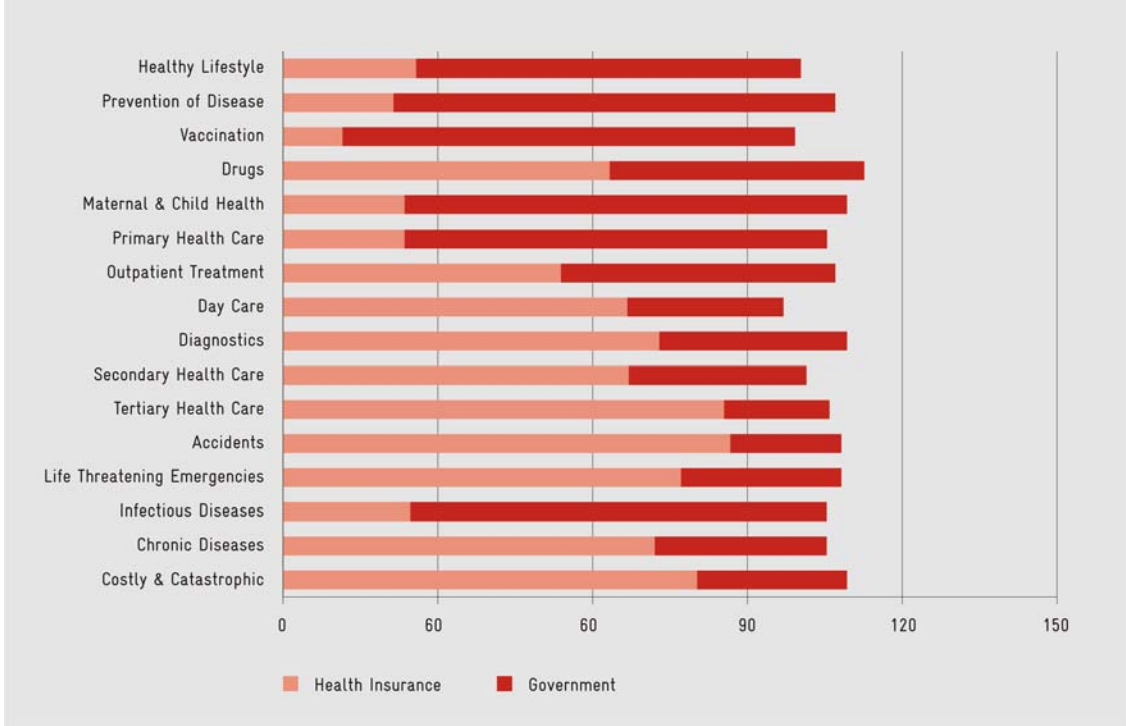
government should not contribute to health insurance because it already provides FHCS.

The contribution of government would consist of funds for start-up of the health insurance, contributions to the health insurance for the poor and funds to make up for deficits that the

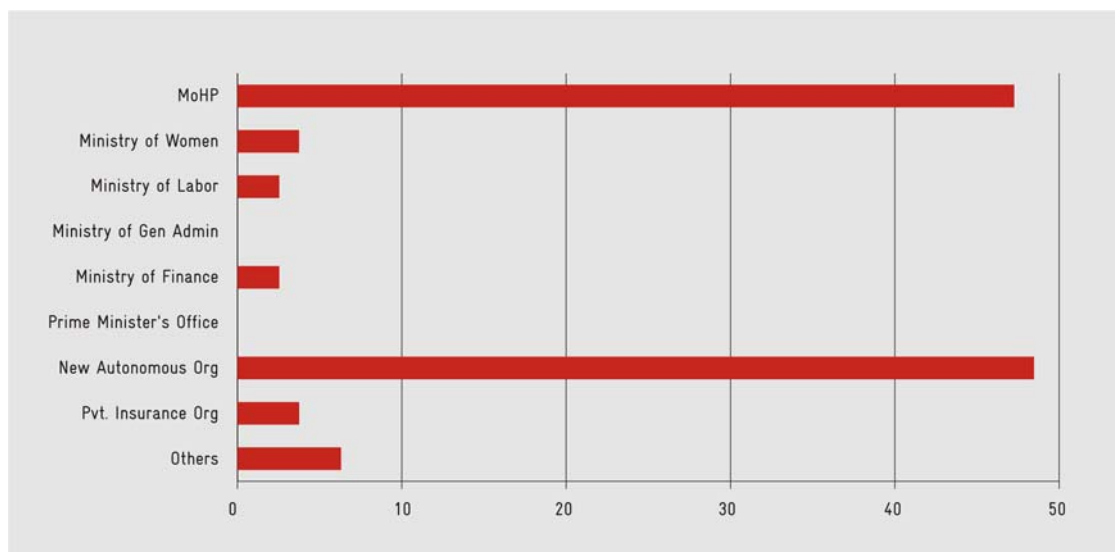
SHI may incur. It is believed that government contribution could be served as a motivation for the general public to enroll.

**Majority of opinion leaders preferred a health insurance that provides coverage for complex and expensive care.**

Figure 21. Distribution of Responses on which Services should be Provided by Government and Health Insurance



**Figure 22. Distribution of Responses on which Agency should be the Leading Agent in Health Insurance**



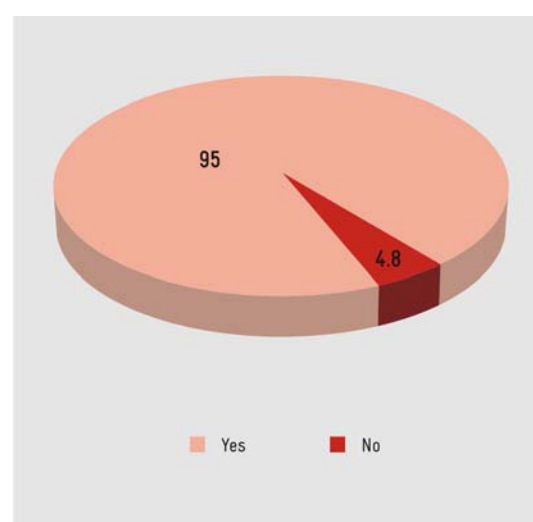
The opinion leaders thought that government should be responsible for the provision of services for Infectious diseases, disease prevention, healthy lifestyle, primary health care, maternal & child health and vaccination. They thought that more complex and expensive health care should be the responsibility of the health insurance. These include costly treatments, chronic diseases, life threatening diseases, accidents, secondary and tertiary care, diagnostics, day care (less than 5 hours hospitalized), outpatient care and drugs (Figure 21).

**Majority of opinion leaders preferred the MoHP or an autonomous organization to be the leading agent in a health insurance system that operates in a decentralized manner.**

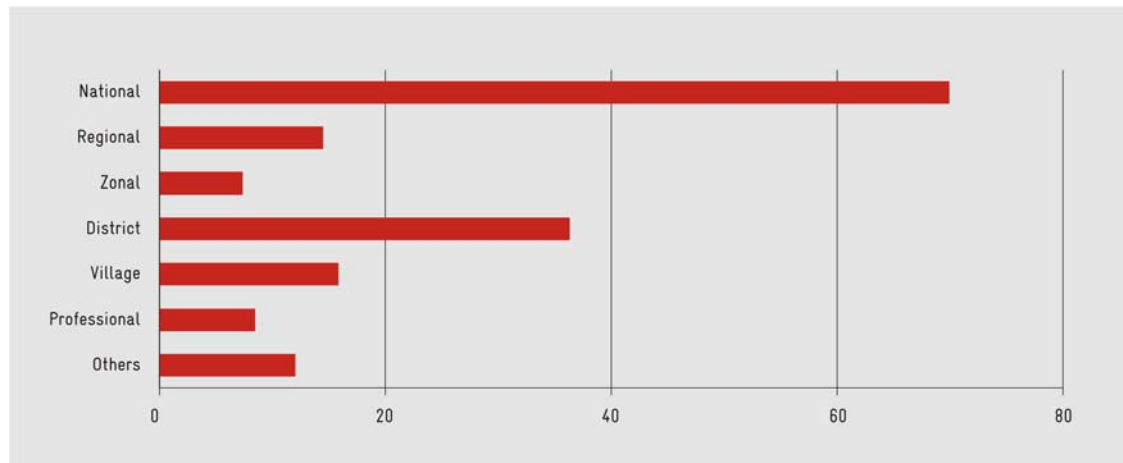
Forty seven percent of opinion leaders (39) would like to prefer the MoHP to be the leading agent in health insurance while 48 percent preferred a new autonomous organization to act on this (Figure 22). Those who preferred the MoHP argued that health insurance is very inter-related with health service provision, which is the responsibility of MoHP. Others preferred a new autonomous

organization because the existing government ministries do not have any experience on the complex tasks of health insurance. Others were of the view that the MoHP should be responsible for the formulation of policies and coordination at the central and sub-national levels. The new autonomous organization will

**Figure 23. Distribution of Responses on Whether or Not the People will Trust an Autonomous Body**



**Figure 24. Distribution of Responses on What Level should Health Insurance be Established**



be responsible for the management and implementation of the health insurance scheme. Majority (95% or 79) of the opinion leaders believed that a new autonomous organization will be accepted and trusted by the people (Figure 23).

Opinion leaders (70% or 58) preferred one organization at the national level (Figure 24) to provide policy directions that will be applied uniformly throughout the country and to coordinate the different stakeholders. One national organization is believed to be more efficient since it can reduce unnecessary administrative costs and can cover all population groups. However, the opinion leaders wanted the national organization to decentralize its operations and services for easier access of the insurance members.

A number of opinion leaders cited the Employees Provident Fund (EPF) as an existing system that provides an example of a way to

organize health insurance. The EPF provides social security benefits in case of retirement, termination of employment, disability and death to its members consisting of all employees in government and semi-governments institutions and employees of private establishments with ten or more staffs who voluntarily enroll its employees to EPF, which has about 425,000 members, out of which 76 percent members were public sector employees and rests were private sector employees. It intends to expand its social security benefits by increasing the coverage of private sector employees by 240,000 in the next five years and by covering the informal/self-employed sector in the next ten years. One of the measures to entice private sector membership and enhance social security benefits of its members is health insurance. It plans to work with MoHP on the design of the health insurance scheme.



# V Policy Issues

In summary, the opinion and stocktaking surveys raised the following issues that could be the subject of the advocacy on SHI.

## **1. Majority of the establishments provided health benefits but a bigger section of the population is not protected except by the FHCP**

The laws in Nepal provide free health care from the SHP to the district level and protection to select workers / employees in government and the private formal and informal sectors. However, a large section of the population is not covered by additional health benefits other than the FHCS. This includes those not in the labor force (retirees except for army and police), the unemployed, overseas workers and agricultural workers. Among the employed, these were the contractual, daily wage earners and non-permanent employees in government. In the private sector, medical expenses for injuries not related to the duties assigned by employers were not covered.

Majority of the establishments interviewed provided health benefits. A common issue raised by employees / workers was that their family members were not covered.

## **2. It is not clear if the people are benefiting from the FHCP**

The opinion leaders were divided in their views on whether or not people benefit from the free health care. While some opinion leaders

claimed that utilization of health services increased, others cited the inadequate awareness of the people, the accessibility, quality of health services and health governance issues as barriers.

## **3. It is not clear if the government has the capability to finance the FHCP that is supposed to provide protection to majority of the population**

Opinion leaders were divided on their views on whether or not government has the capability to finance health care. Government is seriously committed in the implementation of the FHCP. However, the opinion leaders were divided on whether or not government can mobilize the large amount of resources needed to improve the quality of health care services.

## **4. The ceiling of health care benefits provided by the employer or the insurance company is a concern raised by employees / workers**

Majority of the employees / workers and employers are satisfied with the health benefit schemes implemented by companies. However, some workers / employees raised the ceiling in the amount of the health care costs shouldered by the employer or the accident or health insurance as a concern. Employers were also concerned with their current level of social security cost, which was estimated by them at 23 percent (10% for provident fund, 8.33%



for gratuity fund and 4.67 percent for sick, maternity benefits). Employers and employees recognized that the health / medical benefits given by companies depended on the financial capacity of these establishments.

**5. The quality of health care services prevents people from benefiting from the FHCS. The same issue will affect the feasibility of SHI.**

The quality of health care is an issue believed to affect the effectiveness of the FHCP and will affect the feasibility of SHI. The willingness of people to enroll in a SHI scheme depends also on the availability and quality of health benefits.

**6. There were two opinions on who should be covered first by health insurance:**

There were two ideas proposed by the opinion leaders. One group believed that the employed who has the capacity to pay and who can easily be enrolled should be given priority in enrollment in the health insurance scheme. The other opinion leaders thought that the poor and the unemployed who were more in need of protection be prioritized. The poor cannot afford to pay the contribution on their own and are less easy to identify and enroll.

**7. Opinion leaders advocated for everyone to share in the health care costs but government should pay for the poor**

Opinion leaders believed that the national and local governments, the employers, employees / workers and the people should contribute for the premium of the SHI. The government should be responsible for paying the contribution for the poor.

**8. Some employees were dissatisfied with current practice of private health and accident insurance of requiring the patients to pay the health care bill first**

Satisfaction with health and accident insurance was high among employers and employees / workers. Among the reasons cited by those who were not satisfied is the practice of requiring patients to pay the bill first. Dissatisfaction with this system was further reinforced by the lengthy claims processing / re-payment period.

**9. There were two views on the leading agent for SHI: the MoHP or an autonomous organization.**

Some opinion leaders found the MoHP as the appropriate institution because of the link of health financing with service delivery and regulation. Because of the specialized skill required for a health insurance institution, some opinion leaders believed that it might be necessary to establish a new autonomous organization that will focus on health insurance.

## VI Conclusions

The GoN is seriously committed to the promotion and protection of the health of its people. The Interim constitution declared a policy of free EHCS at the HP, SHP and PHCC for all Nepali citizens, and FHCS at the DH level for the targeted group. Various laws on SHPr provide for the medical / health benefits for employees / workers in the government and private sectors. However, a large segment of the population is covered only by the FHCP. These sectors are those outside of the labor force, the unemployed, agricultural and overseas workers and the contractual, daily wage earners and non-permanent employees in government.

Most of the companies interviewed provided health / medical benefits to its workers. Employers provided one or a combination of medical allowance, health benefits related to illness in cash and/or in kind, accident and health insurance. There was a high level of satisfaction among employers and employees with the schemes. Health insurance has the highest percentage of employers and employees / workers that were satisfied. The level of financial protection, coverage of family members and speed of health insurance services were the issues cited by those who were satisfied as well as dissatisfied. Employers and employees / workers recognized that the level of health benefits that were provided by their respective establishment was a function of the financial capability of the employers. The employers expressed their openness to

reforms in the provision of SHPr, but they also expressed their difficulties in contributing over and above their current level of social protection, which was at 23 percent of salaries / wages.

The opinion leaders were divided in their opinion on the benefits of the FHCP and whether or not government has the capacity to entirely finance its implementation. Most opinion leaders believed that people should pay for their health care, but they also saw the need for government to protect those who do not have the capacity to pay for their health care needs. Social health insurance is believed to be a viable option to address the financing of the health care. Various options in designing the scheme were put forwarded. These options pertain to the segment of the population that should be prioritized for enrollment, the benefits that should be covered and organization that should implement SHI.

Another key issue that surfaced in the stock-taking and opinion survey was the quality of care. The present state of health services is believed to affect the benefits from the FHCP and will affect the effectiveness of SHI, if it will be implemented.

Based on the above findings, the following measures may be considered:

1. **Formulate a health financing strategy:** The strategy can identify the level of financial protection that the country wants to achieve and the financing mix and strategy that will

best achieve the set goals. This financing goals and strategy can be incorporated in the health sector goals, and can be a basis for the legal framework on SHPr.

2. **Integrating the FHCP in SHI:** In the event that the country would decide to implement a SHI, an option it may consider is to target at the onset universal coverage and provide benefits that people are entitled to under the FHCP as the minimum benefit package.
3. **Study carefully the possible effects of the health financing strategy and legal**

**framework on the behavior of health providers and people:** The financing strategy and the legal framework create an “incentive” for health providers and the people to behave in a particular manner. The possible effects on behavior of health provider and the people need to be studied carefully so that the resulting health outcomes confirm to the direction that the GoN intends to achieve. Effects of the financing strategy on the quality, access, equity and rational use of care are some areas that may be looked into.

# Bibliography

Badal R (2009). The Current Legal Framework on Health Care Financing and Social Health Protection, GTZ/GFA Consulting Group GmbH, Kathmandu, Nepal.

Foster M and Regmi R (2007). Review of the Nepal Health Sector Programme: A Background Document for the Mid-Term Review, Final Report, Kathmandu, Nepal.

Government of Nepal, MoHP (2007). Free Health Care Services Program Implementation Guideline, DoHS. Kathmandu, Nepal.

Government of Nepal, MoHP (2004). Nepal Health Sector Programme - Implementation Plan (NHSP-IP).

Hachette F (2009). Free Health Care Services in Nepal: Rapid Assessment of the Implementation and Per Patient Expenditure, GTZ/GFA Consulting Group GmbH, Kathmandu, Nepal.

Hohmann J, Weber A, Herzog C and Criel B (2001). “InfoSure Health Insurance Evaluation Methodology and Information System”, GTZ, Germany.

WHO Nepal. [www.who.int/nha/country/npl.pdf](http://www.who.int/nha/country/npl.pdf)







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