ADDRESSING CHALLENGES AND ENHANCING NEPAL'S HEALTH INSURANCE POLICY 2024

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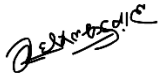
Preface

The Constitution of Nepal 2015 has promised the right to healthcare as a fundamental right. In attempts to fulfill the promise enshrined in our constitution, the Government of Nepal (GoN) has made voluminous efforts to progressively improve access to healthcare for all, enhance the quality of healthcare services in the country and promote health and well-being of its citizens. In pursuit of guaranteeing healthcare as a right, Nepal launched the National Health Insurance Program (NHIP) as a groundbreaking initiative in 2017 to achieve Universal Health Care (UHC) goals and prevent its citizens from falling into poverty while seeking health care and services.

Building on the achievements of NHIP, the GoN must continue to expand its scope and limits of affordable and accessible healthcare for today and the future. NHIP that stands as a crucial pillar in propagating the country's social security initiatives, particularly pertaining to the healthcare, has faced the challenges of lower enrollment nationwide and even lower among the urban population, higher drop-out rates, inadequate coverages, limited network providers, higher out-of-pocket expenses for policyholders, inefficient claims management processes and other implementation bottlenecks specific to our geographic, demographic and administrative function realities.

This report was produced as a supporting document to assist and adequately inform the Ministry of Health and Population (MoHP), Nepal in making key revisions to the scopes of existing NHIP and evaluate necessary amendments or considerations on acts, rules, regulations and policies to improve efficacy of the program and help achieve the holistic vision of safeguarding quality health care in the country. The report lays out the opportunities and shortcomings of the contemporary legislation governing Nepal's healthcare system, challenges in health insurance policies and management of resources, concerns over the duplication of services across different governmental health institutions and mechanisms to foster inter-agency collaboration, reform and oversight of the Health Insurance Board and presents its findings with recommendations and conclusions to support evidence-based policy formulation.

In developing the report, the role of Advocate Pramish Khanal who is serving as the Legal Advisor to Honorable Pradip Paudel, the Minister of Health and Population, GoN remained critical. I would also like to extend my heartfelt appreciation to Advocate Sadichchha Silwal, Mr. Shaksham Shahi, Ms. Ojashbi Ghimire, Mr. Saugat Subedi, Ms. Sabita Sigdel, Ms. Aastha Pokhrel and Mr. Subin Poudel for adeptly synthesizing the research, which I believe will play a momentous role in shaping Nepal's health policies in the days to come.



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List of Abbreviations

UHC	Universal Health Coverage
WHO	World Health Organization
OOPS	Out-of-Pocket Spending
PHCC	Primary Health Care Centre
SDGs	Sustainable Development Goals
HIB	Health Insurance Board
MoHP	Ministry of Health and Population
NHIS	National Health Insurance System
NHIP	National Health Insurance Program
LMICs	Lower Middle Income Countries
OOPE	Out-of-Pocket Expenses
NHI	National Health Insurance
CCS	Country Co-operation Strategy
SSF	Social Security Fund
ANC	Antenatal Care
PNC	Postnatal Care
CSH	Civil Service Hospital
MoGA	Ministry of General Administration

SBH	Shree Birendra Hospital
NAIHS	Nepal Army Institute of Health Sciences
NAMC	Nepal Army Medical Corps
EP	Emergency Purchase
DGMS	Directorate General of Medical Services
TUTH	Tribhuvan University Teaching Hospital
SGNHC	Sahid Gangalal National Health Centre
NHA	National Health Authority
SHA	State Health Authority
IRDIA	Insurance Regulatory and Development Authority
MHLW	Ministry of Health, Labour and Welfare
PM-JAY	Pradhan Mantri Jan Arogya Yojana
GFHI	Government-Funded Health Insurance
SECC	Socio Economic Caste Census
ISAs	Implementation Support Agencies
MAP	Medical Aid Program
CSMBS	Civil Servant Medical Benefit Scheme
UCS	Universal Coverage Scheme
SSS	Social Security Scheme
NHSO	National Health Security Office

SHI	Statutory Health Insurance
Morbi-RSA	Morbidity-based Risk-Adjustment Mechanism
EHI	Employer Based Health Insurance
ILO	International Labour Organization
MAAs	Mutual Aid Associations
JHIA	Japan Health Insurance Association
GSIS	Government Service Insurance System
DOH	Department Of Health
NBB	No Balance Billing

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Definitions

1. **Risk Transfer:** The fundamental principle of insurance is risk transfer. Individuals pay a premium to an insurance provider, which assumes the financial risk of healthcare costs. This arrangement protects individuals from the potentially catastrophic expenses of medical emergencies or chronic conditions. Instead of facing high out-of-pocket costs alone, individuals share these risks with others in the insurance pool.
2. **Copayments**: A copayment, or copay, is a fixed amount that an insured person is required to pay for specific healthcare services at the time of receiving care. This fee is often stipulated in the insurance policy and can vary based on the type of service.
3. **Deductibles**: A deductible is the amount that a policyholder must pay out-of-pocket for healthcare services before their insurance coverage kicks in. This amount is typically set annually, meaning that once a policyholder reaches this threshold, their insurance begins to cover a larger portion of costs.
4. **Premiums**: Premiums are the regular payments made to an insurance company to maintain coverage. These can be paid monthly, quarterly, or annually, and the amount can vary based on the coverage level and the individual's risk profile.
5. **Out-of-Pocket Maximum**: The out-of-pocket maximum is the total amount that a policyholder will pay for covered healthcare services in a given year. Once this limit is reached, the insurance provider covers 100% of the costs for the remainder of the policy year.
6. **Network Providers**: Health insurance plans often have a network of preferred providers, which includes doctors, hospitals, and specialists that have agreed to provide services at reduced rates.
7. **Exclusions and Limitations**: Insurance policies often include exclusions—specific services or conditions that are not covered by the plan. Limitations may also apply to certain treatments, services, or the duration of coverage.

Executive Summary

Nepal's health insurance system is a vital step toward reducing the financial risks of healthcare and ensuring equitable access to services. As a key component in achieving Universal Health Coverage (UHC), it has seen steady evolution, starting with small-scale initiatives in 1976 and culminating in the establishment of the National Health Insurance Program (NHIP) in 2016. Anchored by constitutional mandates and supported by the Health Insurance Act of 2017, the NHIP seeks to minimize out-of-pocket healthcare costs while enhancing service quality and accessibility. However, the system continues to grapple with significant challenges that hinder its ability to fulfill these goals.

Despite its foundational intent, the NHIP has struggled with low enrollment and renewal rates. As of the most recent figures, only 13% of Nepal's population actively uses the program. High out-of-pocket expenditures, which account for 51.3% of healthcare spending, persist as a major obstacle, reflecting gaps in the system's financial risk protection measures. Poor infrastructure, administrative inefficiencies, and regional disparities further exacerbate these issues, limiting the program's reach and effectiveness. Dissatisfaction among beneficiaries has also grown due to the lack of essential services and unclear communication about the program's benefits.

Another pressing issue is the duplication and fragmentation of health insurance schemes. Numerous government programs, including sector-specific schemes for police, military, and civil servants, operate independently of the NHIP. This fragmented approach wastes resources and undermines the goal of a cohesive, national policy. Furthermore, overlaps between NHIP provisions and services offered by health posts and district hospitals create inefficiencies and confusion for patients. Fraudulent claims, accounting for over 5% of total claims, add to the strain on limited resources, highlighting the need for stricter oversight and streamlined processes.

International comparisons offer valuable lessons for improving Nepal's health insurance system. India's PM-JAY, for instance, utilizes a blend of trust-based and insurance models, while South Korea's single-payer system effectively pools risks to cover its entire population. Thailand's tax-funded Universal Coverage Scheme demonstrates how equity can be achieved by eliminating user fees and ensuring access to even the most expensive treatments. Nepal could adopt similar strategies to strengthen its risk-pooling mechanisms and create a more sustainable financial

structure. The NHIP's benefit package includes essential services like emergency care and diagnostics but excludes critical areas such as dental treatments and advanced medical equipment. While subsidies are available for vulnerable groups, the program's flat-rate premiums and financial caps leave many families vulnerable to unexpected healthcare costs. In rural areas, the lack of infrastructure and trained personnel further compounds these challenges, creating barriers to equitable access.

Effective collaboration between federal, provincial, and local governments is crucial for the success of the NHIP. However, the dominance of the federal government often delays decision-making and fund allocation, undermining the autonomy of local bodies. Addressing this requires greater decentralization, improved coordination, and more equitable resource distribution. Integrating data systems and leveraging technology to detect fraudulent claims and optimize resource allocation are also critical for improving program efficiency.

Moving forward, key reforms are essential to strengthen the impact of the NHIP. Amending crucial legislation related to health insurance mechanisms and unifying fragmented schemes under a single framework could help optimize resource allocation and eliminate inefficiencies. The introduction of robust risk-pooling strategies and tailored premium models could ensure financial sustainability while making the program more inclusive. Investments in rural healthcare infrastructure and workforce development are equally vital to bridging service gaps. Drawing from global best practices, Nepal must strengthen the governance and operational capacity of the Health Insurance Board to ensure it can deliver on its promise of universal health coverage for all.

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Chapter I

Introduction to Health Insurance

Health insurance is a system designed to minimize the financial risks associated with health problems, especially the high costs that healthcare can impose on families. It functions as a comprehensive social safety net, ensuring that everyone has access to essential health services. This mechanism involves the proactive participation of individuals, communities, and the government.

Health insurance is an important pillar in realizing the idea of universal access to health or universal health coverage.[1] The World Health Organization (hereinafter 'WHO') defines Universal Health Coverage (UHC) as a condition where "*... [A]ll people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course*."[2]

Through health insurance, the financial burden of potential treatment costs is shared and managed in advance by regular contributions. This approach prevents individuals from being overwhelmed by unexpected, high medical expenses and optimizes the use of available resources by reducing unplanned personal spending on healthcare. By promoting the use of quality health services, health insurance also shields individuals from the financial risks caused by unforeseen health issues.

Genesis of Global Health Insurance

Health insurance began in Germany in 1883, with workers and employers contributing to a medical fund through Chancellor Otto von Bismarck's Health Insurance Act of 1883.[3] While initially limited to just blue-collar workers, the coverage gradually expanded with the final step toward

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[1] HEALTH INSURANCE BOARD (hereinafter 'HIB'), ANNUAL REPORT F.Y. 2074/75 (Sept. 26, 2024) https://hib.gov.np/public/uploads/shares/hib_nepal_annual_report_2075_complete.pdf

[2] WHO, UNIVERSAL HEALTH COVERAGE (Sept. 18, 2024) https://www.who.int/news-room/fact sheets/detail/universal-health-coverage-(uhc)

[3] The Commonwealth Fund, *International Health Care System Profiles: Germany* (Sept. 15, 2024) https://www.commonwealthfund.org/international-health-policy-center/countries/germany

universal health coverage occurring in 2007, when health insurance, either statutory or private, was mandated for all citizens and permanent residents.[4]

By the early 20th century, modern health insurance emerged, covering curative, preventive, and rehabilitative services. Britain introduced health insurance laws in 1911, followed by similar systems in Russia and other industrialized nations. After the Alma-Ata Conference in 1978,[5] the push for universal health access led to the implementation of various insurance programs across Latin America, Africa, and Asia. Today, countries like China and Brazil have over 80% of their populations under Universal Health Coverage.[6]

Health Insurance in Nepal

With a diverse population and varying healthcare needs, effective health insurance systems are essential to mitigate financial risks associated with medical expenses. At its core, health insurance serves as a mechanism for risk transfer, enabling individuals to protect themselves against the unpredictable and often high costs associated with medical care. By pooling resources, health insurance allows people to share financial risks, ultimately aiming to reduce the economic burden of healthcare on any single individual or family.

Health insurance has been considered as an important strategy for Nepal to obtain Universal Health Coverage (UHC). This contributory model aims to preserve residents' finances by lowering their out-of-pocket expenses and catastrophic medical costs, which might cause them to fall into poverty. Many initiatives have been made both domestically in Nepal and abroad to lower Out-of-Pocket Spending (OOPS). In 2033 B.S. (1976 AD), a few villages in the Lalitpur district of Nepal's Shanta Bhawan Hospital began to develop a health insurance program.[7] The BP Koirala Institute

[4] The Commonhealth Fund, *International Health Care System Profiles: Germany* (Sept. 15, 2024) https://www.commonwealthfund.org/international-health-policy-center/countries/germany

[5] WHO, *Declaration of Alma-Ata* (Sept. 12, 2024) https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata#:~:text=International%20conference%20on%20primary%20health,goal%20of%20Health%20for%20All.

[6] HEALTH INSURANCE BOARD (hereinafter 'HIB'), ANNUAL REPORT F.Y. 2074/75 (Sept. 15, 2024) https://hib.gov.np/public/uploads/shares/Annual_Report_Fy_2079_80.pdf

[7] GOVERNMENT OF NEPAL HEALTH INSURANCE BOARD, ANNUAL REPORT FACTSHEET AND EXECUTIVE SUMMARY (2022/23)

of Health Sciences carried out a similar program in 17 different localities throughout the districts of Morang and Sunsari in 2000. The government launched a free health care program in 2007 that covered 35 essential medications and all medical treatments up to the PHCC level. The financial strain of healthcare costs on families increased in spite of this initiative, which prompted the 2013 implementation of a Social Health Insurance Policy. The Social Health Insurance Program was introduced in 2016 following the formation of the Social Health Security Development Committee in 2015. Later, the program was included in the Health Insurance Board (HIB) in 2017 with the objectives of delivering high-quality healthcare services, shielding households from financial hardship, and boosting provider accountability.

Article 51(j) of Nepal's Constitution mandates the implementation of a Health Insurance Program to ensure all citizens have fair access to quality healthcare. Several laws and policies, such as the Health Insurance Act 2017, Public Health Service Act 2018, Health Insurance Regulations 2018, National Health Insurance Policy 2014, National Health Policy 2019, the 15th National Plan, the Sustainable Development Goals (SDGs), Nepal Health Sector Strategic Plan (2023–2030), and the National Health Financing Policy 2019, provide the framework for operating the health insurance system.

The NHIP is currently facing hurdles in essence of financial, regulatory, administrative and rigorous implementation of the scheme. Through the thorough review and assessment of the practices from country with best health insurance schemes like: South Korea, Japan, USA, India, Sri-Lanka, the HIB and MoHP should learn lessons and implement it in a robust manner paving a pathway towards the achievement of UHC and promulgating the essence of constitution and fundamental right to health guarenting swift, sufficient and quality health care to citizens. This document aims to assess and analyze the difficulties and legal obstacles faced by NHIS along with detailed analysis of current scenarios with comparative and analytical study of the opportunities and lessons from renowned practices around the world. The findings of the document are directed to assist the HIB, MoHP as well as research committee oriented towards expanding the notion of quality and efficient health care to all the citizens through the NHIS.

Contemporary Legislation Covering Health Insurance in Nepal

The fundamental right relating to health[8] enshrined under the constitution of Nepal 2015 is committed to the citizen's right to free basic health services from the state. The equal access to health-related services with special addresses to emergency situation paved the way for improving access to healthcare services in Nepal, reaching every single household[9]. The Nepalese government implemented social health insurance in April 2016[10] which substantially created a prerequisite of the legislation to govern the scheme paramount to the enactment of the Nepal Health Insurance Act 2017 and its regulation 2018.

The purpose of the Health Insurance Act of 2017 is to guarantee universal access to healthcare by reducing financial risks for those who are insured through pre-paid health insurance and by enhancing the effectiveness and responsibility of healthcare providers[11]. The act provides a detailed description of the services[12] provided under the scheme, co-payment slab[13], health insurance board[14] and its function, power and duties[15], grievance handling mechanism[16,] and punishment[17] for unaccompanied or delayed health services as prescribed by the act.

As a consequence of the power provided to the Government of Nepal[18], the Health Insurance Regulation 2018 serves as procedural legislation directing towards the plain sailing implementation of the Health Insurance Act. The regulation comprehends the number of individuals to be determined as a family[19], insurance incorporation mechanism[20], selection of

[8] CONST. OF NEPAL, 2015, Art. 35.
[9] Pratik Khanal, *Right to Health in Nepal: Commitment versus Challenges*, Vol 2; HEALTH FOR ALL December; 3, 5 (2014).
[10] Nepal / Health Insurance, https://openimis.org/nepal-health-insurance .
[11] Health Insurance Act, Preamble (2017).
[12] Health Insurance Act, § 5 (2017).
[13] Health Insurance Act § 7 (2017).
[14] Health Insurance Act § 13 (2017).
[15] Health Insurance Act § 15 (2017).
[16] Health Insurance Act § 31 & 33 (2017).
[17] Health Insurance Act §32 (2017).
[18] Health Insurance Act § 39 (2017).
[19] Health Insurance Regulation, rule 3 (2018).
[20] Health Insurance Regulation, rule 5 (2018).

service provider[21], renewal of the service[22], insurance premium[23], insurance coverage[24], relation between the service provider and health insurance board[25], claim settlement[26] and grievance handling mechanism[27].

Health Insurance Board

Nepal began its campaign for health insurance through social health insurance in 2016. The predecessor Social Health Security Development Committee was an autonomous body[28] functioning under the direction of MoHP. After the creation of the Health Insurance Board (HIB) in 2017 pursuant to the Health Insurance Act 2017, the board succeeded the development committee and was officially settled as a supervisory, regulatory, and distributive body for the national health insurance program. The Government of Nepal has implemented the Health Insurance Board (HIB) as a social protection program to allow its inhabitants to receive high-quality medical care without having to pay for it[29]. The objectives of the board are to enhance financial protection through pre-payment and risk pooling, equitably mobilize resources, and improve healthcare delivery in terms of effectiveness, efficiency, accountability, and quality of care. The health insurance board is formed pursuant to Section 13 of the Health Insurance Act 2017 with 6 members on board. The board is composed of a chairman followed by 4 members and 1 member secretary. The member secretary is the working director of the board.

The chairman is appointed by the government of Nepal followed by the Joint secretary of the MoHP, the Joint secretary of the Ministry of Finance, three individuals including two women nominated by the MoHP from among the people who hold a minimum of five years of experience in the concerned field, two individuals from among the insured including one women, and working

[21] Health Insurance Regulation, rule 7 (2018).
[22] Health Insurance Regulation, rule 8 (2018).
[23] Health Insurance Regulation, rule 15 (2018).
[24] Health Insurance Regulation, rule 17 (2018).
[25] Health Insurance Regulation, Chapter 5 (2018).
[26] Health Insurance Regulation, rule 21 (2018).
[27] Health Insurance Regulation, rule 28 & 29 (2018).
[28] Health Insurance Act § 14 (2017).
[29] Nepal Government Health Insurance Board, *About Section* (availbale at: https://hib.gov.np/en/)(accessed on 10th October, 2024)

director are appointed as members of the board. The board has its power, duties, and functions[30] to formulate health insurance-related policies, strategies, plans, and programs approve the budget and implement it, determine the level of service; prescribe the method and rate of payment for the provision of services, decide the management, protection and safe investment policy of the fund, to submit the Ministry for approval of the organizational structure and posts of the Board and to Monitor, regulate and evaluate the service provider's operations.

The board is also entitled to create a sub-committee[31] under the chairmanship of one of the members to delegate its functions in a smooth and efficient manner.

National Health Insurance Program (NHIP)

The National Health Insurance Program (NHIP) under the HIB, implemented nationwide, provides financial risk protection through health insurance to the Nepalese population. The design of the health insurance scheme follows a typical approach used by low- and middle-income countries transitioning away from user fees. The NHIP receives financial contributions from both the government and its insured members in the form of insurance premiums, which must be renewed annually. The current annual premium is NRs3,500 ($26.40) per family, with an additional NRs700 ($5.30) fee for each additional insured member beyond five family members. The government provides subsidies on the premiums for certain targeted groups: ultra-poor, senior citizens, severely disabled, leprosy patients, multidrug-resistant tuberculosis patients, and HIV/AIDS patient households receive a full subsidy. The Government of Nepal provides a 50% subsidy on premiums for female community health volunteers. Members of NHIP are entitled to free care at empaneled health facilities up to a maximum of NRs100,000 ($754) per family annually. Families with more than five members receive an additional benefit of NRs20,000 ($150.80) for each additional member, not exceeding a maximum benefit ceiling of NRs200,000 ($1,508.30) per family.

The NHIP is aligned with the global agenda for universal health coverage (UHC), as established in the Sustainable Development Goals (SDG) adopted by the United Nations. The NHIS has

[30] Health Insurance Act § 15 (2017).
[31] Health Insurance Act § 17 (2017).

significantly contributed to expanding health insurance coverage in Nepal. Although the country is still striving to achieve comprehensive coverage, the scheme has facilitated improved access to health care services for many individuals. Health insurance schemes in low- and middle-income countries (LMICs), like Nepal, have shown potential in reaching underserved populations, thereby helping to fulfill the objectives of UHC. For marginalized groups, such as older adults and individuals with chronic illnesses, the NHIP alleviates the financial burden associated with health care, enabling better access to essential services.

Problem in NHIP Implementation

Despite statutory assurances for population and cost coverage under Nepal's national health insurance scheme, both enrollment and renewal rates remain alarmingly low. NHIP implementation is not progressing as planned. NHIP enrollment increased more slowly than expected, with significant regional differences and a limited number of families continuing enrollment after one year. As of fiscal year 2079/80, only 24.7% (7,215,098) of the total population are enrolled in the insurance program, and only 13% (4,658,331) of total population are active users. [32] Within the active users 23.79% are new enrollee whereas 76.21% are renewed enrollee.[33]

At its core, insurance operates on essential components such as risk transfer, deductibles, and co-payments, which together form the foundation of insurance contracts. Effective risk transfer is a critical component of insurance contracts and plays a pivotal role in managing liabilities. As a risk management strategy, risk transfer entails shifting future hazards from one individual to another. Risk pooling on the other hand is a major cornerstone for effective implementation of a government oriented health insurance scheme which is vacant in the prevailing scheme. The risk pooling would allow the burden to be distributed among the enrolled, ensuring a path towards Universal Health Coverage. The NHIP currently lacks the provision for deductibles, risk transfer and risk-pooling which makes the scheme a burden for the government as well as individuals who are not in the adequate capacity to pursue the insurance service through the co-payment.

[32] HIB, *ANNUAL REPORT 2022/23: FACTSHEET AND EXECUTIVE SUMMARY* (2024) https://hib.gov.np/public/uploads/shares/Annual_Report_Fy_2079_80.pdf
[33] Id

The infrastructure and staffing issues, administrative obstacles such as complex paperwork and excessive power and jurisdiction to the board, elongated time period for insurance activation, limited understanding of services, improper legislation(s), unscientific premium and coverage, dissatisfaction of enrolled groups regarding the services alleviated, limited and insufficient coverage for catastrophic diseases, imbalanced coverage ratio in urban vs rural area i.e Urban areas have higher coverage rates than rural areas for both genders are the major problems in current NHIP.

Chapter II

Challenges in Nepal's Health Insurance Policy

1. Achieving Universal Health Coverage

Universal Health Coverage ensures that all people can use the health promotion, prevention, assistance, rehabilitation, and palliative care services that they need, in sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[34] The National Health Insurance Program came into existence to achieve universal health coverage in Nepal. The scheme was expanded to the entire country by 2023 however; the proportion of the population enrolled is still very low, hindering universal health coverage.

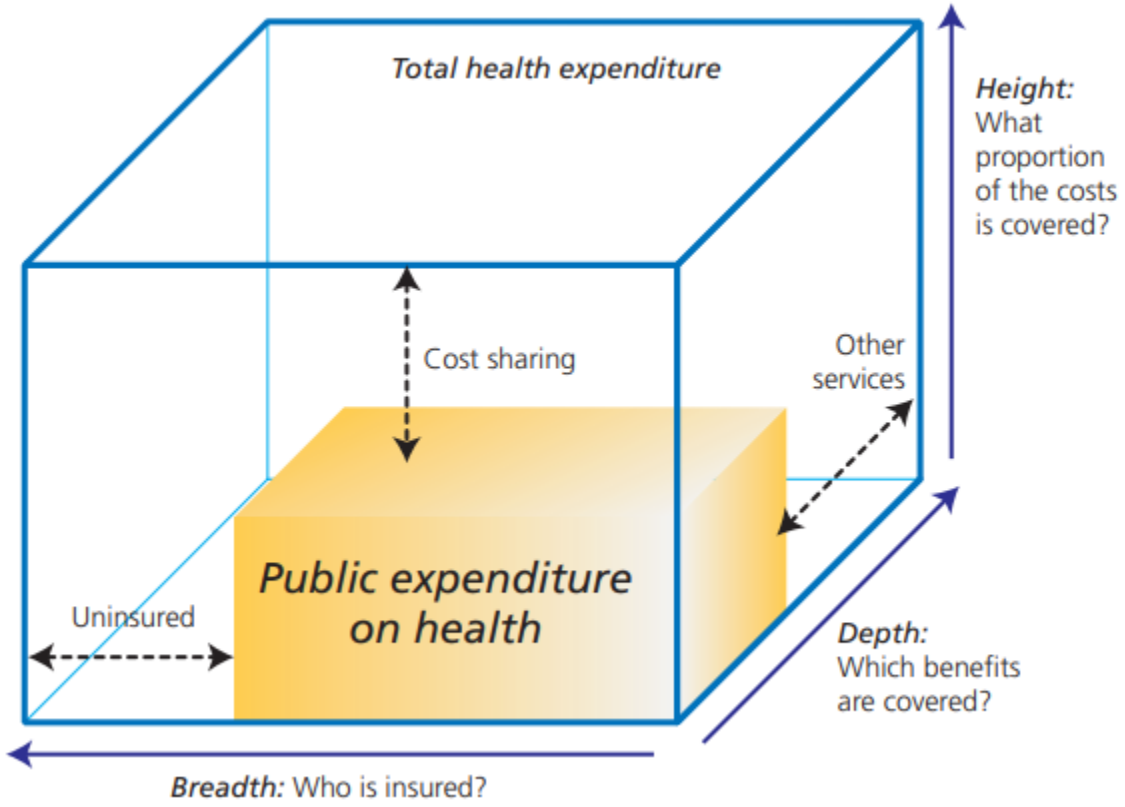

Fig 1: The three dimensions of Universal Health Coverage

Source: Universal Health Coverage

[34] World Health Organization, Health financing for universal health coverage, vol. 2016; 2016.

The UHC concept encompasses three dimensions: coverage for everyone (breadth), type and number of needed health services covered (depth) and the proportion of total health service costs that are publicly funded and not subject to cost sharing (height), also referred to as financial risk protection, and is best reflected in the UHC cube.[35]

1.1 Does the NHIP incorporate three dimensions of UHC?

Benefit Coverage

Nepal has detailed (positive) lists of all goods and services available within the National Health Insurance scheme which is explicitly published as a benefit package by HIB. Within the scheme, HIB has recently published a new updated benefit package in 2081. The NHIP's benefit package covers emergency services, outpatient consultations, inpatient services, selected medicines, and diagnostic services along with their rates.[36] Certain services considered unnecessary or too expensive are excluded, such as cosmetic surgery, secondary equipment or machines (such as artificial organs), prescription eyeglasses costing more than NRs500 ($3.80), hearing equipment, services related to artificial insemination, abortion services, dental services, and treatment for injuries resulting from fights or drug or alcohol consumption.

Population Coverage

The scheme is aimed to cover all the population of Nepal. The Health Insurance Act, 2074 mandates all Nepalese to be enrolled within the scheme. Its wording makes it compulsory for all the Nepalese to have health insurance. Moreover, the government provides subsidies on the premiums for certain targeted groups to ensure that such groups are not burdened with the premium of insurance and are included in the benefits of the program. Targeted groups like ultra-poor, senior citizens, severely disabled, leprosy patients, multidrug-resistant tuberculosis patients, and

[35]Juliane Winkelmann, Dimitra Panteli, Miriam Blümel and Reinhard Busse, *Universal Health Coverage and The Role of Evidence-Based Approaches in Benefit Basket Decisions*, EUROHEALTH SYSTEM AND POLICIES vol 2, No.1 (2018). https://iris.who.int/bitstream/handle/10665/332568/Eurohealth-24-2-34-37-eng.pdf?sequence=1

[36] HIB, *FINAL BENEFIT PACKAGES* (2081) . Available at https://hib.gov.np/public/uploads/shares/Final_Benefit_Package_2081_Aug08_2024.pdf

HIV/AIDS patient households receive a full subsidy in the premium.[37] Similarly, the government provides a 50% subsidy on premiums of female community health volunteers.

Cost Coverage

The cost coverage of the health services within the program are done through the government funds and funds collected as premiums from insured. The current annual premium is NRs. 3,500 ($26.40) per family, with an additional NRs700 ($5.30) fee for each additional insured member beyond five family members. Insured members are entitled to free care at empaneled health facilities up to a maximum of NRs100,000 ($754) per family annually. Families with more than five members receive an additional benefit of NRs20,000 ($150.80) for each additional member, not exceeding a maximum benefit ceiling of NRs200,000 ($1,508.30) per family.

However, the government recently has initiated a co-payment system within which insured have to pay 10% of the rate of service used except for those which have been declared free of cost by the government (basic health services). Similarly the rate of co-payment is 20% in case hospitals other than public. The co-payment is exempted for ultra-poor, senior citizens, severely disabled, leprosy patients, multidrug-resistant tuberculosis patients, HIV/AIDS patient households and female community health volunteers.[38]

1.2 Current Situation of NHIP in terms of achieving universal coverage.

Nepal's National Health Insurance Program (NHIP) aims to encompass the dimensions of Universal Health Coverage (UHC) by striving for broad population coverage, service depth, and financial protection. It mandates universal enrollment and provides subsidies for vulnerable groups to improve access. The program is implemented in 749 local-level governments of all 77 districts.[39] However, since the implementation of the program the population coverage of the insurance has not been as anticipated. As of fiscal year 2079/80, only 33.19% (2,212,814) of the total families

[37] Health Insurance Regulation, Rule 16 (2018).

[38] HIB, Procedure Implementing Co-payment System in National Health Insurance Program (2080). Available at: https://hib.gov.np/public/uploads/shares/CoPayment_Sambandhi_Karyabidhi_Updated_2080.pdf

[39] HIB, ANNUAL REPORT F.Y. 2074/75 (accessed Sept. 26, 2024). https://hib.gov.np/public/uploads/shares/Annual_Report_Fy_2079_80.pdf

and 24.7% (7,215,098) of the total population are enrolled in the insurance program.[40] Only a smaller proportion actively utilizes the program, with only 35% of enrolled families and 13% of the enrolled population being active users.[41] The situation is particularly concerning in Karnali Province, where active insurance users make up just 6%, with only 33 health facilities available in the province under the scheme, out of a total of 463 listed health providers across the country.[42]

The NHIP covers a range of essential services like emergency care, outpatient, and inpatient services, but excludes certain treatments such as cosmetic surgery and dental care, limiting service depth. Financial protection is offered through capped annual benefits, however, a co-payment system still leaves some families exposed to out-of-pocket expenses, particularly for private hospital services. The NHIP in Nepal provides a maximum benefit of $150.80 per person annually for families with more than five members, which is more than double the average per capita health expenditure of $65[43] in Nepal as of 2021. This higher coverage suggests the program aims to offer more substantial support than what is typically spent on healthcare per person in the country.
However, while $150.80 per person may adequately cover many basic or primary healthcare needs, it may fall short for more costly or complex health issues, such as surgeries, specialized treatments, or extended hospital stays, where out-of-pocket costs can be significant. Additionally, for families with fewer than five members, the per-person benefit may be lower if they do not reach the maximum coverage cap.

In sum, while NHIP coverage offers a valuable safety net, it may still be insufficient to fully protect families against high medical costs, particularly in cases of severe or prolonged health issues.

1.3 Possible reasons behind the program's failure to achieve universal coverage.

1.1.1. Low quality services provided in public facilities:

A significant factor behind this underutilization is the perceived poor quality of care in public healthcare facilities, which are often criticized for lacking essential medical supplies, equipment,

[40] HIB, *ANNUAL REPORT 2022/23: FACTSHEET AND EXECUTIVE SUMMARY* (2024).Annual_Report_Factsheet_Summary_English_2022_23.pdf

[41] HIB, *ANNUAL REPORT 2022/23: FACTSHEET AND EXECUTIVE SUMMARY* (2024)

[42] HIB, *ANNUAL REPORT 2022/23: FACTSHEET AND EXECUTIVE SUMMARY* (2024)

[43] World bank Group, Current Health Expenditure per Capita (current US dollar) (accessed on 30th Oct. 2024) https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=8S-NP

skilled health personnel, and services.[44] As a result, people regardless of their financial means frequently seek care from private providers, including basic health services (BHS),[45] even though the national insurance prioritizes the use of public facilities over private.[46]

1.1.2. High Out-of-Pocket Expenditure

The preference for private healthcare has led to a disproportionate reliance on out-of-pocket expenses (OOPE) as a primary means of financing health care. In 2021, Nepal's current health expenditure per person of $65 was significantly lower than the South Asia regional average of $206. Of this expenditure, out-of-pocket spending is 51.3%.[47] More than three quarters of total OOPE is used for pharmaceuticals and medical supplies. Healthcare costs at hospitals constitute 20.8% of total OOPE, and 80% of such spending occurs in private hospitals.[48] Such a high reliance on direct payments for health services contradicts the principle of financial risk protection, a core tenet of universal health coverage (UHC). Empirical data from the 2010 World Health Report highlights a strong correlation between high OOPE and financial catastrophes, as well as impoverishment. In countries where OOPE constitutes more than 15%–20% of total health expenditures, financial hardship is common.[49] This financial burden not only prevents people from accessing needed care but also exposes them to heightened health risks, often trapping them in cycles of poverty.

1.1.3. Duplication and fragmentation of health related schemes under other governmental initiations.

The existence of multiple, fragmented health insurance schemes in Nepal has posed significant challenges to achieving universal coverage under the National Health Insurance Program (NHIP). These schemes, such as Government Special Health Schemes, Sectoral Health Schemes, and

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[44] Ministry of Health Nepal, New ERA Nepal, Nepal Health Sector Support Program (NHSSP), ICF: Nepal Health Facility Survey 2015. Retrieved from https://dhsprogram.com/pubs/pdf/SPA24/SPA24.pdf.

[45] Geha. N Khanal et.al, *Evaluation of the National Health Insurance Program of Nepal: are political promises translated into actions?* HEALTH RESEARCH POLICY AND SYSTEMS 2023 JAN 20;21(1):7. https://doi.org/10.1186/s12961-022-00952-w

[46] Health Insurance Act, 2074

[47] ADB Technical assistance Report, Nepal: Strengthening Universal Health Coverage through Health Insurance (2024). Retrieved from https://www.adb.org/sites/default/files/project-documents/57204/57204-001-tar-en.pdf

[48] Geha. N Khanal et.al, *Evaluation of the National Health Insurance Program of Nepal: are political promises translated into actions?* HEALTH RESEARCH POLICY AND SYSTEMS 2023 JAN 20; 21(1):7.

[49] HIB, ANNUAL REPORT F.Y. 2074/75 (Sept. 26, 2024)

Organizational Health Schemes, often operate independently and provide health insurance benefits that are not aligned with the NHIP. This fragmentation of government resources leads to inefficiencies and duplication of services, as different sectors (like the army, police, and civil servants) have their own health insurance benefits.

This fragmentation dilutes government funding, spreading resources thin across various programs instead of consolidating efforts under a single, cohesive system. This undermines the NHIP's potential to pool risk and resources effectively, reducing its ability to provide equitable health coverage for all. Additionally, individuals covered under these separate schemes may be less incentivized to join the NHIP, further limiting its reach and reducing population enrollment. Without addressing these overlaps and harmonizing the schemes, achieving universal health coverage under a unified national policy remains a significant challenge.

1.4 Additional issues:

1.4.1 Effective Risk Pooling

Risk pooling is essential for sharing the financial burden of healthcare costs among a diverse group. However, in Nepal, effective risk pooling is challenged by:

1. Demographic Disparities: Different age groups and health statuses affect participation. Younger, healthier individuals may avoid insurance, leaving a higher proportion of older or sicker individuals in the pool, which drives up costs.
2. Geographical Disparities: Access to insurance and healthcare services varies significantly between urban and rural areas. Rural populations often have limited access, leading to underrepresentation in the risk pool and higher financial risks for those who are insured.

1.4.2 Individualized Risk Assessment

The lack of tailored risk assessments means that insurance products often fail to meet the specific needs of various demographic segments. Key issues include:

- Standardized Policies: Nepal's health insurance offer one-size-fits-all products, neglecting the unique health needs of different groups. This can result in mispricing and inadequate coverage for those who need it most.

- Ineffective Risk Evaluation: Without comprehensive data on health and demographics, insurers struggle to accurately assess risk, leading to pricing that does not reflect the actual healthcare needs of the population.

1.4.3 Data Integration Challenges

Effective data management is critical for monitoring health insurance performance. In Nepal, challenges include:

1. Fragmented Systems: Separate databases across healthcare providers and insurers create gaps in understanding overall health trends and service utilization that is the most essential part in determining premiums and coverages.
2. Limited Analytical Capacity: Insufficient resources and expertise hinder the ability to analyze data effectively, making it difficult to inform policy decisions and implement necessary reforms.

1.4.4 Unscientific Coverage Models

1. Fiscal Unsustainability: Flat-rate premiums do not accurately reflect the varying health risks among different groups, resulting in financial imbalances within the system.
2. Inadequate Coverage: These models often fail to provide sufficient funding for high-utilization groups, such as the elderly, leading to gaps in necessary services.
3. Adverse Selection: When insurance products do not reflect true risk profiles, healthier individuals may opt out, leaving a sicker population that drives up costs.

2. Ensuring Quality Healthcare Services

The National Health Insurance Policy (NHIP) in Nepal is designed to enhance healthcare access and provide financial protection for the population. However, its implementation faces significant challenges primarily due to inadequate infrastructure, staffing shortages, and systemic inefficiencies that undermine the quality of care. Reports highlight that insufficient budget allocations and poorly planned healthcare initiatives have compromised the NHIP's effectiveness, revealing a persistent pattern of prioritizing short-term political gains over sustainable healthcare

reform[50]. A critical component of health care quality is the availability of skilled human resources. Currently, Nepal falls short of the World Health Organization's recommendation of 45 health personnel (doctors, nurses, and midwives) per 10,000 people, with only 34 available in the country[51]. Moreover, there has been a notable decline in the proportion of frontline healthcare workers, particularly nurses and paramedics, whose representation in the workforce plummeted from 36% in 2015 to just 18% in 2021[52].

Although Nepal's 2015 constitution guaranteed basic health care as a fundamental right, access to high-quality care remains a privilege[53]. Issues such as inadequate or delayed reimbursements, bureaucratic inefficiencies, and insufficient budgets have led to a compromised quality of care for beneficiaries. High drop-out rates and a low interest in renewing premiums highlight the dissatisfaction among enrollees, further complicating the policy's success[54].The quality of health services might further be influenced by the supply-side factors such as providers' motivations and satisfaction,adequate infrastructure and resources, and timely reimbursement from insurance schemes[55]. The participants in assessment conducted by *Rajani Bharati* as a part of her doctoral thesis in CUNY has noted that the hindrances like: lack of quality medicines, hasty referral system, geographical imbalance, non availability of adequate transportation has lead the NHIP being a optional choice rather than a demanding one[56].

A number of operational and structural limitations make it difficult to guarantee high-quality healthcare services under Nepal's National Health Insurance (NHI) program. Although the goal of the policy is to increase access to healthcare, problems such a lack of qualified human resources,

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[50] Bipin Adhikari et.al, T*ransforming Nepal's primary health care delivery system in global health era: addressing historical and current implementation challenges* GLOBALIZATION AND HEALTH volume 18, Article number: 8 (2022)

[51] Sharada Prasad Wasti et.al, *Overcoming the challenges facing Nepal's health system during federalisation: an analysis of health system building blocks* HEALTH RESEARCH POLICY AND SYSTEMS volume 21, Article number: 117 (2023)

[52] *Id*.

[53] Anna Trägård & Ishwar Bahadur Shrestha, *System-wide effects of Global Fund investments in Nepal* Health Policy Plan (2008)

[54] Geha. N Khanal et.al, *Evaluation of the National Health Insurance Program of Nepal: are political promises translated into actions?* HEALTH RESEARCH POLICY AND SYSTEMS 2023 JAN 20;21(1):7.

[55] CL Ranabhat, R Subedi ,S Karn , *Status and determinants of enrollment and dropout of health insurance in Nepal: an explorative study. Cost Effectiveness and Resource Allocation*.;18(1):40. doi:10.1186/s12962-020-00227-7 (2020)

[56] Rajani Bharati, *National Health Insurance Program in Nepal: Early Experiences and Its Effect on Health Service Utilization* CUNY Academic Works (2021)

a lack of effective monitoring systems, and a restricted healthcare infrastructure make it difficult to provide high-quality care. Additionally, the issue is made worse by the differences in service accessibility between urban and rural locations, which underserved vulnerable communities. Stronger accountability structures, ongoing professional development, and improved resource allocation are necessary for the effective application of quality standards. The NHI policy runs the risk of failing to meet its objective of offering all residents access to high-quality, egalitarian healthcare if these issues are not resolved.

3. Fraudulent Claims in NHIP: Problems under Current Working Mechanism

One of the numerous instances of health integrity violations, health insurance fraud is a serious concern for both the insurance business and governments[57]. The motive to gain unauthorized access to insurance claim amounts drives the emergence of fraudulent claims at its peak. Substantial financial challenges especially in countries like Nepal pose a major threat as an upshot of fraudulent claims[58] because of its costly and pervasive nature imposing a substantial economic drain on the national health care system[59]. Service Providers tend to submit fraudulent claims through acts like invoicing for procedures, supplies, and/or services that were never performed; charging for more services than were really rendered; doing activities that were not essential in order to make money portraying as necessary medical care non-covered procedures lying about a patient's condition in order to support examinations, operations, or other treatments charging one procedure's steps individually as though they were several procedures charging a patient more than the maximum amount that the insurer has allowed for co-payment payment of "kickbacks" for referring victims of auto accidents to treatment[60].

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[57] WORLD BANK, CASE STUDY ON INSTITUTIONAL ARRANGEMENT FOR DETECTING FRAUD IN GOVERNMENT HEALTH INSURANCE PROGRAM ANTI-FRAUD EFFORTS IN GOVERNMENT-SPONSORED HEALTH INSURANCE SCHEMES IN FOUR INDIAN STATES (2018)

[58] National Health Care Anti- Fraud Association, *The challenge of Health Care Fund* (Retrieved from: https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/)

[59] NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, INVESTIGATING AND COMBATING HEALTH INSURANCE FRAUD (March 15, 2023)

[60] Shivani S. Waghade & Prof. Aarti M. Karandikar *A Comprehensive Study of Healthcare Fraud Detection based on Machine Learning* INTERNATIONAL JOURNAL OF APPLIED ENGINEERING RESEARCH Vol. 13, Number 6 pp. 4175; 4176 (2018)

3.1 Current Working Mechanism for detection of fraudulent claims in Nepal

The Health Insurance Board of Nepal has published procedural guidelines for Claim assessment and valuation in 2022. The procedural guidelines serve as a major foundation for disbursement of the claim to the service providers. The claim management department[61] is a special body created to function in the assessment of claims whether it is real or fraudulent and the department is also entitled to create a distinct claim investigation committee to render the reimbursement mechanism in a fair and efficient manner. The department is further assisted by a special committee[62] formed under Health Insurance Regulation 2018 which functions as a suggestion-oriented committee rather than a decision-oriented committee. Both the claim management department and the Insurance Claim Review and Evaluation Committee are responsible to HIB for their acts.

3.2 Problems under the current working mechanism

Inside the working mechanism of the National Health Insurance Program (NHIP), there is a manual claim review process to check the reimbursement of the claim amount. Approximately 20 staff are employed for the claim review section[63] whereas incoming claims are at least 25,000-30,000 on a daily basis which is excessive in comparison to the available resources[64]. The ratio of working staff for the claim review and assessment is desperately low which has direct and substantial effect on government and community-oriented hospitals[65]. Similarly, in the lack of any specific guidelines dedicated to countering fraudulent claims the manual mechanism has not been up to the mark. The latest available records of fraudulent claims under NHIP is NPR 714,856,536 (5.2% of the total claim amount)[66]. There is a slight decrease in fraudulent claims as compared to the previous years yet the amount seems high keeping intact the availability of funds and insured

[61] Claim assessment and valuation Procedure, rule 4 (2022)

[62] Insurance Claim Review and Evaluation Committee formed under rule 27 of the Health Insurance regulation (2018).

[63] Pusparaj Chaulagain *Poor quality, cumbersome process: Danger of neglect of health insurance program* (In Nepali) In: Onlinekhabar. Kathmandu, Nepal: Onlinekhabar 2022. https:// www. onlinekhabar. com/ 2022/ 04/1104207.

[64] *Id.*

[65] Rastriya Samachar Samiti (RSS) *Parvat Hospital did not receive health insurance funds* (Retrieved from:https://www.onlinekhabar.com/2024/09/1543633/parvat-hospital-did-not-receive-health-insurance-funds) (23rd September, 2024)

[66]HIB, *ANNUAL REPORT 2022/23: FACTSHEET AND EXECUTIVE SUMMARY* (2024). Available at: https://hib.gov.np/public/uploads/shares/Annual_Report_Factsheet_Summary_English_2022_23.pdf

individuals. The HIB not being able to cope up with technological advancements in accessing the fraudulent claim serves as a major hindrance in the working mechanism.

4. Three-Level Government Collaboration

The transition from a unitary to a federal health system in Nepal introduced new dynamics in health governance. A narrative synthesis of literature indicated that local governments must utilize the advantages of federalization to address existing challenges. For successful implementation, it is vital for local authorities to plan and execute health programs effectively, thereby fostering local ownership[67]. The study identified both opportunities and challenges, including improved health governance and coordination among tiers of government, as well as issues like poor coordination and delayed fund releases[68]. Effective coordination between governmental tiers and external development partners is essential to avoid fragmentation of efforts in health service delivery. Strategies should include enhancing collaboration between academic institutions, national training institutes, and WHO collaborating centers to bolster health service capabilities[69].

Despite the Constitution of 2015 aiming to decentralize authority to local levels, power imbalances persist. Local governments frequently depend on the federal government for resources and support, which complicates the intergovernmental relations necessary for effective health insurance implementation[70]. The interplay among local, provincial, and federal governments must be strengthened to realize the full potential of the health insurance scheme. This involves not only enhancing the capacity and autonomy of local governments but also ensuring that policies and resources are equitably distributed and effectively managed across all levels of governance. In alignment with the Country Cooperation Strategy (CCS) 2023–2027, the Collaborative

[67] Bipin Adhikari et.al, *Transforming Nepal's primary health care delivery system in global health era: addressing historical and current implementation challenges* , Globalization and Health, Vol.18 Article no.8 (2022)

[68] Sharada Prasad Wasti et.al, *Overcoming the challenges facing Nepal's health system during federalisation: an analysis of health system building blocks* HEALTH RESEARCH POLICY AND SYSTEMS volume 21, Article number: 117 (2023)

[69] Chhabi Lal Ranabhat et.al, *Status and determinants of enrollment and dropout of health insurance in Nepal: an explorative study* , BMC Article no.40 of the year (2020)

[70] Keshav K Acharya & John Scott, *A study of the capabilities and limitations of local governments in providing community services in Nepal* , Public Administration and Policy: An Asia-Pacific Journal (2022)

Framework emphasizes a high-quality technical assistance model for advancing universal health coverage (UHC) and supporting the implementation of national health policies. This involves enhancing the capacity of provincial and local governments to utilize evidence-based planning and execution, thereby improving the overall effectiveness and efficiency of the health system in the context of federalism[71].

Despite the intentions of the Collaborative Framework, significant challenges remain. A lack of clear command chains between different government tiers has led to overlapping training initiatives, indicating the necessity for improved coordination to optimize resource allocation[72]. Moreover, the prevailing dominance of the federal government in health system management has raised concerns that the system may not function as intended under the new constitutional framework. Strengthening intergovernmental coordination is vital for achieving a more accountable and responsive governance model in the health sector[73].

Thus, to address the current challenges faced by the health insurance scheme in Nepal, future efforts must focus on strengthening collaboration among the three tiers of government: federal, provincial, and local. Collaborative initiatives can enhance the roles of local governments, which are positioned closer to the community and thus better equipped to address local health needsThe 2015 Constitution of Nepal has established a framework for decentralized governance, promoting coordination among these levels to ensure efficient service delivery and meaningful public participation[74]. Collaborative initiatives can enhance the roles of local governments, which are positioned closer to the community and thus better equipped to address local health needs. The central committee or Health Insurance Board should be accessed as a regulatory and supervisory body, with creation of distinct sub-committees related to service providers, claim assessment, policy-making, data duplication under the supervision of the HIB and the branches of this committee(s) should be decentralized to each provinces to render effective implementation of the

[71] WHO Country Cooperation Strategy (CCS) *Country Cooperation Strategy 2023–2027: Nepal* (2023)

[72] Sharada Prasad Wasti et.al, *Overcoming the challenges facing Nepal's health system during federalisation: an analysis of health system building blocks* HEALTH RESEARCH POLICY AND SYSTEMS volume 21, Article number: 117 (2023)

[73] Id.

[74] Collaborative Framework for Strengthening Local Health Governance in Nepal Signed by MoHP and MoFALD (2013)

NHIP achieving UHC. Bringing provincial and local government into play can significantly boost the risk pooling mechanism promoting quality health service for all. The provincial government will also enhance and promote an effective people-state relationship which is the urgent need of federalism.

5. Duplication and Fragmentation of Government Health Insurance Policies

The Government of Nepal and its institutions have been offering various health insurance schemes to the citizens of Nepal through different initiatives and programs. These schemes, ranging from provisions in the national budget to sector-specific benefits for groups like the army, police, and civil servants, are largely funded by the government. However, these initiatives and programs have had both direct and indirect effects on achieving universal health coverage under the National Health Insurance Policy. Since these initiatives and programs provide health insurance benefits that are not aligned with the National Health Insurance Policy, government resources have been fragmented, and there is significant duplication of services. This duplication and fragmentation of government health insurance schemes can be categorized into the following three areas:

1) Government Special Health Schemes
2) Sectoral Health Schemes
3) Organizational Health Schemes

5.1 Government Special Health Schemes

These schemes are designed to provide healthcare support to citizens suffering from chronic diseases such as cancer, kidney ailments, and reproductive health issues. Every fiscal year budget is allocated by the government for these health related schemes.

Budget speech 2081/82

5.1.1 Federal budget speech[75]

- Allocation of Rs. 3 billion to subsidize treatment for poor citizens suffering from heart disease, cancer, kidney disease, Alzheimer's, Parkinson's, spinal injury, head injury, and sickle cell anemia. Each ailing person will receive 100 thousand for their treatment.

[75] GOVERNMENT OF NEPAL, MINSTRY OF FINANCE, BUDGET SPEECH OF FISCAL YEAR 2024/25 (2024)

- Allocation of Rs. 3 billion 60 million for Mother Protection and Maternal and Newborn Care Program.
- Allocation of Rs. 1 billion 430 million to provide 98 types of medicines, vaccines, and reproductive health materials free of charge from Basic Health Service Centers and Basic Hospitals.
- Provision to deposit into the bank accounts, being provided five thousand rupees per month per person for the treatment of cancer, spinal and paralysis, kidney transplantation, and dialysis services. For this purpose, Allocation of Rs. 2 billion.
- The health insurance program will be expanded to ensure access to health services for the general public. Duplication between health-related social security programs and health insurance will be eliminated. Allocation of Rs. 7 billion 500 million for the health insurance program.

5.1.2 Koshi Province Budget speech[76]

- NPR 11 million allocated for the free treatment of infertility for couples.
- NPR 42.9 million allocated for the free treatment of pregnant women and targeted children under the age of 10.
- NPR 22 million allocated for free health insurance for senior citizens, conflict victims, ambulance drivers, and female community health volunteers.
- Arrangements for a 90% subsidy on laboratory tests for individuals with HIV, cancer, thalassemia, hemophilia, sickle cell anemia, senior citizens, people with disabilities, marginalized communities, those living in extreme poverty, and conflict-affected citizens.
- NPR 54.6 million allocated to improve the quality of laboratory services.

5.1.3 Bagmati Province Budget[77]

- Free breast and cervical cancer screenings will be offered to the public.
- NPR 210 million has been allocated for the treatment of chronic diseases such as cancer and heart disease.

[76] KOSHI PROVINCE GOVERNMENT, MINISTRY OF ECONOMIC AFFAIRS & PLANNING, BUDGET SPEECH OF FISCAL YEAR 2081/82 (2081)

[77] BAGMATI PROVINCE GOVERNMENT, MINISTRY OF ECONOMIC AFFAIRS & PLANNING, BUDGET SPEECH OF FISCAL YEAR 2081/82 (2081)

- Free dental care and equipment will be made available to individuals aged 65 and above at provincial hospitals. Budget provisions will be made to ensure these services are accessible at hospitals in every province.

5.1.4 Gandaki Province Budget[78]

- Continuation of health insurance for targeted groups, while also providing free healthcare services to elderly citizens, financially disadvantaged individuals, and children.

5.1.5 Lumbini Province Budget[79]

- NPR 44.5 million allocated for free treatment of diabetes, blood pressure, and kidney conditions for citizens above the age of 40, along with anemia identification programs for teenage and young women under the "*My Health: My Responsibility*" initiative.
- NPR 55 million allocated for kidney transplants, heart valve surgeries, and cancer treatment.
- Continuation of free emergency service tickets at Lumbini and Rapti Provincial Hospitals.
- Necessary funds will be allocated for the screening and treatment of sickle cell anemia, thalassemia, and hemophilia.
- Arrangements will be made to provide free eye transplants

5.1.7 Sudur Paschim province Budget[80]

- NPR 35 million for the screening, diagnosis, and treatment of diseases such as sickle cell anemia, thalassemia, and hemophilia.
- Arrangements will be made for the treatment of single women, elderly citizens above the age of 70, and individuals with disabilities at Seti Provincial Hospital, Mahakali Provincial Hospital, and Tikapur Hospital.
- Health insurance coverage will be arranged for members of the Provincial Assembly.

[78] GANDAKI PROVINCE GOVERNMENT, MINISTRY OF ECONOMIC AFFAIRS & PLANNING, BUDGET SPEECH OF FISCAL YEAR 2081/82 (2081)

[79] LUMBINI PROVINCE GOVERNMENT, MINISTRY OF ECONOMIC AFFAIRS & PLANNING, BUDGET SPEECH OF FISCAL YEAR 2081/82 (2081)

[80] SUDUR PASCHIM PROVINCE GOVERNMENT, MINISTRY OF ECONOMIC AFFAIRS & PLANNING, BUDGET SPEECH OF FISCAL YEAR 2081/82 (2081)

5.2 Sectoral Health Insurance Schemes:

Health insurance schemes are established under specific legislation, including the Social Security Fund (SSF), and schemes for the Police, Army, and Civil Services.

5.2.1 Contribution-based Social Security Act, 2074

This law provides a comprehensive framework for social security, ensuring protection for employees and workers through a contribution-based system. It allows public and private employees, as well as self-employed individuals, to participate in social security schemes by contributing to a centralized Social Security Fund.

Social Security Fund and Schemes

The Social Security Fund pools contributions from both employers and employees to operate various social security schemes, as specified in the Act.

Operation of Social Security Schemes

The fund operates the following social security schemes:[81]

(a) Medical treatment and health protection scheme,

(b) Maternity protection scheme,

(c) Accident protection scheme,

(d) Disability protection scheme,

(e) Oldage protection scheme,

(f) Dependent family protection scheme,

(g) Unemployment assistance scheme,

(h) Any other social security scheme as specified by the fund.

Each social security scheme must have a separate account, and funds from one scheme cannot be used for another.[82] Employers are required to register themselves and their employees with the Social Security Fund. Employers must maintain accurate records of contributions and provide regular reports to the relevant authorities. Employers who fail to register employees, or who do

[81] Contribution-based Social Security Act, 2074, § 10.

[82] Contribution-based Social Security Act, 2074, § 12.

not make timely contributions to the fund, are subject to penalties under the Act. Similarly, the Act provides penalties for any fraudulent claims or misuse of the Social Security Fund.

The Contribution-based Social Security Act, 2074 specifies certain actions that are considered offenses under the law. These include embezzling funds meant for the Social Security Fund, submitting false or misleading information to claim benefits, receiving more benefits than entitled, or committing any irregularity in social security-related programs. If the embezzled amount is known, the penalty will match the amount stolen. If the amount is unknown, the penalty may be up to NPR 100,000, up to one year of imprisonment, or both. Those who assist or encourage these offenses will face half the punishment imposed on the main offender.[83]

5.2.2 The Social Security Act, 2075 (2018)

The Act is meant to protect vulnerable groups in Nepal, like the elderly, disabled, poor, and those who can't take care of themselves, by giving them financial support.

It provides allowances to help them meet their basic needs. However, it doesn't directly deal with health insurance, which is a big part of taking care of these groups' well-being.

Section 13- Not to get double social security: (1) In cases where any citizen is entitled to more than one kind of social security allowances under Section 3 of this Act, he or she shall get only one social security allowance chosen by him or her.

(2) In cases where any citizen is entitled to the same kind of facility pursuant to this Act and the prevailing law, he or she may get only one of the facilities chosen by him or her.

5.2.3 Labour Act 2074 (2017)

Section 54. Medical insurance to be made: (1) The employer shall procure make an annual medical insurance of at least one hundred thousand rupees for each labor.

(2) The premium required for the medical insurance referred to in sub-section (1) shall be borne by both the employer and the labor on a pro-rata basis.

[83] Contribution-based Social Security Act, 2074, § 47.

5.2.4 Safe Motherhood and Reproductive Health Rights Act 2018

The Safe Motherhood and Reproductive Health Rights Act, of 2018 mandates that the Government of Nepal allocate grant funds in its annual budget for motherhood and reproductive health services to each Local Government.[84] Similarly, the Provincial Government is required to allocate a portion of its budget each year, following provincial laws, as grants for these services to each Local Government.[85] The allocated funds must be used as prescribed, with a focus on providing services to economically disadvantaged women. Additionally, each Local Government must allocate an adequate budget for these services in its annual financial plan, ensuring that government or community health institutions delivering these services receive sufficient resources to operate effectively. Government health institutions and those receiving government grants must offer reproductive health services free of charge, while private, non-government, and community health institutions may charge fees as prescribed by law.[86] However, these institutions are required to make their services affordable and provide free services (quota) to individuals unable to pay the fees. Furthermore, the Government of Nepal will provide maternity allowances to destitute women who give birth, following the guidelines established by law, to support their well-being.[87]

5.2.5 Safe Motherhood Programme under the Ministry of Health and Population[88]

The Safe Motherhood Programme aims to reduce maternal and neonatal morbidity and mortality while enhancing maternal and neonatal health through preventive, promotive, and curative services. The program focuses on addressing avoidable factors that cause complications during pregnancy, childbirth, and postpartum periods. It is designed to ensure safe and accessible healthcare for women and newborns across Nepal, aligning with the goals of universal health coverage and social protection. Some major highlights include:

1. Birth Preparedness Package and MNH Activities at the Community Level
    a. Birth preparedness and complication readiness (e.g., arranging money, selecting healthcare facilities, arranging transportation, and blood donors).

[84] Safe Motherhood and Reproductive Health Rights Act 2018, § 22.
[85] Safe Motherhood and Reproductive Health Rights Act 2018, § 23.
[86] Safe Motherhood and Reproductive Health Rights Act 2018, § 32.
[87] Safe Motherhood and Reproductive Health Rights Act 2018, § 33.
[88] Government of Nepal, Ministry of Health and Population, *Safe Motherhood Programme* https://mohp.gov.np/program/safe-motherhood-programme/en (accessed on: 20th October, 2024)

b. Provision of key Antenatal Care (ANC) and Postnatal Care (PNC) services, including Iron, Td, Albendazole, and self-care guidance (nutrition, rest, avoiding smoking/alcohol).
c. Essential newborn care and prompt identification of danger signs during pregnancy, childbirth, postpartum, and the newborn period.

2. Rural Ultrasound Programme
   a. Ensures access to ultrasound services for early identification of pregnancy complications, especially in rural areas.

3. Aama and Newborn Programme
   a. Transport Incentive for Institutional Delivery:
      - NPR 1,500 for mountain districts
      - NPR 1,000 for hill districts
      - NPR 500 for Terai districts
   b. Incentive for 4 ANC Visits: NPR 400 upon completion of ANC visits in the 4th, 6th, 8th, and 9th months of pregnancy.
   c. Free Institutional Delivery Services:
      - NPR 1,000 for health facilities with less than 25 beds for normal deliveries
      - NPR 1,500 for facilities with 25 or more beds
      - NPR 3,000 for complicated deliveries and NPR 7,000 for C-sections
   d. Health Worker Incentives: NPR 300 per delivery (normal, complicated, or C-section)
   e. Free Sick Newborn Care: Care packages ranging from NPR 0 to NPR 8,000 depending on the level of care (A+B+C).
   f. Health Worker Incentives for Newborn Care: NPR 300 for each newborn care package provided.

4. Reproductive Health Morbidity Prevention and Management Programme
5. Pelvic Organ Prolapse Management Programme
6. Cervical Cancer Screening and Prevention Training
7. Obstetric Fistula Management Programme
8. Emergency Referral Fund
9. Nyano Jhola Programme: Distribution of warm clothing to newborns to reduce hypothermia risks.

A. *Eligibility Criteria*

- Services and incentives are available to all Nepali citizens, especially pregnant mothers and newborns.
- To access the services, beneficiaries must present a valid Nepali citizenship certificate.

B. Service Availability

- Available at all public health facilities with birthing services.
- Free sick newborn care is offered in major hospitals, with plans for a nationwide rollout.

Record Keeping and Monitoring

- All services provided under the Safe Motherhood Programme must be documented and reported by healthcare facilities. Health facilities must maintain accurate records of service delivery and incentive payments.
- A monitoring committee is recommended to evaluate the program's progress and ensure effective implementation.

C. *Penalties for Non-Compliance*

- Healthcare providers and institutions that fail to comply with program guidelines, misuse resources, or engage in fraudulent claims will face penalties under the Social Security framework.

5.2.6 Civil Service Hospital

The Civil Service Hospital (CSH) is an autonomous government institution under the Ministry of General Administration (MoGA), established with the primary objective of providing high-quality, modern, and affordable healthcare services to both current and former civil service employees and their immediate family members. The hospital is responsible for delivering comprehensive medical care to all civil servants and their dependents, as well as to the general public across the country.

Eligible civil servants may extend healthcare benefits to a maximum of six family members, including parents, spouses, and two children under the age of 21. These family members are entitled to a discount on medical services—40% for gazetted employees and 50% for non-gazetted and retired employees. To utilize this discount facility, a discount card can be obtained for Rs. 10. The card must be presented along with photos attested by the head of the office. Additionally, the

personnel code (Shanket) number must be registered with the Nijamati Kitabkhana for proper record-keeping.

5.2.7 Nepal Police Hospital

Nepal Police Hospital was inaugurated on Chaitra 27, 2040 BS, by the late King Birendra Bir Bikram Shah Dev. It was established with the purpose of providing free healthcare services to in-service police personnel, their families, and ex-servicemen and their spouses.[89] Since its inception, the Government of Nepal has covered all hospital-related expenses, including infrastructure development, upgrading human resources, and procuring equipment. However, the routine annual budget allocated by the government has proven insufficient to meet the growing healthcare needs of police personnel. To address this gap, the Prahari Kalyan Kosh (Police Welfare Fund) of Nepal Police has set up a trust to provide healthcare services to the families of serving policemen, ex-servicemen, and their spouses. The police hospital also providing health services via its province hospital as well.

Eligibility for Healthcare Services:

- Police personnel
- Dependents of police personnel (parents, children, spouse)
- Ex-police personnel and their dependents (parents, children under 21 years, spouse)
- Individuals in police custody
- Individuals under police investigation (e.g., for drug trafficking)
- Civilians (with reasonable service costs)

Inpatient Facilities:

- Bed and clothing management during hospital stay
- 24-hour medical services provided by doctors and nurses
- Guest house facilities for visitors of patients
- Free meals
- Access to all available investigations within the hospital

[89] नेपाल प्रहरी अस्पताल, अस्पताल दर्पण, ३९ औँ बार्षीकोत्सव विशेष प्रकाशन (२०७९) nepal-police_hospital_darpan2079.pdf (nepalpolice.gov.np)

- Ambulance services for referral patients

(Note: Public patients are entitled to services at a reasonable cost.)

Facilities for Ex-police and Police Families (including dependents up to 21 years old):

- Free medication services within the hospital's available resources
- Free meal provision
- Guest house for patient visitors
- Nominal charges for investigations within the hospital
- 24-hour inpatient care provided by doctors and nurses

Services Not Covered for Ex-police and Police Families:

- Medicines not available within the hospital must be purchased externally
- Items required for surgical interventions
- Investigations unavailable in the hospital
- Costs incurred at external hospitals

(Note: Free pharmacy services for ex-police dependents, including parents and children under 21 years, are not applicable.)

5.2.8 Army Hospital

Shree Birendra Hospital (SBH) is the main hospital of the Nepali Army, serving active and retired Army personnel, civilian staff of the Nepal Army Institute of Health Sciences (NAIHS), and their families. With 635 beds, it provides a wide range of medical services. While it originally catered only to Army personnel and their dependents, since 2017 it has also offered outpatient services to civilians. SBH provides free medical services in remote areas during both regular times and disasters. It operates under the Nepal Army Medical Corps (NAMC) and the Director-General of Medical Services at Nepal Army Headquarters.

Eligibility for Healthcare Services:

- Serving active Army personnel
- Serving active Army personnel Dependents
- Retired Army personnel

- Retired Army personnel Dependents
- Civilian staff of the Nepal Army Institute of Health Sciences (NAIHS), and their dependents.
- Civilian population during Accident and Mass Casualty following EarthQuake, Landslides, Floods & Air crash etc.
- Outpatient services to civilians.

Services Provided

- OPD cares to Regular soldiers, ex-servicemen and their families.
- Emergency care facility to Regular soldiers, ex-servicemen and their family.
- Bed and clothing management during hospital stay
- Free meals
- 24-hour medical services provided by doctors and nurses
- Guest house facilities for visitors of patients.
- Free ambulance services.
- Free laboratory services.
- Separate Department of Paediatrics for health care and welfare of the children of Nepali Army personnel (both serving and retired).- under 14 yrs.
- Provides Emergency Purchase (EP) medicines to the beneficiaries.
- Sends EP bills to DGMS for cross-checking.
- Reimburse the medical checkup cost from 18 hospitals in case of not treatable at SBH.

5.3 Organizational Health Schemes:

Health schemes offered by government-owned hospitals, such as Teaching Hospital and Ganga Lal Hospital, which provide medical benefits for their staff in accordance with institutional policies.

5.3.1 Tribhuvan University Teaching Hospital (TUTH)

The history of Tribhuvan University Teaching Hospital (TUTH) began with the visit of the late King Birendra Bir Bikram Shah to Japan in 1978. During this visit, an exchange of notes was

signed on September 15, 1981, between the government of Nepal and the Government of Japan. This laid the foundation for the establishment of TUTH.

5.3.2 Sahid GangaLal National Heart Centre

Shahid Gangalal National Heart Centre is providing specialist care in the field of cardiology and cardiac surgery. SGNHC is a full-fledged hospital that deals with a wide spectrum of cardiac cases.

Shaheed Gangalal National Heart Center Staff Service Conditions and Facilities Regulations, 2058 Shaheed Gangalal National Heart Center Staff Service Conditions and Facilities Regulations, 2058[90]

9.9 Medical Expenses:

(1) If an employee or their family member falls ill, the center will contribute annually to a medical expenses fund. This contribution will be equivalent to two months of the permanent employee's salary.

(2) The center will cover medical expenses from the fund up to the individual's available limit. The following costs will be covered:
   a. Fees for treatment as recommended by an authorized doctor and the cost of purchasing medicines as per the prescribed prescription.
   b. Costs incurred during admission to a health institution and for treatment received.
   c. Surgical costs, excluding cosmetic surgeries.
   d. If treatment requires travel to another district or abroad, the center will cover transportation expenses for the employee. If a caregiver is required, the caregiver's full transportation expenses will also be covered, along with 50% of the employee's daily allowance for the caregiver's food expenses.

(3) An employee may request an advance from the medical expense fund under this regulation, provided they clearly state the reason for the request. The advance should not exceed the total amount the employee is entitled to, and a detailed account must be submitted later for proper reconciliation in accordance with the regulation.

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[90] शहीद गंगालाल राष्ट्रिय हृदय केन्द्र कर्मचारीहरुको सेवाका शर्त र सुविधा सम्बन्द्धी नियमावली , २०५८ (available at: https://www.sgnhc.org.np/files/1717390096%E0%A4%A8%E0%A4%BF%E0%A4%AF%E0%A4%AE%E%A4%BE%E0%A4%B5%E0%A4%B2%E0%A5%80.pdf)

(4) If an employee provides false information to claim or receive medical expenses under this regulation, both the employee and the approving authorized doctor (if the doctor is also an employee) will face departmental action.

(5) If an employee is dismissed from service, except in cases where they are deemed unfit for future service, they will still be entitled to any remaining medical expenses owed to them during their period of service.

(9) The official must keep a detailed record of the employee's treatment expenses in the required format.

(10) In addition to the medical expenses provided under this regulation, if any family member of the employee, such as their parents or grandparents, suffers from a heart-related illness, the center will provide medical benefits as per its charity-related guidelines.

6. Duplication of services across different governmental health institutions

The Constitution of Nepal states that basic health care is a fundamental right of its citizens. The state is responsible for ensuring that all citizens have access to quality health services.

In Nepal's healthcare system, health posts serve as the primary contact point for essential health services. National Health Policy 1991 established health posts in all areas and sub-health posts in all village development committees.

Beyond providing basic care, they play a key role in overseeing the work of Female Community Health Volunteers (FCHVs) and act as centers for community-based programs, including outreach clinics, immunization clinics, and community health units. Currently, there are 3,778 health posts operating nationwide.[91]

Services Provided in Health Posts:

- Health posts in Nepal provide essential care for common illnesses like fever, cough, diarrhea, and minor injuries.
- They also educate communities on healthy practices, disease prevention, hygiene, and nutrition.
- Vaccination campaigns for polio, measles, and other preventable diseases.

[91] https://hmis.gov.np/wp-content/uploads/2023/11/Final-PDF-261123-fro-Web-1.pdf

- For minor emergencies, health posts offer first aid and refer serious cases to larger hospitals.
- Basic services are available as well, like blood pressure monitoring, helping people get timely and accurate care.
- Birthing Centre is also present in health posts.

In Nepal, a list of 98 types of medicines is provided for free at Basic Health Service Centers/Health Posts, Primary Hospitals, and Primary Healthcare Centers[92]. Among these, 57 types are available specifically at Basic Health Service Centers/Health Posts.[93]

The government of Nepal provided free health services to senior citizens aged above 60 years who cannot afford treatment and free health insurance to adults above the age of 70 years.

6.1 Duplication of Services

In Nepal, the interplay between services provided by health posts and those outlined in the Health Insurance Act and its accompanying regulations raises concerns regarding the duplication of health services. This duplication can lead to inefficiencies and confusion among patients seeking care.

6.1.1 Services Provided by Health Posts

Health posts serve as the first point of contact for health services in rural areas. They provide essential medical care, including:

- General Medical Care: Health posts address common illnesses such as fever, cold, cough, diarrhea, and minor injuries. Health Education: They conduct awareness programs focused on disease prevention, hygiene, and nutrition.
- Emergency Care: Health posts offer initial treatment for minor emergencies and stabilize patients before referring them to higher-level facilities.
- Basic Laboratory Services: Essential tests and screenings, such as blood pressure measurements are conducted at health posts.

[92] Public Health Update, List of Essential Medicines for Basic Health Services in Nepal, (accessed 11th Nov. 2024) https://publichealthupdate.com/list-of-free-essential-drugs-for-health-institutions-nepal/
[93] Id.

Given that health posts provide a variety of basic services and medications, including 57 types of medicines for free, there is a significant overlap with the services included in the Health Insurance Act and Regulation.

6.1.2 Services provided by District Government Hospitals

A. Basic health services

- Immunization, family planning, ante-natal care, normal delivery, new-born care, nutrition counseling, Treatment of TB and other common communicable diseases and conditions, management of epidemic, basic mental health service, counseling, screening and primary treatment of non-communicable diseases, medicine distribution, pathology lab and other diagnostic services, promotion and prevention of eye/sight and dental problems; and other diagnostic, curative, promotive, and preventive basic health services defined by the federal Ministry of Health.
- Social Service Unit *Social Service Units (SSUs) are institutional structures in select public-sector hospitals in Nepal that manage the provision of free and subsidized health care services to vulnerable populations.

B. Medical services

- Outpatient Service: General Medicine, Gynecology and Obstetrics, Pediatric and Orthopedic Services
- 24-hour emergency service; Treatment for eye/sight and dental Problems; Comprehensive emergency obstetric and neonatal care (CEONC), as well as specialized and major surgery services, including orthopedic surgeries.

6.1.3 Services provided by the Provincial Government Hospital

The Secondary Hospitals will provide services to the referred cases from Primary and other lower-level health institutions and the services will include the following:

A. Public health services:

- Immunization, family planning, ante-natal care, normal delivery, new-born care, nutrition counseling, Treatment of TB and other common communicable diseases and conditions, management of epidemic, basic mental health service, counseling, screening and primary treatment of non-communicable diseases, medicine distribution, pathology lab and other

diagnostic services, promotion and prevention of eye/sight and dental problems; and other diagnostic, curative, promotive, and preventive basic health services defined by the federal Ministry of Health.

- Social Service Unit

B. Medical services:

- General physician services, General Surgery Services, Gynecological and Obstetric Services, Pediatric Services, Dental services, Orthopedic services, Ophthalmological services, Departments and wards: Urology, dermatology, gyne/obs., orthopedics, pediatric, psychiatric, ear, nose and throat (ENT).

C. Emergency services:

- 24-hour emergency with surgery services;

D. Promotion and preventive services Surgical services:

- Simple surgeries, gynecological or obstetric Surgeries, ENT and orthopedic Surgeries.

Others: Hemodialysis, intensive care unit, neonatal intensive care unit.

6.1.4 Health Insurance Act

The Health Insurance Act 2074 encompasses a broad range of services aimed at ensuring comprehensive health coverage for citizens, particularly vulnerable populations. The services include:

- Preventive Services: These encompass consultations, health education, family planning, maternal and child health, and nutrition-related care.
- Diagnostic and Treatment Services: These include physical examinations, minor surgeries, and rehabilitation services for general illnesses.
- Inpatient and Outpatient Care: Coverage for both types of care allows patients to receive necessary treatments at various levels of health facilities.
- Emergency Services: Patients can access emergency care and treatment for disabilities and chronic illnesses.

6.1.5 Duplication Concerns

The overlap between services offered by health posts and those covered under the Health Insurance Act raises important questions. For instance, both health posts and the insurance scheme provide preventive services and emergency care. This duplication can create confusion among patients, particularly in rural areas where health posts are the primary source of care.

Additionally, the Health Insurance Regulation 2075 outlines specific ambulance services and transportation support for low-income individuals and those with severe disabilities. This provision may duplicate existing transportation services offered by health posts, further complicating the patient experience.

The duplication of the services results in contradiction with section 5(1) & (2) of the Health Insurance Act which clearly indicates that primary health care services will be available even without insurance but is unclear on whether the insured amount will get deducted in the context of insured individuals or not. The same goes with other segregated health insurance schemes formulated by the government.

Chapter III

Oversight and Institutional Structure

1. Health Insurance Board vs. National Insurance Authority

Health insurance board and national insurance authority are two distinct and autonomous bodies created under different legislation to oversee, supervise and regulate the insurance related activities. The national insurance authority is established pursuant to the section 3 of the Insurance Act 2079 while health insurance board is a special regulatory body confined to oversee the national health insurance scheme.

1.1 Practice related to the supervisory unit in different Nations

India

India comprises similar health insurance practices as in Nepal. There exists a government mandated special health insurance scheme in addition to the private and individual oriented health insurance. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana[94] is a flagship scheme of Government of India,which was launched as recommended by the National Health Policy 2017, to achieve the vision of Universal Health Coverage (UHC). This initiative has been designed to meet Sustainable Development Goals (SDGs) and its underlying commitment, which is to "leave no one behind." The scheme is governed by a special authority National Health Authority (NHA) which is the apex body responsible for implementing India's flagship public health insurance/assurance scheme. The governing board is composed of 11 members headed by Union Minister of Health and Family Welfare including two domain expert members from but not limited to the insurance sector. In addition to NHA, SHA(State Health Authorities) are also established under each state government to oversee the application of the scheme. The Insurance Regulatory and Development Authority (IRDIA) is formed as a statutory body distinct to the NHA. The IRDIA and NHA possess different jurisdictions under different legislations.

[94] National Health Authority Government of India, About Pradhan Mantri Jan Arogya Yojana (PM-JAY) (accessed 22nd Oct. 2024) https://nha.gov.in/PM-JAY.

Sri-Lanka

The majority of Sri Lanka's health care system is financed by taxes, making it a public system. delivering healthcare services to the general public complimentary at the time of use, which is enhanced by a private sector with fees for services. The executive branch's , the supply side has been the focus of attempts to guarantee universal access to publicly funded health care services via a fair, effective, and affordable public delivery mechanism[95]. Sri Lanka has provided universal, free public health care services for the whole population since 1951, when user fees were abolished[96]. In Sri-Lanka no distinct health care scheme is offered, instead a common health facilities is provided under three levels by the government i.e, primary, secondary and tertiary care hospitals[97] under distinctive care units[98] The medical association is powerful and strongly resists political meddling in the health system. Political patronage has not corrupted the posting and transfer system. Doctor absenteeism is rare. Majoritarian rule has favored effective public service delivery in the rural heartland rather than co-opting of the government by the urban elite[99].

Japan

Japan's constitution expressly declares that citizens have a right to health and that it is the state's responsibility to ensure this right can be realized[100]. The government's commitment to health for all led to universal health care coverage in 1961[101]. The insurers have no privilege to choose a designated plan yet there are no restrictions on access . Regardless of the plan, enrollees can receive care from any medical provider as frequently as they would like. Cost-sharing varies according to age, children under 3 have a 20% copayment and persons over 70 with low incomes have a 10%

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[95] International Labour Organization (ILO), *Extending Social Health Protection in Sri Lanka: Accelerating progress towards Universal Health Coverage*, Dec 2021

[96] Rannan-Eliya, Ravi P., and Lankani Sikurajapathy , *Sri Lanka: "Good Practice" in Expanding Health Care Coverage* , INSTITUTE FOR HEALTH POLICY (2009)

[97] Dr Susie Perera, *Primary Health Care Reforms in Sri Lanka: Aiming at Preserving Universal Access to Health* in ALEXANDER MEDCALF ET.AL HEALTH FOR ALL (2015)

[98] https://www.health.gov.lk/public-health-services/

[99] Smith, O.. "Sri Lanka: *Achieving Pro-Poor Universal Health Coverage without Health Financing Reforms". Universal Health Coverage Study Series No. 38* WORLD BANK GROUP, WASHINGTON, DC (2018)

[100] https://japanhpn.org/en/hs1/#_ftn1

[101] N. Ikegami *Universal Health Coverage for Inclusive and Sustainable Developmen*t. WORLD BANK GROUP, WASHINGTON, DC (2014).

copayment[102]. Public administrative agencies supervise and regulate healthcare through control of the health insurance system. Specifically, government organizations oversee health insurance contracts between the government and healthcare agencies. This power is provided through the 1922 Health Insurance Act[103]. The Central Social Insurance Medical Council, or Chu-i-kyo in Japanese, is run by staff of MHLW's Health Insurance Bureau (HIB) and convenes to advise the Minister of Health, Labour and Welfare on health insurance and health services. The Council includes representatives from the payer side, the provider side and academics representing the public interest. The Medical Service Act stipulates that prefectural governments oversee medical facilities and providers within the prefecture. In contrast with the administrative agencies of the government, which supervise the contracts and payment systems, prefectural governments monitor adherence to regulations related to the establishment of medical facilities, staffing, and the management of pharmaceuticals and other products[104]. The overall health care system is managed by different bureaus like: health insurance bureau, health policy bureau, health and welfare bureau for the elderly, and others.

Evaluating the practises from significant countries around the world with special reference to South Asian Nation we can oversee that the national insurance authority/board and Health Insurance Board are placed under different jurisdictions with distinct power and functions to address. The NHIP being a special insurance approach is regulated through special HIB which is a strategic move yet the board requires some rearrangements to be free from external influences and achieve Universal Health Coverage.

2. Reform within the Health Insurance Board: Conflict of Interest in the Health Insurance Board

The Health Insurance Board (HIB) of Nepal has been at the center of a critical reform movement aimed at addressing conflicts of interest that undermine its integrity and effectiveness. Conflicts

[102] S. Thomson& Osborn, R., Squires, D & Jun, M *International Profiles of Health Care Systems* COMMONWEALTH FUND Pub. No. 1717, p.75–83 (2013).

[103] Ministry of Health, Labour and Welfare. Understanding the system of health insurance Retrieved from http://www.mhlw.go.jp/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/dl/shidou_kansa_01.pdf

[104] Ministry of Health, Labour and Welfare. Regional healthcare.Retrieved from http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/tiiki/index.html

of interest arise when board members personal interests may compromise their decision-making, potentially leading to biased policies that do not prioritize the public good[105]. This issue has become particularly significant in the context of Nepal's ongoing efforts to achieve universal health coverage amidst systemic challenges, including bureaucratic inefficiencies and resource misallocation. Critics argue that the HIB's governance practices and transparency issues hinder the delivery of essential health services, particularly for marginalized communities[106]. Notable reform initiatives include policy changes aimed at improving accountability, transparency, and citizen engagement in health governance. Despite these efforts, the HIB has faced criticism for slow progress and inadequate communication with the public, raising concerns about the actual implementation of promised reforms. Community involvement remains limited, with many citizens unaware of their rights and the available health services[107]. The management of conflicts of interest within the HIB is pivotal for restoring public trust and ensuring fair decision-making.

Proposed solutions include establishing clear policies for disclosure, regular reporting mechanisms, and a robust governance framework that encourages transparency and accountability among board members. Ultimately, the path toward effective reform within the Health Insurance Board is fraught with challenges. Leadership within the NHIP has exhibited high levels of political commitment; however, there has been a weak translation of these commitments into actionable results Moreover, the engagement of external actors has been primarily limited to technical assistance in policy design rather than practical implementation support[108]. The centralization of authority within the federal Ministry of Health and Population (MoHP) has resulted in a continuation of a centralized mindset, countering the federalism envisioned in the 2015 Constitution[109] . The board should be reformed as a regulatory and supervisory body, while the

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[105] Sharada Prasad Wasti et.al., *Overcoming the challenges facing Nepal's health system during federalisation: an analysis of health system building blocks*, HEALTH RESEARCH POLICY AND SYSTEMS, volume 21, Article number: 117 (2023).

[106] Bipin Adhikari et.al., *Transforming Nepal's primary health care delivery system in global health era: addressing historical and current implementation challenges Globalization and Health* volume 18, Article number: 8 (2022) https://doi.org/10.1186/s12992-022-00798-5

[107] Sushmita Ghimire et.al., F*actors affecting health insurance utilization among insured population: evidence from health insurance program of Bhaktapur district of Nepal* BMC Health Services Research volume 23, Article number: 159 (2023) https://doi.org/10.1186/s12913-023-09145-9

[108] Sushmita Ghimire et.al., Factors influencing the Utilisation of National health insurance program in urban areas of Nepal: Insights from qualitative study, PLOS Glob Public Health 4(7): e0003538. https://doi.org/10.1371/journal.pgph.0003538, July 26 2024

[109] Shiva Raj Mishra et.al., *National health insurance policy in Nepal: challenges for implementation Global Health Action* (2015)

action-oriented functions like: approving service providers, regulating claims, management of resources should be executed through a different autonomous institution. The current structure of the board requires an addition of member positions from areas like: insurance/commercial law, policy-making and data analytics. The creation of this position will render the regulatory and supervisory function smoothly allowing less political autonomy upon the board.

Chapter IV

Management of Financial Resources and Risk-Pooling Mechanism: An analysis of countries with best health insurance practices

1. India

The Indian government introduced the historic Pradhan Mantri Jan Arogya Yojana (PM-JAY), a national health insurance program, in September 2018. PM-JAY is intended to give financial security to around 500 million people, or the poorest 40% of the nation's population, by extending comprehensive health coverage to economically disadvantaged communities.[110] By offering insurance coverage of up to INR 500,000 (approximately USD 6,800) per family annually, the program seeks to enhance access to a wide range of medical and surgical services at both public and private hospitals, thereby addressing significant gaps in healthcare accessibility across India [111].

1.1 Financial Resources Management

The budget allocated under AB- PMJAY for the Financial Year 2023-24 is Rs. 7200 crore , out of which Rs. 4554.4 crore have been released to States/UTs implementing the scheme as part of central share of funds. There is no State specific allocation under the scheme. Central share of funds is released to the States/UTs on the basis of actual utilization of the scheme by the beneficiaries, subject to a ceiling.[112] The program allows states to choose their operating model for funding, which could involve direct service provision or payments to private insurance providers, reflecting a blend of public and private sector involvement[113]. The financial responsibility for the

[110]Acko Group of Companies, *Ayushman Bharat: Pradhan Mantri Jan Arogya Yojana (PMJAY) (*(available at: https://www.acko.com/health-insurance/ayushman-bharat-yojana-scheme/) (accessed on 24th October 2024)

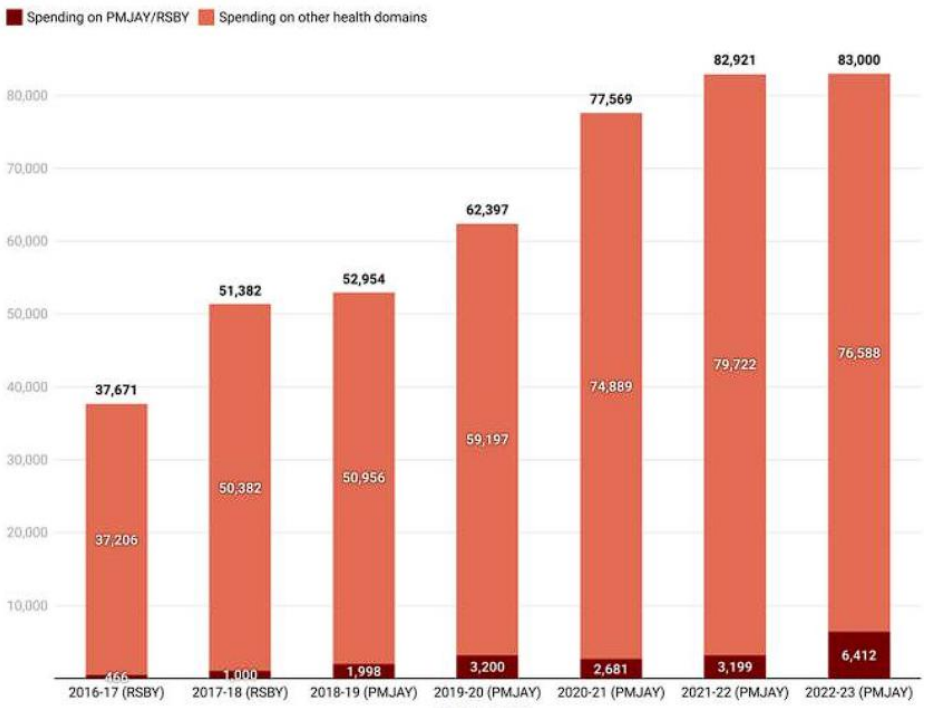
[111] Blake J Angell et.al, *The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance* PLOS MED 16(3) March 7, 2019 https://doi.org/10.1371/journal.pmed.1002759

[112]https://sansad.in/getFile/loksabhaquestions/annex/1715/AU125.pdf?source=pqals#:~:text=The%20budget%20allocated%20under%20AB,of%20central%20share%20of%20funds.

[113] Mayur Trivedi et.al , *Experiences and challenges in accessing hospitalization in a government-funded health insurance scheme: Evidence from early implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India*, May 12, 2022 https://doi.org/10.1371/journal.pone.0266798

program is shared between the central and state governments, with the Indian government contributing between 60% to 100% of the expenditure based on state wealth and legislative arrangements. Such a framework not only supports the sustainability of the program but also aims to provide universal coverage across public and private healthcare facilities [114]. India's healthcare is financed by multiple sources - domestic government sources, private sources, and external/global sources, Out-of-pocket expenditure (OOPE), a major source of health financing in the country, contributes to 54.7% of total health expenditure.[115]

Fig. 2: Financing of health system and GFHIS in India: Central Government spending on PMJAY/RSBY scheme and other health domains (in crore Indian Rupees)

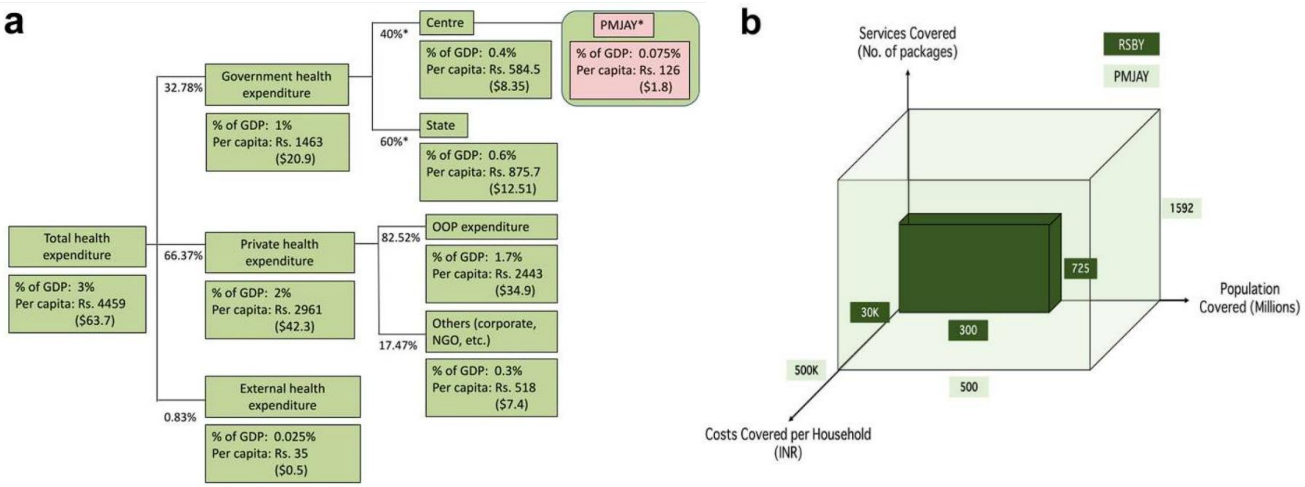


Source: PubMed Central

[114] Sulakshana Nandi & Helen Schneider , *Using an equity-based framework for evaluating publicly funded health insurance programmes as an instrument of UHC in Chhattisgarh State*, INDIA HEALTH RESEARCH POLICY AND SYSTEMS
volume 18, Article number: 50 (2020)

[115]World Bank *Out-of-pocket expenditure (% of current health expenditure) - India | Data. 2022*. https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=IN&name_desc=true published online Jan 30.

Fig. 2.1: Financing of health system and GFHIS in India: (a) Sources of healthcare financing in India, (b) Universal health coverage (UHC) Cubes: RSBY vs PMJAY, (c)



Source: PubMed Central

1.2 Risk-Pooling Mechanism

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) employs a risk-pooling method meant to promote the financial sustainability and affordability of health insurance coverage for different populations. This strategy's effectiveness is mostly dependent on having a large risk pool that includes both high- and low-income households. This technique tries to reduce concerns of adverse selection and promote essential cross-subsidization within the system[116].

The risk-pooling mechanism initiated under the PM-JAY are:

- Comprehensive Coverage to Socioeconomic Caste Census (SECC)

Targeting the lowest 40% of India's population as determined by the Socioeconomic Caste Census (SECC) 2011, PM-JAY offers health insurance coverage for secondary and tertiary care services

[116] Samir Garg et.al, *The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) after four years of implementation – is it making an impact on quality of inpatient care and financial protection in India?* BMC HEALTH SERVICES RESEARCH volume 24, Article number: 919 (2024) https://doi.org/10.1186/s12913-024-11393-2

up to ₹5 lakh per family annually. This extensive coverage reduces individual financial burdens during health crises by spreading the risk among many recipients.[117]

- Flexibility in implication models

Different Indian states utilize various models to implement PM-JAY, including trust and assurance models, insurance models, or a combination of both[118]Under the Insurance model, the SHA can contract an insurance company (IC) through annual payments of fixed premiums per family covered. In turn, the IC covers beneficiaries for the pre-defined benefits package. Insurance companies retain a defined proportion of the premium as administrative costs and return the unspent balance to the state. The IC bears financial risk; however, if claims ratios exceed 120%, the excess amounts are shared by the State and the IC. In this model, the SHAs retain responsibility for overseeing functions contracted to the IC. In the Trust model, the SHA is registered as a society or a trust and purchases services directly from empanelled healthcare providers. The SHA may contact implementation support agencies (ISAs) to augment its capacities for carrying out purchasing functions. Most States/UTs (24) is implementing the scheme in a Trust mode.[119]

- Reduction of out-of-pocket expenditure (OOP) through cashless cover

By providing coverage for hospitalization and surgical procedures, PM-JAY has prevented beneficiaries from incurring substantial medical debt, which is often a barrier to accessing necessary healthcare services[120]. PM-JAY covers approximately 90% of inpatient medical costs, including hospitalization, surgeries, diagnostics, and follow-up care[121]. Studies indicate that PM-JAY has led to a notable reduction in catastrophic health expenditures. For instance, the share of families spending more than 10% of their annual consumption on hospital expenses has decreased significantly since the program's implementation[122]. The implementation of standard treatment

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[117] Harpreet Grewal et.al, *Universal Health Care System in India: An In-Depth Examination of the Ayushman Bharat Initiative* 15(6): e40733. Published online 2023 Jun 21.

[118] https://www.amrita.edu/school/project-egovmmcases/cases/pmjay/

[119] World Health Organization, *An assessment of the trust and insurance models of AB PM-JAY implementation in six states* (2022)

[120]Anurag Saxena et.al, *Improving hospital-based processes for effective implementation of Government funded health insurance schemes: evidence from early implementation of PM-JAY in India ?* BMC HEALTH SERVICES RESEARCH volume 22, article number: 73 (2022)

[121] Divya Parmer et.al, *Effects of the Indian National Health Insurance Scheme (PM-JAY) on Hospitalizations, Out-of-pocket Expenditures and Catastrophic Expenditures* (2023)

[122] https://nha.gov.in/img/pmjay-files/Policy-Brief-12-PM-JAY_Impact-on-Inpatient-OoPE.pdf

protocols, quality certifications, and performance-based incentives for empanelled hospitals has contributed to improved healthcare quality and efficiency, further alleviating out-of-pocket expenses for beneficiaries[123].

- National portability of the scheme

The scheme's design incorporates national portability of care, allowing beneficiaries to access services from empanelled hospitals across the country, thereby ensuring comprehensive coverage for catastrophic illnesses[124]. The national portability scheme not only facilitates the insured individuals but also reduces and shifts the financial burden among different states and individuals can choose dedicated service provider either in primary, secondary or tertiary level. The national portability initiation has been proved to reduce the risk of coverage limitation upon individuals as they can benefit under different state operated health scheme in addition to the PM-JAY[125].

2. South-Korea

South Korea introduced mandatory social health insurance for industrial workers in large corporations in 1977, and extended it incrementally to the self-employed until it covered the entire population in 1989[126]. This comprehensive scheme covers approximately 97% of the population through the National Health Insurance Service (NHIS), with the remaining 3% benefiting from a tax-funded Medical Aid Program for low-income individuals and families[127]. The implementation of the NHI involves a systematic approach, phased over several years, to transition from a dual public-private healthcare system into a singular, nationalized framework. The scheme is designed to deposit all health revenue into a single fund, facilitating a more streamlined and equitable

[123] Saxena, *Supra Note* at 94.

[124] Shawin Vitsupakorn et.al , *Early lessons from India's health insurance scheme, Pradhan Mantri Jan Arogya Yojana* https://www.brookings.edu/articles/early-lessons-from-indias-health-insurance-scheme-pradhan-mantri-jan-arogya-yojana/

[125] Deepshika Sharma, et.al, *Understanding the extent of economic evidence usage for informing policy decisions in the context of India's national health insurance scheme: Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana (PM-JAY)*,BMJ GLOB HEALTH (2024).

[126] Soonman Kwon, *Thirty years of national health insurance in South Korea: lessons for achieving universal Health Policy and Planning* OXFORD UNIVERSITY PRESS , 24:63–71 (2008)

[127] Dasuel Moon et.al, *Universal health coverage saves more lives among severely ill COVID-19 patients: A difference-in-differences analysis of individual patient data in South Korea Health Res Policy* (2024). https://doi.org/10.1186/s12961-024-01212-9

distribution of healthcare resources[128]. The co-payment rate is determined differently according to the types of service and the level of health care institutions. This is to curb people's strong preference of tertiary hospitals to general hospital and clinics nearby so that to help use of medical resources more efficiently[129]. For outpatient services, patients typically pay a 30% co-insurance for medical care and prescription drugs. However, for elderly patients aged 65 and older, this can be adjusted to a fixed co-payment model, where they may pay significantly less (e.g., 1,500 won for outpatient visits costing less than 15,000 won)[130] with exemptions to certain groups such as low-income individuals and enrolled in the Medical Aid Program (MAP)[131].

2.2 Financial Resources Management

The system operates as a single-payer model managed by the National Health Insurance Service (NHIS), which oversees the eligibility of enrollees, collects insurance contributions, and negotiates fees with healthcare providers.[132] The financial burden of healthcare is shared among all enrollees through monthly contributions, which are assessed based on income and property values[133]. The financial structure of South Korea's National Health Insurance (NHI) scheme is primarily composed of premiums paid by insured individuals, government subsidies, and taxes, such as those levied on tobacco sales[134]. In the NHI system, the financial burden is primarily shared between employees, employers, and the government. Employees contribute a certain percentage of their income, which is matched by their employers, thereby promoting a shared responsibility in funding

[128] *Korea:HealthSystemHistory,Reforms,andChallenges* https://healthsystemsfacts.org/national-health-systems/national-health-insurance/south-korea/korea-health-system-history-and-challenges/

[129] https://www.nhis.or.kr/english/wbheaa02600m01.do

[130] Enuja Park and Sookja Choi, *Who Benefits from the Fixed Copayment of Medical and Pharmaceutical Expenditure among the Korean Elderly?* INT J ENVIRON RES PUBLIC HEALTH.; 17(21): 8118 (2020) Published online 2020 Nov 3. doi: 10.3390/ijerph17218118

[131] David Coady et.al, *Coverage Expansion and Cost Containment in the Republic of Korea* (2012) https://www.elibrary.imf.org/display/book/9781616352448/ch012.xml

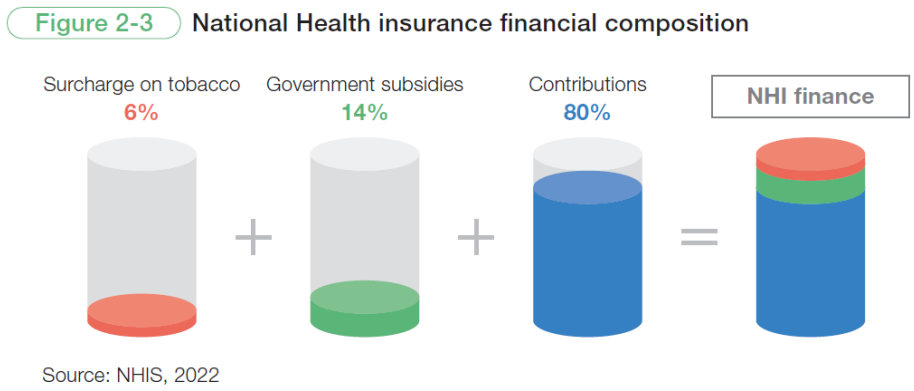
[132] National Health Insurance Service Korea, *Health Security System,* (available at: https://www.nhis.or.kr/english/wbheaa02300m01.do) (accessed on: 24th October 2024)

[133] Tae-Jin Lee et.al, *Equity of health care financing in South Korea: 1990–2016* , BMC HEALTH SERVICES RESEARCH volume 21, Article number: 1327 (2021)

[134] South Korea's *"Catastrophic Medical Expenses Program" supports low-income families' healthcare costs* (2023) https://www.sdg16.plus/policies/south-koreas-catastrophic-medical-expenses-program-supports-low-income-families-healthcare-costs/

health services.[135] Each year, the NHIS receives subsidies from the government, corresponding to 14% of the contribution revenue expected for that year. The NHIS may also receive subsidies from the National Health Promotion Fund, which corresponds to 6% of the contribution revenue expected for that year. This, however, is limited to up to 65% of the estimated surcharge on tobacco, the major source of funding. Contributions collected from the insured make up the majority of financial resources (80%) and the remainder is covered by government subsidies.[136]

Fig.3: National Health Insurance Financial Composition of South Korea



Source: NHIS, 2022

2.3 Risk-Pooling Mechanisms

The implementation of a single risk pool made it possible to pool risks better and to cross subsidize the poor. The fact that insurance membership was family-based (that is, included family members and dependents along with the family head) was one of the factors that contributed to the rapid expansion of coverage. The institution of multiple insurers was more practical in the Korean context, as the inclusion of different population groups with diverse characteristics into a single risk pool from the beginning of the NHI program would have required costly and complex

[135] Jihyung Hong et.al, *Values, challenges, and responses associated with high-priced potential cures: perspectives of diverse stakeholders in South Korea*, https://resource allocation.biomedcentral.com/articles/10.1186/s12962-024-00527-2 (2024)

[136] NHIS Korea, *National Health Insurance & Long-Term Care Insurance System Republic of Korea*, (2024)

managerial structures. This pragmatic choice also contributed to the rapid extension of population coverage[137].

The risk-pooling mechanism initiated under the National Health Insurance are:

- Automatic Coverage for Vulnerable and low-waged individuals

Persons with low incomes are entitled to enrol in the MAP, and membership criteria is set and revised annually by the MOHW. Beneficiaries of the National Basic Livelihood Security System (NBLSS) and households making less than 40 per cent of the median income in the Republic of Korea qualify for medical aid[138]. Additional to it is LTCI (Long term Care System) , affiliation to the LTCI scheme is mandatory for individuals aged 65 or over and those below 65 with debilitating conditions[139]. The recently introduced Moon Jae-in care scheme has protected patients and their families from financial burdens in the event of any medical emergency that may require expensive procedures. For instance, lung cancer patients now pay only 5 percent of expensive anticancer medicine fees, which could otherwise cost them more than KRW 3 million (USD 2,500), since the national health insurance covers 95% of the fees. A mother, who had to pay around KRW 300,000 (USD 250) every time her kid with cleft lip and palate received orthodontic treatment over 10 years, now doesn't have to worry about the expenses, since the treatment fees are covered by Moon Jae-in Care.[140]

- Single Payer System

The republic of Korea's single-payer insurance system presupposes every citizen to be enrolled in the NHI or the MAP, depending on their income levels and criteria set by the Government[141]. In 2000, all insurance schemes were merged into a single payer with a uniform contribution schedule

[137] Sanggon Na & Soonman Kwon, *Building Systems for Universal Health Coverage in South Korea*, WORLD BANK GROUP (2015) https://documents1.worldbank.org/curated/zh/367221468186565282/pdf/98266-WP-Box385353B-PUBLIC-UHC-in-South-Korea.pdf

[138] Moon, C & M. Moon, *Routledge Handbook of Korean Politics and Public Administration*. NEW YORK: ROUTLEDGE (2020).

[139] Kang, I., C. Park, & Y. Lee. *Role of Healthcare in Korean Long-Term Care Insurance*, JOURNAL OF KOREAN MEDICAL SCIENCE 27 (Suppl): S41–S46. (2012).

[140] Sohn Ji-ae, *Inclusive Moon-Jae In Care* (available at: https://www.kocis.go.kr/eng/webzine/202110/sub09.html) (accessed on: 24th October 2024)

[141] Lu, J. fen R., Sheu, J. T., & Lee, T. J, *A Tale of Two Social Insurance Systems in South Korea and Taiwan: A Financial Risk Protection Perspective* (2022).

and benefits coverage.[142] Under a single-payer health insurance system, it has become feasible to collect utilization data of the entire population, as a single payer system, health insurance has a uniform contribution formula and benefits coverage nationwide. The NHIS 39 as the single health insurance agency collects the premium. The poorest 3–4% of the population do not pay contributions and are managed through the Medical Aid Program, which is financed by the general revenue of the central and local governments but administered (including payments to providers) through the health insurance system[143]

- Mandatory participation in NHIS

Under the single-payer insurance system, it is mandatory for every citizen to be enrolled in the NHI. There is no choice of health insurer within the NHI, although purchase of private health insurance from multiple private insurers is permitted. The government imposes mandatory participation, as legal obligation for both insurers and providers, and insurers must provide NHI services. The step-by-step expansion of coverage took into careful consideration the insured's ability to pay and the insurer's administrative capacity[144].

3. Thailand

Thailand achieved universal health coverage in 2002, when the whole population was covered by one of the three public health insurance schemes: the Civil Servant Medical Benefit Scheme (CSMBS), the Social Health Insurance (SHI) and the Universal Coverage Scheme (UCS). While CSMBS and SHI are employment-related coverage, UCS is an entitlement to health care for Thai citizen[145]. The National Health Insurance Scheme (NHIS) in Thailand is designed to ensure active citizen participation in its governance. Citizens are empowered to influence various aspects, including the standards and scope of health services, the appointment of the secretary general, and

[142] Soonman Kwon et.al, *Republic Of Korea Health System Review*, ASIA PACIFIC OBSERVATORIES ON HEALTH SYSTEM AND POLICY Vol. 5 2015

[143]https://p4h.world/en/documents/social-health-protection-and-health-financing-for-universal-health-coverage-in-the-republic-of-korea/

[144] Yuri Lee et.al, *Ethical Consideration of National Health Insurance Reform for Universal Health Coverage in the Republic of Korea*, ASIAN BIOETH REV ; 11(1): 41–56 (2019).

[145] IHHPP &NHSO, *Case Study: Thailand Universal Coverage Scheme*

the approval of financial plans and administrative policies[146]. The benefits of the policy comprise essential services in preventive, curative and palliative care for all age groups. Extension of coverage to high-cost services, such as renal replacement therapy, cancer therapy and stem-cell transplants, has improved financial protection for patients[147], well coordinated district health systems enable individuals to seek care or referral at health units close to home[148]. The USC in Thailand is wholly tax funded thus entitling that no citizen is left out of the benefits entitled.

3.1 Financial Resources Management

Thailand's model is supported by a mixed funding approach, including government subsidies and contributions from the general population, facilitating more equitable healthcare access[149]. The financial framework of the NHIS is primarily funded through progressive tax financing, which allows wealthier citizens to contribute a higher proportion of their income compared to poorer citizens[150] with the exception of the contributory SSS scheme, which is financed via tripartite financing arrangements, equally shared between employers, employees and the government. The payroll tax contribution to the SSS scheme is set at 1.5 per cent, borne equally by each of the three parties, namely the worker, the employer and the government[151]. Thailand is considered as a relevant example of a country making a rational use of pluralistic methods of financing. Thailand provides universal coverage through multiple public schemes: automatic coverage is granted to all persons registered with a local health provider (and not otherwise covered by another public programme) which is financed through general revenue, social health insurance is provided to private sector employees through the Social Security Office, the refund of health expenditure is available to public sector employees and their dependants through the Government health scheme. In 2002, the implementation of a purchaser-provider split was introduced through the establishment of the NHSO, which contracts health care providers to provide health services for

[146]Thailand Simple, *Health Insurance in Thailand: A 2024 Guide For Foreigners (available at:* https://thailandsimple.com/health-insurance-in-thailand/) (accessed on 24th October, 2024)

[147] Tantivess S et.al, *Universal coverage of renal dialysis in Thailand: promise, progress, and prospects.* BMJ. (2013).

[148] Nittayarumpong S, *Evolution of primary health care in Thailand: what policies worked*? HEALTH POLICY PLAN. 5(3):246–54 (1990).

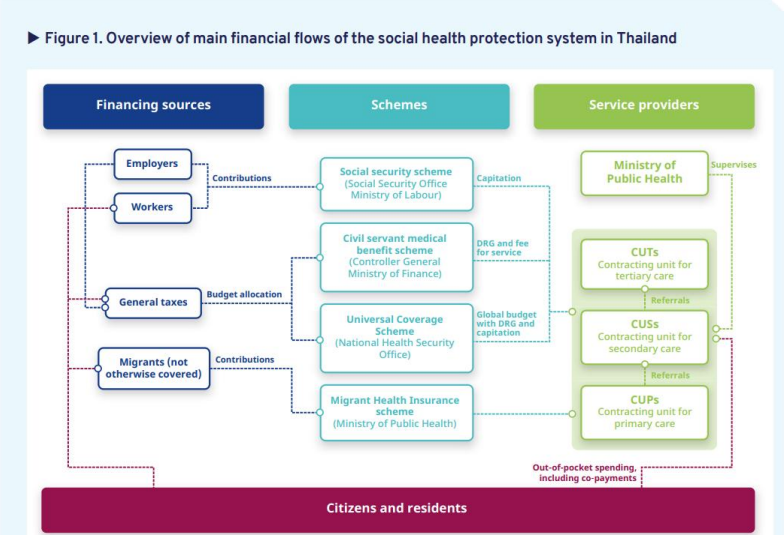
[149] Viroj Tangcharoensathien et.al, *Promoting universal financial protection: how the Thai universal coverage scheme was designed to ensure equity Health Research Policy and Systems* Article number: 25 (2013)

[150] *Id.*

[151]WHO (WORLD HEALTH ORGANIZATION), THE KINGDOM OF THAILAND HEALTH SYSTEM REVIEW. WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC (2015).

its beneficiaries. This signalled a move away from the previous model of budget allocation from the central MOPH to health care providers[152].

Fig.4: Overview of Financial Flows of the Social Health Protection System in Thailand



Source: ILO

3.2 Risk-pooling mechanism

The pooling arrangements in Thailand are characterized by compulsory coverage for the entire population, which mitigates segmentation and promotes a diverse mix of health risks within the pools[153]. In Thailand's UCS, a single national pool operated by the Ministry of Public Health facilitates the distribution of resources and services across different population groups. This arrangement aims to maximize redistributive capacity by ensuring that contributions are not directly linked to health risks, thereby enabling healthier individuals to subsidize the healthcare costs of those with higher needs[154].

[152] PHCPI (Primary Health Care Performance Initiative) T*hailand: Improved Geographic and Financial Access to Care Strengthens Primary Care*. (2018).
[153]Inke Mathauer et.al, *Pooling arrangements in health financing systems: a proposed classification International Journal for Equity in Health* volume 18, Article number: 198 (2019).
[154] Wylie Barker et.al, *The Gap Persists: The Differential Usage of Healthcare in Urban and Rural Areas in Thailand's Universal Coverage Scheme*,MCGILL JOURNAL OF GLOBAL HEALTH Vol VIII, (2019).

The risk-pooling mechanism in UCS are:

- Single National Pooling system

In Thailand's UCS, a single national pool operated by the Ministry of Public Health facilitates the distribution of resources and services across different population groups. This arrangement aims to maximize redistributive capacity by ensuring that contributions are not directly linked to health risks, thereby enabling healthier individuals to subsidize the healthcare costs of those with higher needs[155]. To avoid losing momentum, the government compromised and only pooled the budgets for the MWS and HCS—schemes for the poor and near-poor.

- Strategic Purchasing

It is funded by the federal government and is distributed to providers via a system of strategic purchasing, where the buyer and supplier are independent of one another. The UCS uses a number of strategies to keep expenses under control while still offering its clients care. The program employs global budget case-based and capitation payments as payment mechanisms to give providers with strong cost-containment incentives. In order to reduce costs, the UCS can also bargain with suppliers and pharmaceutical firms using its monopoly power. To increase utilization, several high-cost treatments and interventions may come with supplemental add-on payments. There is also a monitoring and assessment mechanism in place.[156]

- Tax-funded scheme

The scheme is primarily financed by general income taxes, so it is proportionately more heavily funded by the rich than the poor[157]. Tax became the sole source of financing the universal coverage scheme thus entitling transparency, multi stakeholder engagement and use of evidence informed budgetary negotiations. Adequate funding for UHC was achieved, providing access to services and financial protection for vulnerable populations. Out-of-pocket expenditure, medical impoverishment and catastrophic health spending among households decreased between 2000 and

[155] Id.

[156] Piya Hanvoravongchai, *UNICO Study Series 20 Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints,* THE WORLD BANK, (2013)

[157] https://eng.nhso.go.th/view/1/DescriptionNews/Enhancing-convenience-22nd-year-of-UCS/587/EN-US#:~:text=Over%2099%25%20of%20Thai%20citizens,healthcare%20coverage%20in%20the%20country.

2015[158]. By covering approximately 76% of the Thai population, including those in the informal sector, the UCS pools risk across diverse income groups. This broad coverage reduces the likelihood that any single group will bear a disproportionate share of health care costs [159].

4. Germany

The German healthcare system is based on a mandatory health insurance model, covering all residents, with approx 89% of the population covered by statutory health insurance (SHI) (contribution-based) and 11% by private health insurance (risk-related, premium-based).[160]

The contributions to the 105 sickness funds constitute the major system of financing health care in SHI. Sickness fund membership is mandatory for all whose gross income does not exceed the opt-out threshold which was earning above EUR 62,3550 annually as of 2020.[161] Almost every person covered by SHI has the right to choose between sickness funds (the exception is the farmers' sickness fund).[162] Furthermore, members can switch to a new sickness fund every 18 months with two months' notice.[163] Sickness funds must offer the same benefits to their insured, although they can add benefits (e.g. health promotion, homoeopathy) to compete for members.

4.1 Financial Resources Management for SHI

Germany manages the financial resources for its statutory health insurance (SHI) through a combination of contributions, government funding, and user charges. A key source of funding comes from contributions by employees and employers, where 14.6% of the employee's gross

[158]Viroj Tangcharoensathien et.al, *Political economy of Thailand's tax-financed universal coverage scheme,* BULL WORLD HEALTH ORGAN. 98(2): 140–145 (2020).

[159] Kanitsorn Sumriddetchkajorn et.al, *Universal health coverage and primary care, Thailand,* BULL WORLD HEALTH ORGAN, 97(6): 415–422 (2019).

[160] EUROPEAN COMMISSION, STATE OF HEALTH IN EU- GERMANY COUNTRY PROFILE (2023) p8. Retrieved from https://health.ec.europa.eu/document/download/1b4f8d46-d378-4626-8aeb-630e7ee61420_en?filename=2023_chp_de_english.pdf

[161] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. *Germany: Health system review*. *HEALTH SYSTEMS IN TRANSITION*, 2020; 22(6); p 79. https://iris.who.int/bitstream/handle/10665/341674/HiT-22-6-2020-eng.pdf?sequence=1

[162] Id.

[163] Health Systems in Transition (HiT) profile- Germany, European Health Observatory (accessed on 21st October 2024) https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/germany-2020/financing/overview-of-the-statutory-financing-system/.

salary is shared equally between them.[164] This contribution is collected by sickness funds and is transferred to the central allocation fund.[165] If total health expenditure exceeds central allocation fund, sickness funds can levy a supplementary contribution,[166] which averaged 1.3% of gross income in 2022, also shared between the employer and employee.[167]

The government budget plays a significant role, particularly in capital investments for hospitals, which come from state-level budgets.[168] Sickness funds also receive federal subsidies for benefits like maternity care, parental sick pay, in-vitro fertilization, sterilization for contraception, and legal abortions.[169] Since 2017, the federal government has allocated a fixed annual subsidy of €14.5 billion to the SHI's central reallocation pool.[170]

Other contributions come from specific groups like the self-employed, artists, and journalists, who receive government subsidies. Students pay a uniform premium set at 70% of the general contribution rate (around 10.22%) of their assumed income level (currently €752 per month), amounting to €76.84 per month as of October 2020.[171]In the case of retired and unemployed people, the institutions that administer statutory retirement insurance and the Federal Employment

[164] Deutshe Flagge, Federal Ministry for Digital and Transport (accessed on 22nd October 2024) https://www.deutsche-flagge.de/en/social-security/contributions-and-notfications/current-contributions/current-contributions-and-operands-of-social-security.

[165] Health Systems in Transition (HiT) profile- Germany, European Health Observatory (accessed on 21st October 2024) https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/germany-2020/financing/overview-of-the-statutory-financing-system/

[166] Additional contribution: List of health insurance funds by contribution rate, Krankenkassen Deutschland (accessed on 22nd October 2024) https://www.krankenkassen.de/gesetzliche-krankenkassen/krankenkasse-beitrag/zusatzbeitrag/.

[167] Anna Maresso (Series Editor), Germany Health System Summary, European Observatory on Health Systems and Policies (2022) https://iris.who.int/bitstream/handle/10665/366160/9789289059350-eng.pdf?sequence=1.

[168] Germany: Health System Financing, World Health Systems Facts (accessed on 22nd October 2024) https://healthsystemsfacts.org/national-health-systems/bismarck-model/germany/germany-health-system-financing/?_gl=1*1h3nw80*_up*MQ..*_ga*OTUzNDgyNDEwLjE3MjkzMDg4Njc.*_ga_SDY74B5S30*MTcyOTMwODg2NS4xLjAuMTcyOTMwODg2NS4wLjAuMA.

[169] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: Health system review. HEALTH SYSTEMS IN TRANSITION, 2020; 22(6).

[170] Germany: Health System Financing, World Health Systems Facts (accessed on 22nd October 2024) https://healthsystemsfacts.org/national-health-systems/bismarck-model/germany/germany-health-system-financing/?_gl=1*1h3nw80*_up*MQ..*_ga*OTUzNDgyNDEwLjE3MjkzMDg4Njc.*_ga_SDY74B5S30*MTcyOTMwODg2NS4xLjAuMTcyOTMwODg2NS4wLjAuMA..

[171]Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: Health system review. HEALTH SYSTEMS IN TRANSITION, 2020; 22(6).

Agency respectively take over the financing role of the employer.[172] Pensioners must pay contributions also from company pensions and other non-statutory pensions from which they deduct the full contribution rate.[173]

Germany also uses cost-sharing mechanisms, requiring co-payments for certain health services, such as inpatient care, pharmaceuticals, and dental services.[174] However, exemptions are available for people with low incomes or chronic conditions. For example, individuals can be exempt if their co-payments exceed 2% of their annual income, or 1% for those with severe chronic conditions.[175]

Despite these exemptions, co-payments do not apply to services not covered by SHI, such as price differentials for pharmaceuticals.[176] This blend of contributions, government support, and cost-sharing helps Germany maintain its robust SHI system.

Fig.5: User-Charges for Health Services in Germany

[172] Id.

[173] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: Health system review. HEALTH SYSTEMS IN TRANSITION, 2020; 22(6).

[174] Anna Maresso (Series Editor), Germany Health System Summary, European Observatory on Health Systems and Policies (2022) p4. Retrieved from https://iris.who.int/bitstream/handle/10665/366160/9789289059350-eng.pdf#:~:text=Germany:%20Health%20system%20summary,%202022.%20ISSN%202958-9193%20(online)

[175] Health Systems in Transition (HiT) profile- Germany, European Health Observatory (accessed on 21st October 2024) https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/germany-2020/financing/out-of-pocket-payments/

[176] Id

HEALTH SERVICE	TYPE OF USER CHARGE IN PLACE	EXEMPTIONS AND/ OR REDUCED RATES	CAP ON OOP SPENDING	OTHER PROTECTION MECHANISMS
Ambulatory primary and specialist care	None	n/a	n/a	n/a
Outpatient prescription drugs	• Co-insurance (10%; min. € 5, max. € 10) • Reference pricing	• Children and adolescents up to the age of 18 • Women needing maternity care		• Up to 2% of annual income (1% for patients with chronic conditions), but not for charges above reference prices or fixed subsidies
Inpatient stay	• Co-payment (€ 10/day)		• Up to 28 days/€ 280 per year	
Dental care	Formally no co-payments but patients must pay the difference where the provider charges over the standard price (extra-billing)			
Crowns and dentures	• Fixed subsidy	• Higher subsidy with proof of prevention		
Orthodontic treatment	• For children: Co-insurance (20%) • For adults: not covered	• Reduced cost-sharing for second and subsequent child		
Medical aids	• Co-insurance (10%; min. € 5, max. € 10)	• Children and adolescents up to the age of 18 • Maternity care		
Non-physician care (e.g. physiotherapy)	• Co-payment (€ 10) plus • Co-insurance (10%)	• Children and adolescents up to the age of 18 • Maternity care	• Up to 28 days/€ 280 per year for homecare	
Transportation	• Co-insurance (10%; min. € 5, max. € 10)			

Source: Euro Health Observatory

4.2 Risk Pooling Mechanism

Germany's statutory health insurance (SHI) system uses a central reallocation pool (Gesundheitsfonds) as its primary risk pooling mechanism. Contributions from employers and employees are collected by sickness funds, which receive these directly from employers or public agencies.[177] The collected contributions, along with federal government subsidies, are then transferred to the Gesundheitsfonds.[178]

The Federal Office for Social Security administers this central pool and redistributes funds to sickness funds through a morbidity-based risk-adjustment mechanism (Morbi-RSA).[179] This system allocates resources to sickness funds based on factors like age, gender, and the health status

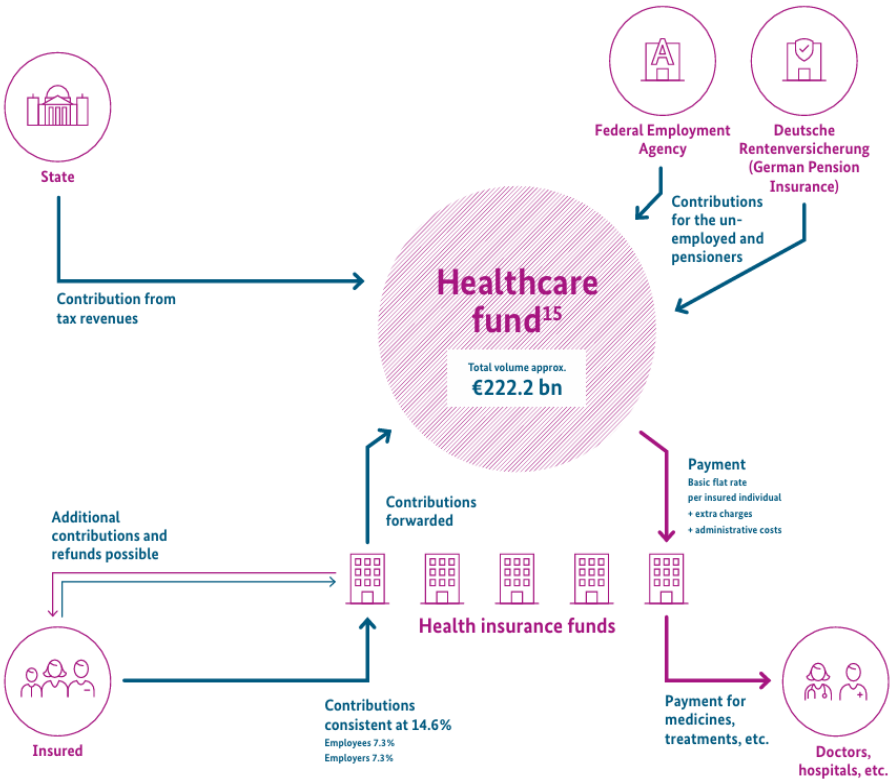
[177] Health Systems in Transition (HiT) profile- Germany, European Health Observatory (accessed on 21st October 2024) https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/germany-2020/financing/overview-of-the-statutory-financing-system/

[178] Id

[179] Id

(morbidity) of insured individuals. Initially, a basic flat rate per insured person, set at the average per capita expenditure, forms the foundation for payments.[180] In 2019, this flat rate was €262 per month.[181] Further adjustments are made to this flat rate using age-, sex- and morbidity-based premium or discount to ensure that payments are aligned with the healthcare needs of individuals.[182] This risk adjustment ensures that funds are distributed equitably across sickness funds, regardless of the health status of their members, promoting fairness and sustainability in the SHI system.

Fig.6: Statutory Health Insurance in Germany



Source: The German Health Care System

[180] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: Health system review. HEALTH SYSTEMS IN TRANSITION, 2020; 22(6).

[181] Health Systems in Transition (HiT) profile- Germany, European Health Observatory (accessed on 21st October 2024) https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/germany-2020/financing/overview-of-the-statutory-financing-system/

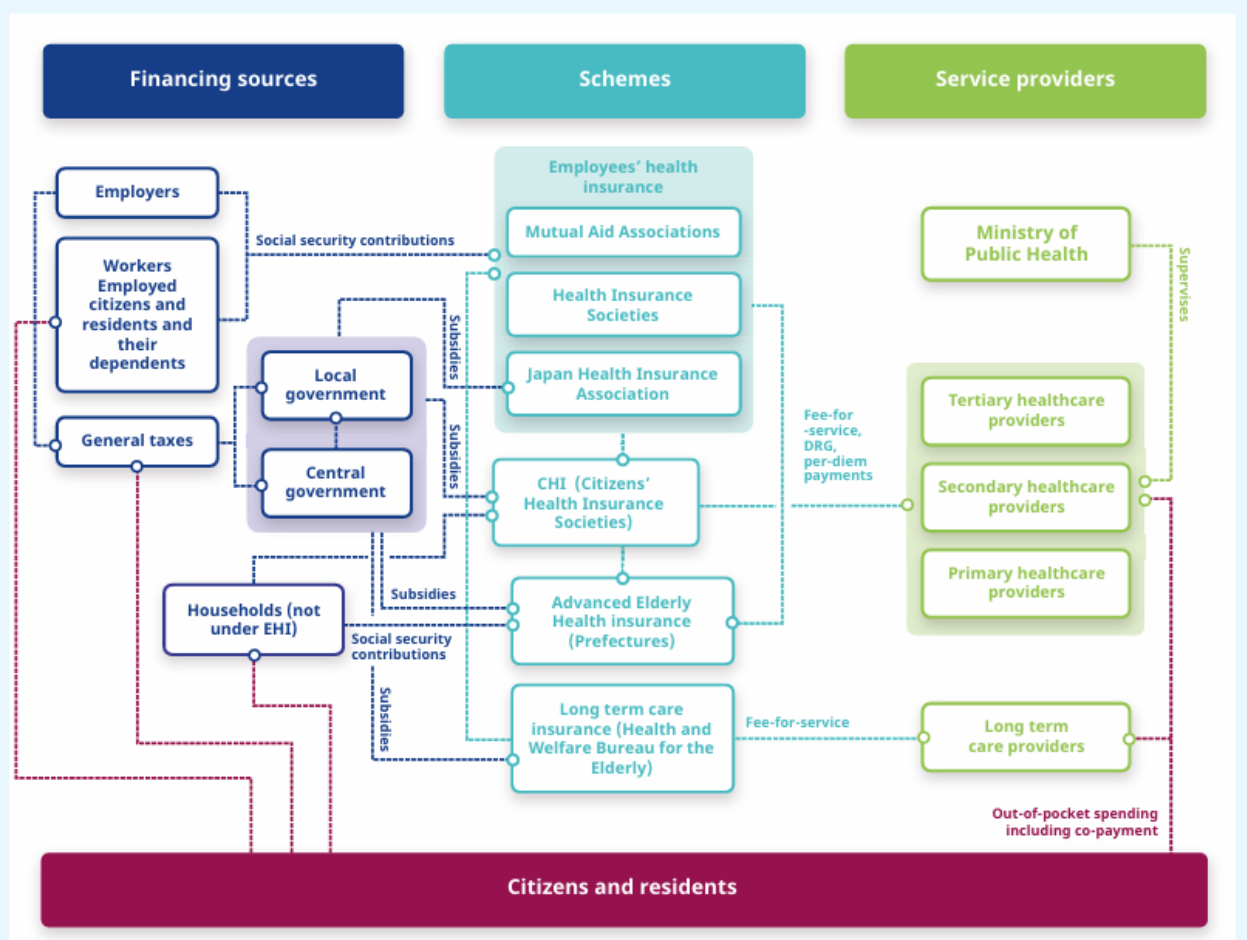
[182] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: Health system review. HEALTH SYSTEMS IN TRANSITION, 2020; 22(6).

5. Japan

Japan's health insurance system is mandatory for all residents, regardless of citizenship, who have resided in the country for three months or more. It operates as a social insurance system but receives significant tax subsidies. Enrollment is required in either employment-based or residence-based health insurance, depending on one's situation. In addition to paying premiums, enrollees cover 30% of coinsurance for most services. There are reduced coinsurance rates for young children and low-income elderly citizens, with annual out-of-pocket limits based on age and income. In 2015, 58.7% of the total population was covered by EHI, 28.3% by NHI, and 12.4% by the late-stage scheme.[183]

Fig.7: Overview of main financial flows of social health protection in Japan

[183] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.



Source: ILO

5.1 Financial Resource Management

Financial Resource Pooling for Health Insurance is done majorly through:

- Premiums
- Public Funding
- Co-payments

According to National Health Care Expenditure (NHCE), insurance premiums contribute to 48.7% of financial contributions followed by public subsidies (38.8%) and patients' copayments (11.7%).[184]

[184] Japan: Health System Financing, World Health Systems Facts (accessed on 23rd October 2024) https://healthsystemsfacts.org/japan-health-system-

Premium Calculation Across Schemes

- Employer-Based Health Insurance (EHI):

  The methods for calculating insurance premiums vary depending on the public health insurance scheme, so premiums paid by enrollees also vary. Premiums in the EHI are shared between employees and employers, with employers covering half the cost. These premiums are calculated by multiplying a contribution rate by the insured's average monthly remuneration. Contribution rates vary across different Health Insurance Societies and JHIA branches. In the case of EHI, the average rate is 10% of a salary with a cap of 13%, of which one half in principle is paid by their employer.[185]

- Residence-Based National Health Insurance (NHI):

  NHI premiums are determined regionally (so varies from one region to another) and are based on four factors:[186]

  - Income: Levied on the head of the household's income.
  - Assets: Levied on household assets.
  - Equality: Calculated per enrollee.
  - Equity: Calculated per household.

  For the NHI, the local government determines the premium rate which differs in accordance with the local governments from an average of US$2,586 per year to US$5,635 per year.[187] Premiums generally increase with income and cover benefits not only for the enrollees but also for those aged 65-74 and those over 75.

Public Funding

Public funding is mobilized to finance a proportion of health care expenses, and support schemes that have an inadequate financial basis, as well as to subsidize contributions for the elderly

financing/?_gl=1*6yyb2u*_up*MQ..*_ga*MTE2Nzc1MzI3NS4xNzI5MzAxNTA2*_ga_SDY74B5S30*MTcyOTMwMTUwNC4xLjEuMTcyOTMwMjc1My4wLjAuMA.

[185] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.

[186] Japan's Health Insurance System, Japan Health Policy Now (accessed on 23rd Oct, 2024) https://japanhpn.org/en/section-3-1/#:~:text=Characteristics%20of%20Japan%E2%80%99s%20UHC%20system%20are%20as%20follows:

[187] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.

population.[188] For NHI, 50% of the total cost is covered by governmental subsidies and cross-subsidies[189], in which 32% come from the Central Government, 9% come from the prefectural government and 9% from an adjusting subsidy of the total NHI budget. The Central and prefectural governments also support premium revenues that flow into NHI by contributing: subsidies for poor household premiums, subsidies for NHI who have a larger number of poor household, subsidies for adjusting differences among premium rates across municipalities, and subsidies for high-cost medical procedures.[190]

Similarly, about 50% of the Medical Care System for the Advanced Elderly's funding comes from public subsidies (shared between the national, prefectural, and municipal governments at a ratio of 4:1:1).[191] Hence, the Japanese Health Insurance System receives a large amount from the government.

Co-payments

All insured are required to pay a certain portion of the amount for any kind of health services they receive under any scheme as a copayment. It is however reduced for certain age groups. From elementary school entry age (i.e 6 years) to age 69, it is 30%; for children under elementary school age and those aged 70 to 74, it is 20%; for those aged 75 and older, it is 10%.[192] However, Japan limits out-of-pocket payments through coinsurance and sets annual household maximums based on income and age, which prevents individuals from facing catastrophic health expenditures. The threshold of monthly co-payment was US$707 for those aged 50 years with annual incomes of

[188] ILO, Extending Social Health Protection in Japan: Accelerating progress towards Universal Health Coverage (2021). Retrieved from: https://www.social-protection.org/gimi/Media.action;jsessionid=Q9iig3kMau-36gbMrXyKekBLSZFhUtl7v1v4536eKCi3m8wZEiNl!11591451?id=18723

[189] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.

[190] Sakamoto H, Rahman M, Nomura S, Okamoto E, Koike S, Yasunaga H et al. Japan Health System Review. Vol. 8 No. 1. New Delhi: World Health Organization, Regional Office for South-East Asia, 2018.

[191] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.

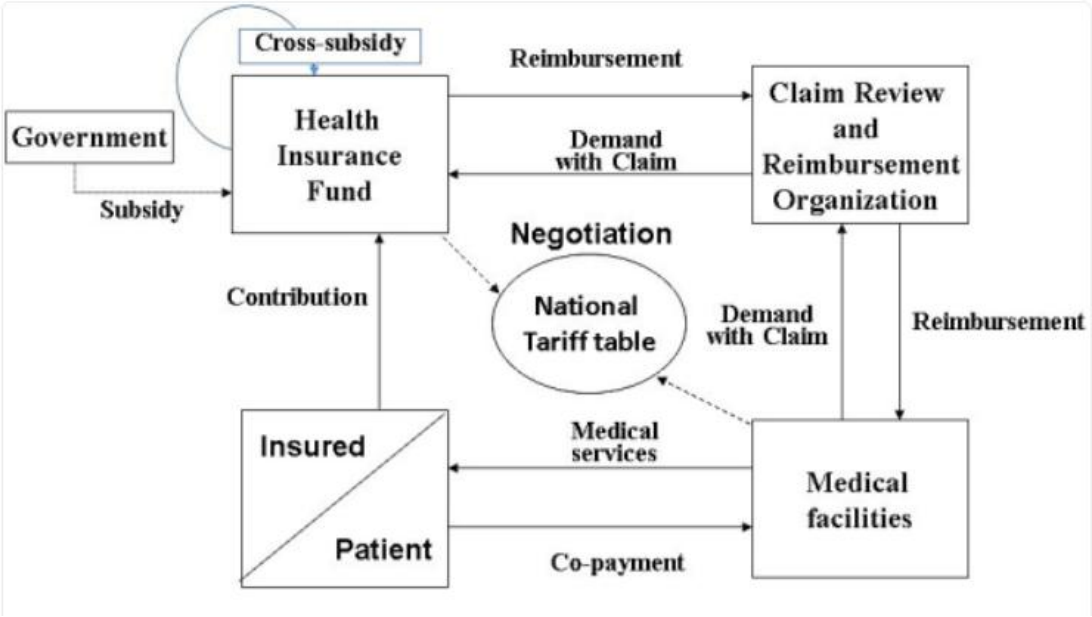
[192] Ministry of Health, Labor and Welfare (Japan), Overview of Medical Service Regime in Japan (2009). (accessed on 24th Oct. 2024) https://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/dl/01_eng.pdf.

US$50,000 as of 2019.[193] This cap differs according to annual income, age, and frequency of medical service use.

5.2 Risk Pooling

Japan's health financing system does not have a single payer for all insurance funds; there are over 3000 health insurance funds divided between three insurance schemes: employer based health insurance, residence-based National Health Insurance (NHI), and health insurance for persons over 75. Each scheme contributes to a common fund that is used to support the other schemes.[194] Health insurance schemes cross-subsidize in order to financially stabilize the plans due to the variation in enrollee income level across schemes.

Fig.8: Structure of Social Health Insurance Scheme in Japan



Source: PubMed Central

Additionally, Japan has a fiscal adjustment mechanism that supports the elderly population and ensures uniform coverage. For the Medical Care System for the Advanced Elderly (75+),

[193] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.
[194] Ministry of Health, Labour and Welfare. Health and Medical Services. (accessed on 15 October 2024) http://www.mhlw.go.jp/english/policy/health-medical/health-insurance/index.html.

approximately 50% of funding comes from public subsidies (split between national, prefectural, and municipal governments in a 4:1:1 ratio), while contributions from working-age enrollees in EHI, NHI, and Mutual Aid Associations (MAAs) cover 40%. Only 10% of the funding comes from premiums paid by the elderly themselves.[195] For the 65-74 age group enrolled under NHI, Health Insurance Societies, JHIA, and MAAs contribute to retirement premiums and medical costs.[196] These contributions are integrated into these schemes as expenditures and are factored into the fiscal adjustments to ensure coverage across the entire system.

6. Philippines

The National Health Insurance Program (NHIP) in the Philippines

The National Health Insurance Program (NHIP) of the Philippines was established under the 1995 National Health Insurance Act (Republic Act 7875).[197] The NHIP is managed by the Philippine Health Insurance Corporation (PhilHealth) and aims to provide a unified public health insurance scheme for all Filipinos.[198] It took over the previous Medicare system, which was managed separately by the Social Security System (SSS) for private sector employees and the Government Service Insurance System (GSIS) for government employees.[199]

PhilHealth introduced three major components to the NHIP[200]:

[195] Matsuda S. *Health Policy in Japan - Current Situation and Future Challenges*. JMA J. 2019 Mar 4;2(1):1-10. doi: 10.31662/jmaj.2018-0016.

[196] ILO, Extending Social Health Protection in Japan: Accelerating progress towards Universal Health Coverage (2021). Retrieved from: https://www.social-protection.org/gimi/Media.action;jsessionid=Q9iig3kMau-36gbMrXyKekBLSZFhUtl7v1v4536eKCi3m8wZEiNl!11591451?id=18723

[197] PHILIPPINE HEALTH INSURANCE CORPORATION (hereinafter PHILHEALTH), The Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606). Available at: https://www.philhealth.gov.ph/about_us/IRR_NHIAct_2013.pdf#:~:text=The%20National%20Health%20Insurance%20Program%20(NHIP)%20administered%20by.

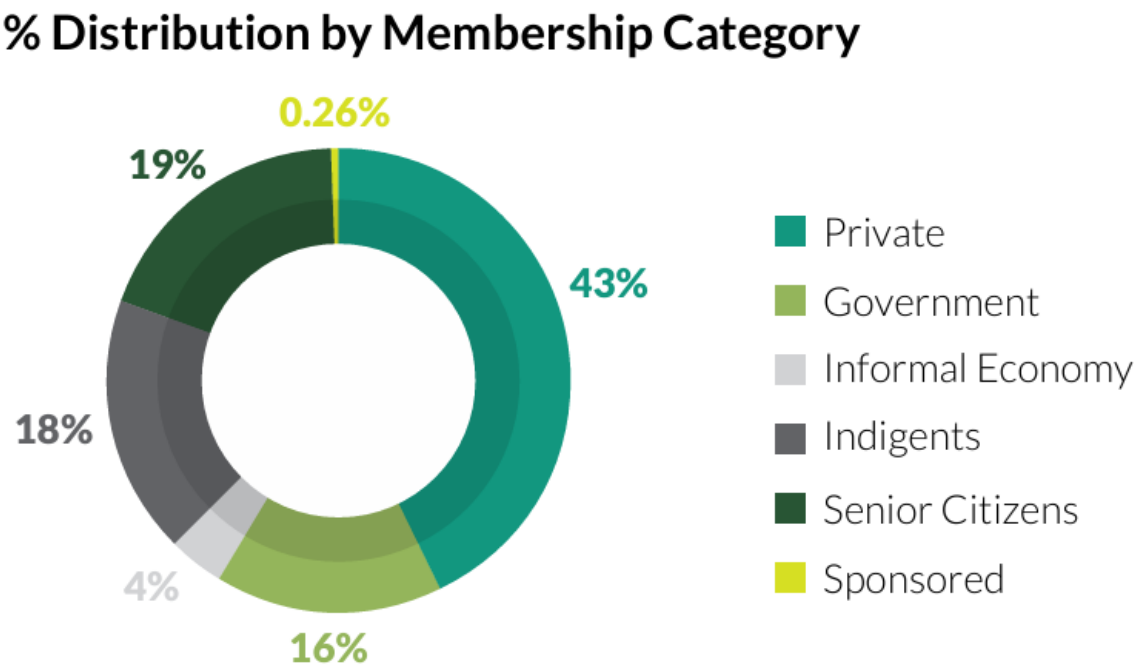
[198] The Global Goals for Sustainable Development, National Health Insurance Program. (accessed on 26th Oct. 2024) https://sdg.neda.gov.ph/national-health-insurance-program-nhip/.

[199] Bredenkamp, C., V. Gomez, and S. Bales, *Pooling Health Risks to Protect People: An Assessment of Health Insurance Coverage in the Philippines*, WORLD BANK GROUP (2017). available at https://documents1.worldbank.org/curated/en/770741512371309140/pdf/121816-WP-P133115-PUBLIC-Philippines-report-on-Pooling-Health-Risks-to-Protect-People.pdf

[200] Id

1. Contributory Health Insurance for the Formal Sector: This included private and government sector employees, continuing the functions of Medicare. Contributions are shared between the employer and employee.
2. Subsidized Health Insurance for the Poor: National and local governments finance the premiums of poor citizens, identified by the Department of Social Welfare and Development (DSWD) and provide them access to essential healthcare services without requiring direct contributions from them.
3. Voluntary Contributory Insurance for the Informal Sector: This allows informal sector workers to voluntarily contribute to PhilHealth. Their contributions are based on income and assets, with different contribution rates compared to the formal sector.

Fig.9: Distribution of Insured Across Different Membership Category in NHIP of Philippines



Source: Annual Report 2022

The program features different membership categories based on employment and income status, each with distinct contribution rates and copayment structures. However, the system ensures redistribution and cross-subsidization across these groups.

Fig.10: PhilHealth membership categories and contribution rates

Membership Group	Eligibility Criteria	Premium
1. Members in the formal economy	Those with formal contracts and fixed terms of employment, including workers in the government and private sector	Split equally between employer and employee: 2.5% of salary (1.25% employer and 1.25% employee), with minimum of PHP 2,400 and maximum of PHP 10,500 per year
2. Members in the informal economy	Those who are self-employed or lack a fixed-term contract	Paid fully by member. PHP 2,400 per year for those earning PHP 25,000 per month or less, and PHP 3,600 per year for those earning more than PHP 25,000 per month.
3. OFWs	(a) Sea-based Filipino workers or (b) land-based OFW	For sea-based Filipino workers, the premium contribution schedule of the formal economy group applies. For land-based OFWs, PHP 2,400 per year.
4. Indigents	The poor, identified through the DSWD's NHTS-PR/*Listahanan* targeting mechanism	Paid by national government: PHP 2,400 per principal member per year
5. Sponsored members	Those sponsored by local governments, individuals, other government agency, or private entities	Paid by sponsor: PHP 2,400 per principal member per year
6. Lifetime members	Those who have reached 60 years of age and have made at least 120 monthly contributions	No premiums to be paid
7. Senior citizens	Those who have reached 60 years of age and are not covered by any of the above membership types	Paid by national government: PHP 2,400 per principal member per year

Source: The World Bank

6.1 Financing the NHIP

Resources for PhilHealth are generated through premium collections and infusions of earmarked taxes from the national government. [201] While some of its money comes in through the government budget, the corporate identity and autonomous standing of PhilHealth1 allows it great flexibility to utilize its resources. Formal and informal economy members directly pay their premiums to PhilHealth. Premiums for indigents or vulnerable families are subsidized by the national government and are included within the budget proposal of the DOH.[202] A large proportion of this premium subsidy is sourced from revenues generated by sin taxes on alcohol, cigarettes and

[201] Health Financing in the Philippines, The Philippine UHC Law Series: Brief 3. Available at: https://thinkwell.global/wp-content/uploads/2020/12/PH-UHC-Law-Series_Health-Financing-final_updated.pdf
[202] Id

tobacco.[203] All the revenues from Sin Tax are allocated for health, of which 80% are for achieving UHC and 20% for medical assistance and the improvement of health facilities.[204] This has allowed PhilHealth to cover over 90% of the population.[205] According to the annual report 2022 of PhilHealth,[206] direct contributors make up roughly 63% of the total contributions, while indirect contributors (whose premiums are subsidized) make up 37%.

6.2 Risk Pooling Mechanism

Risk-pooling through health insurance institutions, whether public or private, reduces the unpredictability of health expenditure for the individual and distributes the burden of financing more evenly across the population.[207]

Philippines' National Health Insurance Program (NHIP) is a single risk pool that integrates contributions from all member groups—formal sector employees, indigents (subsidized members), and informal sector workers.[208] This unified pool offers significant advantages for achieving both efficiency and equity in healthcare financing through cross-subsidization.[209] Contributions from higher-income formal sector members are used to finance the healthcare costs of indigent members, and vice versa.[210] This cross-subsidy mechanism promotes equity, ensuring that poorer members of society have access to health services without being disadvantaged by their inability

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[203] Health Financing in the Philippines, The Philippine UHC Law Series: Brief 3. Available at: https://thinkwell.global/wp-content/uploads/2020/12/PH-UHC-Law-Series_Health-Financing-final_updated.pdf

[204] DEPARTMENT OF HEALTH, SIN TAX ANNUAL REPORT 2024. Available at: https://drive.google.com/file/d/1eeaOBNzTyoA9ayTLMGJGrhPsSBgI3Ylf/view.

[205] PHILHEALTH, *SECURING AND PROTECTING THE FILIPINOS' HEALTH THROUGH AN INNOVATIVE NHIP (2017 ANNUAL REPORT)*., 2017. Available at: https://www.philhealth.gov.ph/about_us/annual_report/ar2017.pdf.

[206] PHILHEALTH; ELEVATING CARE ENHANCING AND INNOVATING HEALTH CARE SERVICES FOR ALL FILIPINOS (ANNUAL REPORT) 2022. Available at: https://www.philhealth.gov.ph/about_us/annual_report/AR2022_v1.pdf

[207]Bredenkamp, C., V. Gomez, and S. Bales, *Pooling Health Risks to Protect People: An Assessment of Health Insurance Coverage in the Philippines*, WORLD BANK GROUP (2017). available at https://documents1.worldbank.org/curated/en/770741512371309140/pdf/121816-WP-P133115-PUBLIC-Philippines-report-on-Pooling-Health-Risks-to-Protect-People.pdf

[208] Id

[209] Bredenkamp, C., V. Gomez, and S. Bales, *Pooling Health Risks to Protect People: An Assessment of Health Insurance Coverage in the Philippines*, WORLD BANK GROUP (2017). available at https://documents1.worldbank.org/curated/en/770741512371309140/pdf/121816-WP-P133115-PUBLIC-Philippines-report-on-Pooling-Health-Risks-to-Protect-People.pdf

[210] Id

to contribute. Insurance, thus, redistributes from those at low risk of OOP spending on health care to those at high risk of OOP spending on health care.[211]

Furthermore, PhilHealth has moved from a fee-for-service model to a fixed case rate payment system for inpatient services to ensure uniform benefits across both government and private healthcare institutions.[212] Poor patients benefit from the "no balance billing" (NBB) policy, which forbids government-owned hospitals to charge patients (indigent, sponsored, senior, lifetime members) anything over and above what PhilHealth reimburses for case rates, Z-benefits and primary benefits at all accredited government health care institutions.[213]

[211] Bredenkamp, C., and L. Buisman; *Providing Financial Protection from Health Spending in the Philippines: Policies and Progress*; HEALTH POLICY AND PLANNING 31 (7): 919–2; (2016).
[212] PHILHEALTH, Guiding Principles of the Rationalized Inpatient Case Rates (2023). Available at: https://www.philhealth.gov.ph/circulars/2023/PC2023-0025.pdf
[213] PHILHEALTH, Strengthening the Implementation of No Balance Billing Policy (Revision 1) (2017). Available at: https://www.philhealth.gov.ph/circulars/2017/circ2017-0006.pdf

Chapter V

Findings, Conclusion and Recommendations

Findings

1. Inadequate infrastructure, staffing shortages, and systemic inefficiencies degrade the quality of healthcare under the NHIP.
2. Significant disparities in service distribution between urban and rural areas result in unequal access to healthcare.
3. Hasty referral systems and geographical imbalances in resource allocation make the NHIP an optional rather than essential choice.
4. Insufficient human resources delay claim processing and reimbursement, reducing program efficiency.
5. The absence of specific guidelines to counter fraudulent claims contributes to data duplication and resource misuse.
6. Current NHIP legislation is riddled with loopholes and ambiguities, often benefiting institutions over beneficiaries.
7. Centralization of authority within the Ministry of Health and Population allows excessive political interference in HIB operations.
8. The HIB is burdened with excessive jurisdiction but lacks the autonomy required for effective functioning.
9. Fragmented health insurance schemes place the financial burden solely on the central government, undermining federalism and creating fiscal strain.
10. The existence of multiple isolated health schemes causes inefficiencies in resource management and duplication of services.
11. Non-integration of formal sector insurance schemes, such as those for the military and civil services, limits risk pooling and reduces financial sustainability.
12. The absence of a co-payment cap exposes lower-income families to significant financial hardship, especially for high-cost chronic diseases.

13. The HIB lacks strategic purchasing power, limiting its ability to negotiate effectively with service providers.
14. The NHIP's lack of national portability restricts beneficiaries' access to services across different regions.

Conclusion

The National Health Insurance Program (NHIP) of Nepal is at a critical juncture, facing significant challenges that threaten its effectiveness, accessibility, and long-term sustainability. There are inefficiencies in the system, over dependence on the central government, non-inclusion of province and local governments for finances and issues of governance which have been a hindrance to the progress and attractiveness of the Program. Reform measures aimed at improving operations, ensuring equity or fairness in distribution of healthcare services and enhancing outreach or public trust to the contrary program are needed in such a context. The plans and policies should be oriented towards promoting the practices of engaging both Government at Federal, Provincial and Local levels as well as Innovative financing approaches.

Nepal's National Health Insurance Program (NHIP) could become more inclusive, sustainable, and equitable through integrated reform of existing health schemes, coordinated under a centralized authority. The current fragmentation among insurance schemes weakens resource management, hampers risk pooling, and prevents cross-subsidization across different income groups. By consolidating resources, NHIP could enable better service delivery and equitable financial protection. Adopting earmarked taxes on alcohol, tobacco, and sugary drinks, similar to the Philippines, would also create dedicated funding streams, while an income-based premium model would allow wealthier participants to subsidize costs for lower-income families. Given the low levels of the public's appetite to use the scheme, a different and more active complement and public information strategies will ensure that there will be more participation in the scheme.

Improvements in public health facilities are essential to build public trust; implementing quality monitoring systems and partnerships with private facilities could alleviate pressure on public services, enhance care standards, and improve NHIP's credibility. Additional reforms, like cost-sharing caps based on income and expanded NHIP coverage for essential medicines, would shield vulnerable families from catastrophic health expenses. Transportation subsidies or mobile health services would further address accessibility gaps in rural areas, helping NHIP reach underserved communities. Further, community outreach programs would build awareness and acceptance of NHIP, fostering trust, particularly in rural areas. Comprehensive reforms across infrastructure, policy, finance, and governance are crucial to revitalizing the NHIP and ensuring it delivers

equitable, accessible, and high-quality healthcare for all Nepalese citizens. With a strategic, collaborative, and well-governed approach, the NHIP has the **potential** to be a cornerstone of Nepal's path towards achieving sustainable health security and universal health coverage.

Recommendations

1. Address Fragmentation of Health Schemes: Separate health insurance schemes (such as those for army personnel, police, and civil servants) should be integrated under a unified National Health Insurance Program (NHIP) that would allow for consolidated resources and reduce service duplication providing comprehensive coverage and pool risks more effectively.
2. Reformation of legislation: The contradictory and hasty provisions of Health Insurance Act, Regulation and directives should be reviewed and amended enabling demanding interest in the scheme and less room for vague interpretation.
3. Strengthening Financial Resource Management: Adopting the Philippines' model, Nepal could levy taxes on products like alcohol, tobacco, and sugary drinks, earmarking these funds for the NHIP to reduce the financial burden on government budgets, and expand NHIP funding.
4. Risk Pooling and Resource Redistribution Mechanism: Integrating all the public health insurance schemes to NHIP, Nepal could unify its risk pool to include all insured groups like formal employees, the poor, and informal sector workers which can allow contributions from wealthier or lower-risk groups to cross-subsidize for poorer or higher-risk individuals, promoting financial sustainability and social equity.
5. Enhancing Financial Protection and Accessibility: Nepal should introduce a cost-sharing model that includes an annual maximum out-of-pocket cap based on annual income to provide greater financial protection and attract more people to enroll and use the NHIP services with cost subsidization for the ultra-poor group of people.
6. Improve Quality of Care in Public Health Facilities: The concerned authority should focus on implementing a robust monitoring and evaluation system for regular assessments of service quality provided under NHIP in public facilities to build public confidence.
7. Reduce Out-of-Pocket Expenditures (OOPE): Expand coverage of essential medicines within the NHIP to reduce OOPE, as a majority of OOPE currently goes toward pharmaceuticals.
8. Increasing Awareness and Trust in NHIP: Implementing community outreach programs and health literacy campaigns could be transformative for Nepal’s National Health Insurance Program (NHIP), especially in rural and underserved areas where awareness about the program may be limited

9. Development of Public-Private Partnership: Public-Private partnerships should be developed in order to bridge infrastructure gaps and enhance service delivery capacity.
10. Reducing the disparity in Urban vs Rural Area: Mobile health units should be deployed along with adoption of a geographical resource allocation assessment to reduce urban vs rural area disparities
11. Standardize the referral protocols: Hasty and unnecessary referrals should be eliminated through a directive which should act as a mandatory and strict guidelines to facilitate the referral mechanism.
12. Use of automated mechanism in Fraudulent Claim detection: The current manual working mechanism is hasty and non-effective due to inadequate human resources, it should be replaced with an automated detection mechanism to reduce cost and reimbursement time.
13. Three tier government collaboration: The province and local government should be included share in financial cost of the scheme, thus enabling effective risk-pooling mechanism reducing financial hardship in central level.
14. Reformation in the structure of HIB: The HIB should be restructured with inclusion of additional member positions from distinct areas of insurance, commercial law, data analytics and policy-specialist and HIB should be reformed as a regulatory and supervisory body disseminating the action-oriented functions through different autonomous institutions under the board.

ANNEX

1. List of 57 types of medicines provided for free at Basic Health Service Centers/Health Posts, Primary Hospitals, and Primary Healthcare Centers

1. Acetylsalicylic acid (aspirin)
2. Adrenaline (epinephrine)
3. Albendazole
4. Aluminium hydroxide gel + Magnesium hydroxide (Antacid)
5. Amitriptyline
6. Amlodipine
7. Amoxicillin
8. Ampicillin
9. Artesunate
10. Atropine
11. Azithromycin
12. BCG Vaccine
13. Calamine
14. Calcium gluconate
15. Carbamazepine
16. Cetirizine HCL
17. Charcoal, activated
18. Chlorhexidine (CHX)
19. Chloroquine (CQ)
20. Ciprofloxacin
21. Clotrimazole
22. Clove Oil
23. Cloxacillin
24. Combined Oral Contraceptive (COC)
25. Cotrimoxazole (Sulphamethoxazole and Trimethoprim 5:1)
26. Dapsone, Clofazimine, Rifampicin (MDT Combi Pack)
27. Diazepam
28. Diclofenac Sodium
29. Doxycycline
30. Ferrous sulphate and folic acid
31. Folic acid
32. Furosemide
33. Gentamicin
34. Gentian Violet

35. Glimepiride
36. Levonorgestrel (LNG)
37. Lignocaine hydrochloride
38. Lignocaine with adrenaline 1:10,000
39. Magnesium sulphate
40. Metformin
41. Metoclopramide
42. Metronidazole
43. Misoprostol
44. Neomycin Skin
45. Nitrofurantoin
46. Normal Saline (NS)
47. Oral Rehydration Salts (ORS)
48. Oxymetazoline
49. Paracetamol
50. Povidone iodine
51. Prednisolone
52. Pyridoxine
53. Ranitidine
54. Ringer's Lactate (RL)
55. Salbutamol
56. Silver Sulfadiazine
57. Zinc sulphate

ANNEX

2. Three columns comment on the necessary amendments in Health Insurance Act 2074, Health Insurance Regulations 2075, Social Security Act 2075, Contribution Based Social Security Act 2074 and Labour Act 2074.

स्वास्थ्य बिमा ऐन २०७४

हालको व्यवस्था	कारण	प्रस्तावित संशोधन
३. स्वास्थ्य बीमा कार्यक्रममा आवद्ध हुनेः (१) प्रत्येक नेपाली नागरिक स्वास्थ्य बीमा कार्यक्रममा आवद्ध हुनु पर्नेछ ।	यस दफालाई संशोधन गरी स्वास्थ्य बिमा कार्यक्रममा नागरिकहरु अनिवार्य आवद्धहुने व्यवस्था गर्ने।	दफा ३ (१) मा "अनिवार्य" भन्ने शब्द थप्ने।
दफा ३ को उप दफा(४) प्रचलित कानून बमोजिम राष्ट्र सेवक मानिने व्यक्ति तथा बैदेशिक रोजगारीमा जाने कामदारको परिवारले स्वास्थ्य बीमा कार्यक्रममा आवद्ध हुनु पर्नेछ ।	दफा ३को उपदफा (१) प्रत्येक नेपाली नागरिक स्वास्थ्य बीमा कार्यक्रममा आवद्ध हुनु पर्नेछ भन्ने व्यवस्था हुदा हुदै सोहि दफाको उपदफा (४) मा राष्ट्र सेवक मानिने व्यक्ति तथा बैदेशिक रोजगारीमा जाने कामदारको परिवारले स्वास्थ्य बीमा कार्यक्रममा आवद्ध हुनु पर्नेछ भन्ने व्यवस्था हुदा स्वास्थ बिमा कस्को लागि बाध्यकारी हो कस्को लागि voluntary हो भन्ने विषयमा दुविधा गरेको देखिन्छ। तसर्थ, सबै नेपाली नागरिकलाई अनिवार्य गराउन कुनै वर्गलाई अनिवार्य गर्न पर्दैन।	दफा (३)को उप-दफा (४) लाई हटाउन पर्ने ।
दफा ३ मा नँया उप-दफा थप्ने	संगठित संस्थाका कर्मवारीलाई अनिवार्य स्वास्थ्य बिमा कार्यक्रममा आवद्ध गर्न।	प्रचलित कानुन बमोजिम स्थापित संगठित संस्थाका रोजगारदाताले

		आफु मातहत काम गर्न श्रमिकलाई स्वास्थ बिमा कार्यक्रममा आवद्ध गराउनु पर्नेछ।
दफा ५ सेवा	हालको व्यवस्थाले सिमित सुविधा प्रदान गर्ने र risk polling समेत सिमित हुने हुँदा साविकको सेवाको प्रावधान पुर्णरुपले हटाई सेवालाई बृहत बनाउनु पर्ने। जस्तै (1) आधारभुत स्वास्थ बिमा (2) प्रिमियम स्वास्थ्य बिमा यस्तो सेवा अन्तर्गत प्राप्त हुने सुविधाहरु तोकिए बमोजिम हुने भने नियमावलीमा व्यवस्था गर्ने।	
दफा ७	ऐनको परिभाषा खण्डमा सह-भुक्तानीको परिभाषा गर्नु पर्ने।	
दफा १० संग सम्बन्धित	ऐन को दफा २(ठ)(१)(२)(३)(४)(५)(६) ले सेवा प्रदायक भनी स्वास्थ्य सेवा उपलब्ध गराउन निकाय तोकी सकेकोमा दफा १०(१) ले सुरुमा सेवा लिदा उपखण्ड (१) बमोजिमको स्वास्थ्य संस्था बाट सेवा लिनु पर्नेछ भनी तोक्नुले उपखण्ड (२)(३)(४)(५)(६) अन्तर्गतको सेवा प्रदायकले बाट सेमत सेवा प्राप्त गर्न सक्ने दफा १० लाई संशोधन गर्नु पर्ने। कुनै पनि वर्गको सेवा प्रदायक लाई प्राथमिकता दिनु उचित नभएकाले बिमितले आफुलाई पायक पर्ने गरी २(ठ) ले व्यवस्था गरे बमोजिमको जुन सुकै पनि सेवा प्रदायक मार्फत सेवा भुक्तान लिन मिल्ने गरी ऐन संशोधन गर्नु पर्ने।	

दफा ९	स्वास्थ बिमा कार्यक्रमलाई universal बनाउनको निमित्त अनिवार्य रुपले सेवा प्रदायक बनाउने। सम्झौता गर्ने प्रावधान हटाउने।	
दफा ११	मौजुदा ऐन र नियमावलीले क्यापिटेशन शुल्क, प्रति केस रकम, प्रति सेवा शुल्क परिभाषित नभएको हुँदा परिभाषित गर्नु पर्ने।	
दफा ३२ संग सम्बन्धित	दफा ३१ अन्तर्गत सेवा प्रदायकले सेवा प्रदान नगरेमा, सेवा प्रदान गर्न् ढिला सुस्ती गरेमा वा निर्धारित सेवास्तर भन्दा न्यून गुणस्तरको सेवा प्रदान गरेकोमा उजुरि परेमा हुने सजाय अन्तर्गत तोकिएको पन्ध्र हजार देखि पच्चिस हजार सम्मको जरिवाना भन्दा बिमित लाई भएको क्षती बढी भएको अवस्थामा के हुने? सोहि दफामा पन्ध्र हजार देखि पच्चिस हजार सम्मको जरिवाना वा बिमित लाई भएको क्षती जुन बढी छ त्यही बमोजिम हुने व्यव्स्था राख्नु उचित हुने वा नहुने?	
	स्वास्थ्य बिमा ऐन एक सेवाप्रदायक (Beneficial) ऐन भएकाले गर्दा मनासिब क्षतीपुर्ती को समेत व्यवस्था समावेस गरीनु पर्ने।	

हालको व्यवस्था	समस्या	संशोधित
नियम ३ को उप नियम (६)- यस नियममा अन्यत्र जुनसुकै कुरा उल्लेख भएको भए तापनि सत्तरी वर्ष उमेर पुगेका प्रत्येक जेष्ठ नागरिकलाई एक एकाइ मानी कार्यक्रममा आवद्ध गर्नु पर्नेछ ।	Risk pooling principle मा आधारित भई सत्तरी वर्ष उमेर पुगेका प्रत्येक जेष्ठ नागरिकलाई एक एकाइ मानी कार्यक्रममा आवद्ध भए जस्तै अन्य दिर्घ रोगीहरु पनि एक एकाइ मानी कार्यक्रममा आवद्द गर्नु पर्ने।	यस नियममा अन्यत्र जुनसुकै कुरा उल्लेख भएको भए **तापनि सत्तरी वर्ष उमेर पुगेका प्रत्येक जेष्ठ नागरिक र दिर्घ रोग भएका नागरिकलाई** एक एकाइ मानी कार्यक्रममा आवद्ध गर्नु पर्नेछ ।
नियम ६(३) दर्ता सहयोगीले उपनियम (१) बमोजिम परिचयपत्र प्रदान गर्दाको बखत बीमितले पाउने सेवा सुविधा सम्बन्धमा सम्पूर्ण जानकारी दिनु पर्नेछ ।	बिमितले पाउने सेवा शुल्क बारे के कति जानकारी सम्प्रेषण भईरहेको छ भन्ने कुरा को मुल्याङ्कन गरिनु पर्ने (Implementation issue)	
नियम ७(१) बीमितले सेवा प्रदायकहरूमध्ये कुन सेवा प्रदायकबाट उपचार सेवा लिने हो सो कुराकार्यक्रममा आबद्ध हुँदाको बखतमा रोज्नु पर्नेछ	बिमितले आबद्ध हुदाकै बखतमा प्रथम स्वास्थ्य सेवा विन्दु रोज्नु पर्ने भन्ने व्यवस्थाले बिमितले स्वास्थ बिमाको प्रदान गर्ने स्वास्थ सेवाको सहज पहुचँलाई असर गर्ने साथै यसम व्यवहारीक समस्या समेत पर्ने हुदा प्रथम स्वास्थ्य सेवा विन्दु रोज्नु पर्ने	नियम ७(१) बीमितले सेवा प्रदायकहरू मध्ये **कुनै दुई सेवा प्रदायकबाट उपचार सेवा लिने हो** सो कार्यक्रममा आबद्ध हुँदाको बखतमा रोज्नु पर्नेछ। **यसरी दुई सेवा प्रदायकलाई रोज्द प्रथम सेवा प्रदायक र दितिय सेवा प्रदायक पनि छुटाउनु पर्नेछ।**

	भन्ने व्यवस्थाले संशोधन गरि प्रथम र दितिय स्वास्थ्य सेवा विन्दु रोज्न व्यवस्था गर्ने र उपचार गराउन परेको बखत सबै भन्दा पायक पर्ने स्वास्थ सेवा प्रदायकबाष सेवा लिन सक्ने व्यवस्था गर्नु पर्ने।	**आवस्यकता अनुसार जुन सेवा प्रदायकबाट उपचार सेवा लिन पायक पर्छ सोहो बाट उपचार लिनु पर्नेछ।**
नियम ८ (१) बीमितले नियम ६ को उपनियम (४) बमोजिमको अवधि समाप्त हुनुभन्दा एक महिना अगावै अनुसूची-३ बमोजिमको ढाँचाको निवेदन सहित योगदान रकम संलग्न गरी नवीकरणको लागि निवेदन दिनु पर्नेछ ।	नविकरण को निम्ती एक महिना अगावै निवेदन दिनु पर्ने कुरामा समय अवधि बारे संसोधन आवश्यक रहेको। स्वास्थय सेवा बिमाको जनतामाझ थप आकर्षण पुर्याउनका निमित्त नविकरणका लागी भूक्तानी रकम अनलाईन मार्फत नै तिर्ने व्यवस्था मिलाई कुनै समय अवधी नराखी Auto-renewal प्रणालीमा जान तर्फ विचार गर्नु पर्ने।	(१) बीमितले नियम ६ को उपनियम (४) बमोजिमको **अवधि समाप्त हुन लागेमा वा भएमा** अनुसूची-३ बमोजिमको ढाँचाको निवेदन सहित योगदान रकम संलग्न गरी नवीकरणको लागि निवेदन दिनु पर्नेछ ।
नियम ११(२) (ख) कार्यक्रमको बारेमा जनचेतनामूलक कार्यक्रम सञ्चालन गर्ने, गराउने,	जनचेतनामुलक कार्यक्रम के कति काम भएका छन् र आगामी दिन हरुमा के कस्तो रणनिति आवश्यक पर्दछ भन्ने कुरामा अनुसन्धान आवश्यक रहेको। स्वास्थ्य बिमा सेवाको बिस्तार गरिने वा संल्ग्न हुने जनताको संख्या बढाउने निति	

	रहेको हुनाले गर्दा स्वास्थय बिमाका निमित्त agent बाट बिमा गराउने व्यवस्था भन्दा हामिले नजिकैको स्वास्थय सेवा क्लिनिक वा हेल्थ पोष्ट मार्फत पनी बिमा गराउन सकिने व्यवस्था राखी बिमित आफुले चाहेको अवस्थामा स्वयमले बिमा गराउन सकिने व्यवस्था लागु गर्न सकिने। (implementation issue)	
नियम १५. योगदान रकम : (१) कार्यक्रममा आबद्ध हुँदा लाग्ने योगदान रकम अनुसूची-१ बमोजिम हुनेछ । (२) प्रतिष्ठानको हकमा सो प्रतिष्ठानले व्यहोर्ने योगदान रकमको अनुपात राष्ट्रसेवक कर्मचारीहरुका लागि तोकिएको योगदान रकमभन्दा कम हुने छैन। (३) बीमितको कार्यक्रम अन्तर्गत उपलब्ध हुने सुविधाको लागि तोकिएको कुनै पनि रकम खर्च नभई अर्को वर्ष नियमित	नियम १५(२) को भाष्य प्रष्ट नभएको र नियिम १५(५) अन्तरगत कुनै बिमित को मृत्यु भएमा र बिमा अन्तरगत को रकम बचेमा के हुने भन्ने बारे अध्ययन जरुरी रहेको। (Implantation issue)	

नवीकरण भएमा बीमितलाई योगदान रकममा दश प्रतिशत छुट हुनेछ । (४) बीमितले कार्यक्रममा सहभागी हुन तिरेको रकम कुनै पनि कारणबाट फिर्ता हुने छैन र सो रकम सेवा उपयोग नगरेको कारणले अर्को वर्षको लागि सञ्चित भएको पनि मानिने छैन।		
नियम १६. व्यहोर्ने योगदान रकम (१) कार्यक्रममा आबद्धताको लागि नेपाल सरकार, प्रदेश सरकार वा स्थानीय तहले व्यहोर्ने योगदान रकम देहाय बमोजिम हुनेछ :- (क) प्रचलित कानून बमोजिम अति गरिबको परिचयपत्र प्राप्त परिवारको [योगदान रकमको शतप्रतिशत, (ख) अति अशक्त अपाङ्गता, कुष्ठरोगी, एच.आई.भी. सङ्क्रमित, जटिल खालका क्षयरोग (एम.डि.आर.टि.वि.) बिरामी भएकाको परिवारको योगदान रकमको शतप्रतिशत,	यसमा नियम १६ ले वर्गिकृत गरेको समुहहरुलाई बिमा रकम एकल बेहोर्ने हो वा एक एकाई मानी बेहोर्ने हो? Risk pooling principle लाई यसमा नियममा आत्मसाथ गर्नु पर्ने हो (Implementation issue)	

(ग) सत्तरी वर्ष उमेर पुगेका जेष्ठ नागरिकको योगदान रकमको शतप्रतिशत, (घ) महिला स्वास्थ्य स्वयंसेविका संलग्न भएको परिवारको योगदान रकमको पचास प्रतिशत । (२) उपनियम (१) मा जुनसुकै कुरा लेखिएको भए तापनि प्रदेश सरकार वा स्थानीय तहले नेपाल सरकारबाट अनुदान प्राप्त गरी वा आफ्नै स्रोतवाट आर्थिक रुपले विपन्न तथा गरिव लगायतका लक्षित वर्गको लागि स्वास्थ्य बीमा कार्यक्रम सजालन गरेको अवस्थामा सोको लागि नेपाल सरकारले थप योगदान रकम व्यहोर्ने छैन।		
परिच्छेद -५ सेवा प्रदायक स्वास्थ्य संस्थाको सूचीकरण र सेवा प्रदान गरे बापतको रकमको भुक्तानी	परिच्छेद -५ अन्तरगत को विषय लाई real time claim settlement अन्तरगत विस्तृत रुपमा हेर्नु पर्ने।	
नियम २७ दाबी समीक्षा र मल्याङ्कन समिति बोर्डले कार्यक्रम अन्तर्गत सेवा प्रदायकबाट प्रदान	नियम २७ अन्तरगत को दाबी समिक्षा र मुल्याङ्कन समितिको काम कर्तव्य हेर्दा यसले सेचा	दाबी समीक्षा र मल्याङ्कन समिति बोर्डले कार्यक्रम अन्तर्गत सेवा प्रदायकबाट प्रदान गरिने सेवा बापत

गरिने सेवा बापत भुक्तानी हुनु पर्ने रकमको लागि बीमा व्यवस्थापन सूचना प्रणाली मार्फत प्राप्त दाबीहरुको भुक्तानी गर्ने प्रक्रियाको सम्बन्धमा कुनै विवाद देखिएमा सो विषयमा आवश्यक छानविन गरी सिफारिस गर्ने प्रयोजनको लागि देहाय बमोजिमको एक दावी समिक्षा तथा मूल्याङ्कन समिति गठन गर्न पर्नेछः (क) विशेषज्ञ चिकित्सक- संयोजक (ख) रेडियोलोजिष्ट- सदस्य (ग) प्याथोलोजिष्ट- सदस्य (घ) नर्सिङ्ग अधिकृत- सदस्य (ङ) फर्मासिष्ट- सदस्य (च) जनस्वास्थ्य विज्ञ- सदस्य (छ। बोर्डको अधिकृत स्तरको- कर्मचारी सदस्य-सचिव	प्रदायक र बिमा बोर्ड बिचको विवाद समाधानको लागि गठन हुने समिति भएकाले यस समितिमा बोर्डको अधिकृत स्तरको- कर्मचारी लाई सदस्य सचिव बनाउदा conflict of interest देखिन सक्ने हुदा, यस दाबी समीक्षा र मल्याङ्कन समितिलाई बोर्डको कर्माचरी राख्न नहुने।	भुक्तानी हुनु पर्ने रकमको लागि बीमा व्यवस्थापन सूचना प्रणाली मार्फत प्राप्त दाबीहरुको भुक्तानी गर्ने प्रक्रियाको सम्बन्धमा कुनै विवाद देखिएमा सो विषयमा आवश्यक छानविन गरी सिफारिस गर्ने प्रयोजनको लागि देहाय बमोजिमको एक दावी समिक्षा तथा मूल्याङ्कन समिति गठन गर्न पर्नेछः (क) विशेषज्ञ चिकित्सक- संयोजक (ख) रेडियोलोजिष्ट- सदस्य (ग) प्याथोलोजिष्ट- सदस्य (घ) नर्सिङ्ग अधिकृत- सदस्य (ङ) फर्मासिष्ट- सदस्य (च) जनस्वास्थ्य विज्ञ- सदस्य (छ) **स्वास्थ मन्त्रालयले तोकेको अधिकृत स्तरको- कर्मचारी सदस्य-सचिव**

सामाजिक सुरक्षा ऐन, २०७५

हालको व्यवस्था	कारण	संशोधन
दफा २ (झ) संग सम्बन्धित	ऐनले स्वास्थ्य बिमालाई समाजिक सुरक्षा भित्र समेटेको छैन। नेपाल सरकारले नसक्ने नगरिकलाई बिमाको किस्ता तिरिदिन यस दफामा स्वास्थ बिमालाई थप गर्ने गरी संशोधन गर्नु पर्ने।	दफा २ को खण्ड (झ) मा रहेको "वा सहायता" भन्ने शब्दहरु पछि **"तथा स्वास्थ्य बिमा कार्यक्रममा आवद्ध भई भुक्तानी गर्ने प्रिमियम"** भन्ने शब्दहरु थप्ने।
दफा ३ सँग सम्बन्धित	स्वास्थ्य बिमा कार्यक्रमलाई सामाजिक सुरक्षामा समेट्न	दफा ३ को उपदफा (२) मा "भत्ताहरु" भन्ने शब्दपछि "एवम् स्वास्थ्य बिमा प्रिमियम" भन्ने शब्दहरु थप्ने।
दफा १० पछि "**स्वास्थ्य बिमा प्रिमियम**" सँग सम्बन्धित दफा १०क थप्ने	ऐनमा स्वास्थ्य बिमा कार्यक्रम थप्न	ऐनको दफा १० पछि देहाय बमोजिमको दफा १०क थप्ने: "१०क. **स्वास्थ्य बिमा प्रिमियम** — (१) जेष्ठ नागरिक, अपाङ्गता भएका, आर्थिकरुपले विपन्न व्यक्तिको स्वास्थ्य बिमा प्रिमियम नेपाल सरकारले व्यहोर्ने छ। (२) उप-दफा (१) बमोजिम स्वास्थ्य बिमा प्रिमियम दिने प्रक्रिया प्रचलित स्वास्थ्य बिमा ऐन र नियमावलीमा तोकिए बमोजिम हुनेछ।"
दफा १३ संग सम्बन्धित	वर्तमान व्यवस्था अनुसार, नेपाली नागरिकले एकैपटक दुई प्रकारका सामाजिक सुरक्षा लाभहरू प्राप्त गर्न पाउँदैनन्। यसले नागरिकहरूलाई आर्थिक भत्ता (financial allowances) र स्वास्थ्य बिमा (Health insurance) मध्ये एक रोज्नुपर्ने अवस्थामा पुर्याउन सक्छ।	ऐनको दफा १३ को उप-दफा (३) पछि देहाय बमोजिम उप-दफा (४) थप्ने: "(४) यस दफामा जुनसुकै कुरा उल्लेख भएको भएता पनि स्वास्थ्य बिमा प्रिमियमको हकमा नागरिकले दोहोरो सुरक्षा भत्ता पाउन सक्नेछ।"

योगदानमा आधारित समाजिक सुरक्षा ऐन २०७४

हालको व्यवस्था	संशोधन सुझाव	संशोधनको कारण
दफा १०ः **सामाजिक सुरक्षा योजना सञ्चालन गर्ने** : (१) कोषले यस ऐनको अधीनमा रही देहायका सामाजिक सुरक्षा योजनाहरु सञ्चालन गर्नेछ :- (क)औषधि उपचार तथा स्वास्थ्य सुरक्षा योजना, (ख) मातृत्व सुरक्षा योजना, (ग) दुर्घटना सुरक्षा योजना, (घ) अशक्तता सुरक्षा योजना, (ङ) वृद्ध अवस्था सुरक्षा योजना, (च) आश्रित परिवार सुरक्षा योजना, (छ) बेरोजगार सहायता योजना	दफा (१०) को उप-दफा (१) को खण्ड (क) लाई हटाउने	दफा (१०) को उप-दफा (१) को खण्ड (क) मा उल्लेख भएका विषयहरु स्वास्थ बिमा कोष मार्फत सम्बन्धन हुने हुँदा सामाजिक सुरक्षा कोषको योजनाबाट हटाउनु उपयुक्त हुने

श्रम ऐन, २०७४

हालको व्यवस्था	समस्या	संशोधनको सुझाव	संशोधनको कारण
दफा ५४ः **औषधि उपचार बीमा गराउनु पर्नेः** (१) रोजगारदाताले प्रत्येक श्रमिकको कम्तीमा वार्षिक **एक लाख रुपैयाँ** बराबरको औषधि उपचार बीमा गराउनु पर्नेछ । (२) उपदफा (१) बमोजिमको बीमा गर्दा लाग्ने बीमा शुल्क रोजगारदाताले र श्रमिकले आधाआधा व्यहोर्नु पर्नेछ ।	यो कामदारहरूको स्वास्थ्य संरक्षणतर्फको सकारात्मक कदम भए तापनि, एक लाख रुपैयाँले ठूला स्वास्थ्य उपचारका खर्चहरू धान्न नसक्ने सम्भावना छ। साथै, बिमा शुल्कको केही भाग कामदारहरूबाट लिँदा न्यून आय भएका कामदारहरूलाई आर्थिक बोझ पर्न सक्छ, जसले उनीहरूलाई आधारभूत स्वास्थ्य सेवामा पहुँच गर्न थप कठिन बनाउँछ।	(1) दफा ५४ को उप-दफा (१) मा रहेको "एक लाख रुपैँया" हटाई "प्रचलित स्वास्थ्य बिमा सँग सम्बन्धित कानुनमा तोकिए बमोजिमको रकम" राख्ने (2) उप-दफा (१) पछि देहाय बमोजिम उप-दफा (२) राखी त्यसपछिको साबिकको उप-दफा क्रम मिलाई देहाय बमोजिम राख्ने "(२) उप-दफा बमोजिम रोजदारदाताले श्रमिकको औषधी उपचार गराँदा प्रचलित स्वास्थ बिमा ऐन बमोजिम गराउनु पर्नेछ।	औषधी उपचारको सिमा ५ लाख बनाउन र संगठित संस्थाले आफ्नो श्रमिकको स्वास्थ बिमा नेपाल सरकारको स्वास्थ बिमा कार्यक्रम मार्फत गराउन अनिवार्य पार्न।

		(३) उपदफा (१) बमोजिमको बीमा गर्दा लाग्ने बीमा शुल्कको एक चौथाई रोजगारदाताले व्यहोर्नु पर्नेछ भने बाँकी श्रमिकले व्यहोर्नु पर्नेछ ”	

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