

**WILLINGNESS OF COMMUNITY PEOPLE TO PAY FOR HEALTH  
INSURANCE IN NEPAL**

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## **Abstract**

Nepal is one of the poorest countries in the world where majority of the people earn less than one US dollar a day. Due to the low income, more than 60% of the household annual income is spent for food and there would be less income left for health care and other needs. However, HMG, Nepal is planning to implement community based health insurance scheme where people are expected to pay for the health services. The key question comes whether or not community people would be willing to pay for it. This study endeavors to find out the willingness of community people to pay for the health insurance.

The study was done in Lalitpur, Morang and Sunsari Districts. In Lalitpur District, UMN has implemented the Lalitpur Medical Insurance Scheme and in Morang and Sunsari District BPKIHS has implemented the Social Health Insurance. This study covers willingness as knowledge, satisfaction, participation and ability to pay in the two health insurance schemes. It also covers willingness as ability to pay in the area where the schemes are not implemented. This is a qualitative descriptive study. Total seven Focus Group Discussions were conducted in these districts.

In the study the FGD participants in LMIS have good knowledge of the scheme and have high-level of satisfaction to the scheme since the essential health care services are available locally through the scheme. The people in the scheme think that the premium is affordable and are willing to pay for the scheme. They highly recommend that the scheme should be replicated to other rural health institutions. Although, there is limited participation from the general members of the scheme, the scheme has strengthened the local HPs and has established the good referral system in the health care system of the district.

The participants in the SHI have good knowledge of the scheme and are generally satisfied with the access to the health care services in the hospital through the scheme. They are able and willing to pay for the scheme. However, they have comments on the quality of the services and benefit packages. There is no real participation from the community in the decision making process of the scheme. The people in the SHI implemented area have higher expectation

on the level of the services and were also willing to pay for it. It may be due to the higher socio-economic status of the community.

The people in the area where the schemes are not implemented are also able and willing to pay for the health care services. In these areas, the local health institutions are very underutilized and people are paying high expenses for health services outside local health institutions. They expressed their willingness to pay if the health care services are available locally.

People are willing to pay for the health insurance schemes if it is affordable and quality care is made available. Therefore, the schemes could be implemented in Nepal. The LMIS is especially appropriate for the primary health care level.

## **Recommendations**

People are willing to pay for the health insurance schemes if it is affordable and quality care is made available. Therefore, the schemes could be implemented in Nepal. The LMIS is especially appropriate for the primary health care level.

The health insurance cannot be thought in isolation. Proper organization of the appropriate level of health services is a pre-requisite for implementing the health services. Therefore, the health services should be well managed before implementing the schemes in the country.

The health institutions where the schemes are implemented need to be linked to the appropriate level of health care system for referral so that they would function in proper system.

Awareness about the health insurance scheme is vitally important at the community level so that people understand the benefits of the scheme. Therefore, promotional activities should be organized about the scheme to encourage people to get enrolled.

Participation of the members of the scheme is important to make them feel ownership on the scheme and the health services. A system and mechanism should be developed to ensure that the voices of the members would be recognized and heard.

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## **List of abbreviations**

<b>BPKIHS</b>	<b>PB Koirala Institute of Health Sciences</b>
<b>CDHP</b>	<b>Community Development and Health Project</b>
<b>FGD</b>	<b>Focus Group Discussion</b>
<b>HMGN</b>	<b>His Majesty's Government of Nepal</b>
<b>HP</b>	<b>Health Post</b>
<b>HPC</b>	<b>Health Post Committee</b>
<b>LMIS</b>	<b>Lalitpur Medical Insurance Scheme</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>NPC</b>	<b>National Planning Commission</b>
<b>NGO</b>	<b>Non-government Organization</b>
<b>OPD</b>	<b>Out Patient Door</b>
<b>SHI</b>	<b>Social Health Insurance</b>
<b>SHP</b>	<b>Sub-Health Post</b>
<b>UMN</b>	<b>United Mission to Nepal</b>
<b>UNICEF</b>	<b>United Nations Children's Emergency Fund</b>
<b>VDC</b>	<b>Village Development Committee</b>

# **Part I**

## **Introduction**

### **1.1. Introduction**

Although the physical access to the health services for the community people has significantly improved in Nepal in general, access to the quality health care is extremely poor. According to a survey done in 1998, only 8% of those who seek health care content with the services they receive (UNDP 2001). The quality and access of the health service is much poorer especially in the rural health institutions. Therefore, universal access to primary health care services to the poor and disadvantaged is a big challenge for the health care system in Nepal.

There are several reasons for the poor access to quality health care services in the country. One of them is shortage of or irregularities of health workers in the institutions. Another important reason is the lack of timely and adequate medical supplies and supporting facilities in the health institutions. Poor management system is another reason for unavailability or poor quality services.

However, shortage or poor mobilization of resources is the fundamental reason for poor health services in the country. Although the public investment in health care has increased significantly from 3.2% of the national budget in FY 1993/94 to 5.7% in FY 1999/00 in the country, the per capita public health expenditure in Nepal is among the lowest in the world. The country's public health expenditure is only US\$ 2 per person per annum compared to the average per capita cost of US\$ 12 for primary health care cost alone for the developing countries. As a result of the low public expenditure in health, private sector has to compensate the expenditure. The data shows that people pay 76% of the health expenditure from out of pocket. This fact vaguely indicates that there is a considerable scope for recovering the cost of health expenditure from the private household.

The His Majesty's government of Nepal (HMGN), Ministry of Health (MOH) has a plan to adopt alternative health financial schemes to make up the health service expenditures. As a



result, they have brought a “Policy for Drug Financing Schemes” in 2000 (MOH 2000). The government has also highlighted the program for implementing the community based health insurance as a pilot program in the country.

In fact, there are a couple of community-based health insurance schemes being operated in the country in different sectors. Their coverage is limited and they are being operated in the NGO and semi-government or academic sector. Study of willingness of people in the schemes could give significant information to be used for implementing the schemes in the country. This is a comparative study of the two schemes: Lalitpur Medical Insurance Scheme (LMIS) run by United Mission to Nepal (UMN), Community Development and Health Project (CDHP) in Lalitpur District and the Social Health Insurance (SHI) run by the Bisheswar Prasad Koirala Institute of Health Science (BPKIHS) in Morang and Sunsari Districts.

## **1.2. Rationale of the study**

The HMGN is going to implement community based health insurance scheme in Nepal based on the existing models of the scheme. This study finding will be useful for looking at how the willingness of the community people to pay for a community based health insurance.

Since the government is in the verge of implementing a health insurance scheme, this study rightly follows the need of the government program and is relevant.

There are some studies done in the area of health economics in the country but there is no such studies done on willingness. This would be one of the few studies done in this field in the country, which would be useful for various sectors in different ways in the future.

### **1.3. Objective**

#### **1.3.1. General objective**

To find out the willingness of community people to pay for health insurance scheme in Nepal

#### **1.3.2. Specific objectives**

- a. To find out the level of knowledge of the community people on the existing health insurance schemes
- b. To compare the satisfaction of the community people on LMIS of UMN and SHI Scheme of BPKIHS
- c. To measure the level of community participation in these two health insurance schemes
- d. To identify the ability to pay for the two schemes and the people in the new area where there are no schemes

### **1.4. Operational definition**

#### **Willingness:**

This study covers the willingness as satisfaction, participation, and knowledge of the community people in the areas where LMIS and SHI have been implemented and ability to pay in the area with and without the schemes.

#### **Health insurance:**

For the purpose of this study, *health insurance* refers to the pre-paid schemes run by UMN-CDHP, Lalitpur and BPKIHS Dharan.

## **1.5. Brief introduction of the health insurance schemes**

### **1.5.1 Lalitpur medical insurance scheme**

Lalitpur medical insurance scheme is one the oldest Community-Based Health Insurance Scheme existing in the country. United Mission to Nepal was running the scheme in five Health Posts in rural parts of Lalitpur District since 1976 but some of those HPs now are running under the government structure.

#### **Objectives of the scheme:**

1. To ensure the continuous supply of essential drugs at HP throughout the year by mobilizing the community resources
2. To distribute costs for the health services in the community and thereby contribute to equity and equal opportunity for all
3. To increase the awareness of the health services available in the community and encourage appropriate utilization of such services including the base hospital

It's a voluntary pre-payment scheme in the household level. It's an annually renewable scheme according to the Nepali fiscal year. Once a family is enrolled in the scheme, the family is provided a family health card, which is the simple evidence of the membership. The premium varies from NRS 120-150 (FY 2060/61) in the HPs. There is five rupees registration fee in every visit. The scheme covers all the essential health services available at the HP for the cardholders in the scheme. The enrollment in the scheme is mandatory to get the essential health care at the HP. However, for the maternal and child health services, and the emergency care, it's not necessary to get enrollment in the scheme. The local Health Post Committee (HPC) is the responsible body to manage the scheme in the respective HP.

The HPC has the important roles to run the scheme as follows:

1. To establish rules and regulations for the scheme
2. To supervise and support health post staff
3. To manage fee collection and management of the fund
4. To market the program and establish good public relations
5. To provide charity services for the genuinely poor.

Currently, the scheme has been able to cover the expenditures for the essential drugs at the HPs. The scheme is also considered as one of the main sources of income at the HPs.

### **1.5.2 Social health insurance scheme**

The Social Health Insurance has been implemented by the BPKIHS since 1999. The scheme has been implemented in few VDCs and urban areas in Morang and Sunsari Districts in the eastern Nepal. The scheme is operated by BPKIHS in direct collaboration with the local groups and organizations such as VDC, Municipality.

It's the voluntary pre-payment scheme based on individual members of the household but its mandatory to insure the whole family to avoid the adverse selection.

The premium rate for rural area is:

Rs. 15/month or 185/year for adults

Rs. 7.50/month or 95 Rs./year for children below 14 years

Premium for urban area:

Rs.50/month or 600/year for adults and

Rs.25/month or 300 for children below 14

Although the scheme is targeted to the rural and urban communities, the care is for the tertiary level care at the BPKIHS hospital in Dharan. The benefit package from the scheme is unlimited medical consultation at the OPD and inpatient care at the hospital. However, there is a ceiling up to RS.2500 for drugs and RS.10, 000 for surgery from the scheme. The scheme also

covers the basic dental services such as Zinc Oxide filling and general investigation but excludes the high technologies like CT Scan and MRI.

## **1.6. Literature review**

HMGN has a plan to introduce alternative health care financing in the country (2<sup>nd</sup> Health Long-term plan). The Ministry of Health (MOH) has already brought a policy to implement Community Based Health Insurance in the country. The question comes whether or not the people in Nepal would be willing to pay for the health insurance.

Willingness to pay is affected by various factors. Mathiyazhagan (1999) mentions that socio-economic factors of the community people and physical accessibility to quality health services are the significant determinants of willingness to pay for a health insurance scheme. Another study in Africa (Dong et.al) also shows that willingness to pay was influenced by household and individual ability to pay along with other characteristics such as age, gender, and education. In the study, higher level of willingness to pay was found among the people with higher income level, higher previous medical expenditure, higher education, younger people, and male gender (2001).

If we review the socio-economic situation of Nepal, it's one of the poorest countries in the world where per capita income is 210 US\$. More than 40% of the people in the country are under the poverty line. It can be presumed that many people in the country especially in the rural area can hardly pay for their health care expenditure. Its been stated in the Nepal Human Development Report 1998 that the income of the most rural people is so low that more than 60% of the H/H annual income is invested only for food. They would have very less income to invest for other needs such as health and education.

The level of education in Nepal is also one of the lowest in the world. The literacy rate in Nepal is 42%(UNDP 2001). Moreover, the literacy rate is much lower in the rural area and the lowest among the female. Since the previous studies show higher level of willingness to pay for

health among the better-educated people, it's expected that there would be lower willingness in the context of Nepal.

Access to quality health services is a big problem in the context of Nepal. Until 1995, access to quality health service was limited to 15% of the people. After the opening of Sub-HP in every Village Development Committee (VDC) in the country, the physical access to health service is significantly improved, but the quality of the services leaves much to be desired (Nepal Human Development Report 2001). A survey report by NPC/UNICEF shows that only 8% of those seeking the health services content with the quality of services they receive.

Patients' satisfaction is another important factor for willingness to pay. A study in China (Mao, 2000) shows that quality of service is one of the determining factor for farmers to join or not to join the Cooperative Medical System. Stanton (1989) suspects that families would be less willing to pay for allopathic government health services compared to the private health services provided at the local level. At this point, willingness to pay for the public health services in the context of Nepal is questionable.

It's the fact that 76% of the health care expenditure in Nepal is paid by the household. It could be interpreted that people are able to or are willing to pay their health care expenditures. However, Steven Russel (1996) states "payment for health service is made at considerable social cost to the families and can scarcely be said to represent a "willingness to pay in the normal sense of word".

Finally, the socio-economic factors in Nepal are not very favorable for better willingness to pay for health insurance. The quality of health service is very poor and satisfaction of people, who seek the services, is very low in the public health services. In this point, it's necessary to study the willingness of community people to pay for the health-financing scheme in the context of Nepal before any schemes would be implemented. This study best aims to fulfill the study gap to find out the willingness to pay for health insurance scheme in the country.

## **Part II**

### **Methodology**

#### **2.1. Method**

Qualitative method

#### **2.2. Type of the study**

Descriptive

#### **2.3. Study variables**

- Knowledge of the community people.
- Satisfaction of the community people.
- Level of participation of the community people.
- Ability to pay for health insurance.

#### **2.4. Study site and justification**

Lalitpur, Morang and Sunsari Districts are the chosen area for this study. UMN has been running Lalitpur Medical Insurance Scheme in Lalitpur District and BPKIHS has run Social Health Insurance in Morang and Sunsari Districts.

Lalitpur is one of the hilly districts in Nepal. Although Lalitpur is generally considered an accessible district, part of which lies inside Kathmandu Valley, two third part of the district in the southern part, lies outside the valley in the remote hills. Most of these parts of the district are without motorable roads, electricity, and telecommunication. The local Health Posts and Sub-Health Posts are the only institutions to provide health care services to people in the area until they get to Patan Hospital. The Community Development and Health Project of United Mission to Nepal were running Lalitpur Medical Insurance Scheme in five Health Posts in the Southern rural parts of the district some of which are already handed over to the District Health Office,

Lalitpur now. The community in the district represents a backward and low economic group. Chapagaon and Bhattedanda VDCs were taken for the conducting the FGD where the LMIS has been implemented. Two other VDCs: Lele and Chhampi were also taken for the study where there is no LMIS implemented officially.

Morang and Sunsari are the district where BPKIHS has implemented the SHI. Only few VDC and few groups in the municipality area have been taken for the SHI. Sundarpur VDC of Morang is one of the rural VDCs taken for the study where the SHI been implemented. Two other VDCs: Indrapur of Morang and Panmara of Sunsari were also the study site where the scheme was not implemented. The communities with no scheme were also taken from the same districts to represent the respective districts better.

## **2.5. Target population in the study**

The target population of this study is the members of the schemes specifically the household heads who make decision for health care expenditure of the family.

## **2.6. Sampling method**

Non-probability sampling method (purposive) was used in this study.

The districts where LMIS and SHI have been implemented were purposively selected for the study. Even among the scheme implemented VDCs, four VDCs were also purposively selected to conduct the study. Likewise, the other four VDCs where the schemes were not implemented were also taken from the same districts. However, for both the insurance implemented VDCs and not implemented ones, consideration was given to represent the rural and semi-urban communities where the community based health insurance is more relevant and also to represent different socio-economic characteristics. But for selecting the participants in the FGD, the participants were randomly invited from the wards around representing the socio-economic characteristics.



## **2.7. Sample size**

Two FGDs were conducted in the LMIS implemented area in Lalitpur District and only one FGD could be conducted in SHI implemented Morang District. One FGD planned in Sunsari District could not be conducted due to some communication and planning problems. Two FGD in Lalitpur, one Morang and one in Sunsari were conducted where the schemes were not implemented.

## **2.8. Study tools/technique**

Focus group Discussions were conducted using guidelines

## **2.9. Study period**

The study was done in the month of Baishakh and Jesth 2060 (May 2003) and report was written up over the period of 2003 after the fieldwork.

## **2.10. Limitation of the study**

The study was conducted in the three districts where the two schemes have been implemented. Since the schemes are implemented in a community, which has a specific socio-economic characteristic, it may not really be realistic in other community with different socio-economic characteristics. In terms of methodology, this is a qualitative descriptive study to understand the view of the community people on their willingness to pay. It's not quantitatively assessed how much people would pay based on their economic status. It mainly indicates the people's attitude on paying for the health insurance schemes. The sample size of the study is relatively small. Therefore, it may not be very much representative for the whole district or the national level.

## **2.11. Data analysis**

**Reporting:** Reporting of the various focus group transcriptions were done in an organized way.

**Verification:** The transcriptions were verified to check the discrepancy while reporting

**Tabulation:** The FGD findings were tabulated based on the FGD guidelines and variables

## **Part III**

### **Results**

#### **3.1. Lalitpur medical insurance scheme**

Total two FGD have been conducted in Bhattedanda and Chapagaon HP where the LMIS has been implemented by the UMN. Bhattedanda HP was run by UMN for more than ten years and handed over to the local HPC for management with the support of the DHP. The HP is still continuing the LMIS as one of the sustainable and reliable income sources for maintaining the essential drug supply. Chapagaon HP is still being run under the management of UMN/CDHP where the HPC manages the LMIS in the HP to maintain the essential drug supply. In both of the HPs, the revenue collected from the scheme is nearly sufficient to cover the cost of essential drugs at the HPs.

##### **3.1.1. Bhattedanda FGD**

There were 11 participants from ward no. 8, and five of the VDC. They were all male household heads the age ranging from 35 to 53 years. Since the household heads were invited for the FGD, only the male participants came for the discussion. All of the participants were literate and one was educated to an intermediate level. Five of them were fully dependant on agriculture for living and the additional income was from selling milk. Three of them were the jobholders in the local area who also had agriculture as their additional family income. Their average annual family cash income ranged from NRS 15,000 to 50,000. Most of them were literate by education level. All of them had renewed their membership in the scheme in the current year. The PI conducted FGD for the first one hour and later switched to Mr. Krishna Poudel, the public health worker took the note of the discussion. The FGD was conducted in the HP. Bhattedanda HP was run by the UMN/CDHP for 12 years and now its being under the overall management of the HPC with the HMG support.

### **a. Knowledge**

About half of the participants mentioned that LMIS is useful in avoiding the risk of high treatment cost in the private health care sector. Nearly a quarter of the participants provided the reason why the insurance scheme was needed. “ *Bima (LMIS) ensures the essential drugs at HP. We used to face the problem even getting cetamol from the government run HP. Since the scheme was introduced, we have no problem in getting the essential drugs from the HP*”, a middle aged male from Bhattedanda said. The remaining quarter of the participants responded that insurance scheme was needed because it was beneficial for the low-income group.

Most of the participants mentioned that LMIS provides an opportunity for essential health care and there is no need to go to the distance hospital for it.

Almost all the members agreed that the LMIS significantly decrease financial risk by ill health. “ *We do not have cash in hand every time, but my family members may fall sick anytime. Bima (LMIS) is helping us to overcome from the financial problem*” a 53-year-old male from Bhattedana ward 5 expressed.

All of the participants were well known about the general policy of the LMIS. Every participant were aware of the time for renewal and the scheme premium.

### **b. Satisfaction**

All of the participants were fully satisfied with the LMIS. Most of them responded that LMIS is useful for their family and themselves. “*Bima (LMIS) is useful because we are getting the HP level services locally from the HP*”, a 50 year male responded. All of the participants were continuing the membership in the LMIS. However, they were aware that few of the H/H in the community disconnected from the LMIS membership.

Most of the participants expressed the need of continuing LMIS in the HP. “ *We need to continue the Bima, because it is useful in getting basic level health services in the local level*”

*and cost of the drug could be covered from the Bima”* expressed by a 35-year old men from Bhattedanda.

All the participants recommended implementing the LMIS in other HPs/SHP in the area. Their recommendation is the important indicator of the satisfaction of the LMIS members.

### **c. Participation**

Most of the participants noted that HPC makes the decision for the LMIS. However, many participants don not know details about the HP committee. Most of the members provide the advice when the HPC organizes the annual gathering.

About half of the participants noted that involving more people form every ward could be beneficial to improve the scheme. *“ I am communicating my opinion and comments through FCHVs of my ward”*, a man from ward no 8 said.

About half of the participants responded that they are fully heard by the HPC. However, some of the participants mentioned that they were not always heard.

### **d. Ability to pay**

All of the participants agreed that the insurance premium was affordable for them. Majority of the participants expressed their willingness to pay for the scheme even if the premium was increased. However, participants expected the level of treatment would be improved accordingly. But the two participants disagreed to increase the premium. *“If we want to make Bima successful, we should not increase the premium because; the majority of the people cannot afford it. Rather, the members should be increased through promotion”* a 52 year man said in Bhattedanda.

Six out of eleven participants had paid for outside treatment for their family in the last year ranging from RS. 1500 to 5000.

Most of the participants responded that they could pay the health expenditure from their savings if it's a small amount. But for higher amount of the expenses, they need to borrow money on interest. About half of the participants were satisfied in terms of timing of the LMIS premium. However, half of the participants were suggesting the month of Mangshir (November) for renewal.

### **3.1.2. Chapagaon FGD**

The FGD was conducted among eight participants in Chapagaon HP. Seven of the participants were male household heads and one female from five wards of the VDC in the FGD. The PI conducted the FGD for one and half-hour and Mr. Krishna Poudel took note of the discussion. Most of the participants were literate. Five out of eight participants were farmers, two jobholders and one a businessman. Except one participant, all had been enrolled in the LMIS in the current year.

#### **a. Knowledge**

Most of the participants mentioned that the LMIS was for health care at low cost. Some of them also said that the LMIS prevents them from the high treatment cost at the private clinics and medical shops when they have health problems. One of the participants also expressed that LMIS is for health service of the whole family.

Half of the participants said that main benefit from the LMIS was to get the essential health care from the local HP. Others added that they don't have to spend time to go to far distance and can save transportation cost since the services are available locally. Most of the participants also mentioned referral to the hospital as one of the benefits. They said that they get quick services and some discount in the expenses when they had referral services. One of the participants said that every member in family could get access to the services in the scheme without the presence of the household head.

All of the participants agreed that the scheme minimized the financial risks due to the health care expenditure. Their reasons were that they were getting essential health care at the local level with the affordable cost and saves time and transportation cost. A 58-year old male said, *“We don’t have to go to the far hospital for the most of health care required for our family. It saves the transportation cost and whole day time to go to hospital”*.

The participants had good awareness on the policy and benefits from the scheme. All of the participants could say when to renew in the scheme, premium rate, and benefits of the scheme.

#### **b. Satisfaction**

All of the participants said they were satisfied with the scheme because the scheme had helped them get the required essential health services at the local HP and there was no need to pay for the expensive private health care outside. One of the participants said, *“The essential services are available when necessary, and there is no need to go to the medical shops when sick. If we go to a medical shop, they would give you a lot medicines even for the simple problem”*.

Most of them mentioned that the HP was providing the essential health services from the scheme. Since they don’t have to go to hospital for most of the health services, they were contented with the scheme. One of the participants said that the scheme covered treatment for unlimited number of visits for the family and it was especially useful for the services of children since they fell sick more frequently. However, one of the participants said that there was lack of high-level drugs at the HP.

Most of the participants mentioned that they had renewed their membership in the LMIS. Two of them had not renewed their membership until the date of the FGD. They said that they would renew it when they needed. They expressed that they would not come to the HP just to renew the membership but when they needed the health services.

Every participant expressed that the scheme should be continued in future. One of the participants said, “ *How can we get the services if there is no scheme. The HP may not provide the current services. The rich people can go to the city but we, the poor people will suffer*”. The participants recommended the scheme to be implemented in other HPs/SHP. They expressed that the scheme is fit especially for the rural community where there is no hospital or other health services. They mentioned that the other HP/SHPs in the periphery could provide better services if they run the scheme.

### **c. Participation**

The participants were not aware who makes the decision for the scheme. All of them expressed that the decision about the premium is made at the CDHP/UMN level and managed by them. All of them never had provided input in setting the premium so far. However, they had given their comments about the services to the HP staff. Some of them also said that they promote about the scheme with their neighbors.

### **d. Ability to pay**

Three of the participants said that the premium is low and can be increased. But other five participants said the premium is just OK. All the participants agreed to increase the premium if the drugs are increased in the HP. Some of the participants had spent significant amount of money for higher-level health care ranging from RS.40-6000 in the last six months. In case there would be indoor services available at the HP, they were willing to RS. 500 or even more. However, they wanted to increase the premium in a gradual manner. All the participants agreed that the time for renewing the membership in the scheme is acceptable. Therefore, the participants said the current premium is affordable and were willing to pay more in case the services are increased.

### **3.1.3. Conclusion**

There has been observed good level of knowledge/awareness about the LMIS among the participants in the LMIS implemented area. They have good understanding that the LMIS protects from the financial risks from the essential health care expenditure especially by avoiding to pay high expenditure to go to far hospital and private clinics. They consider the benefits of the LMIS: essential health care at the HP, referral services, and discount in the hospital expenses. They were satisfied to get the essential healthcare at the local HP through the scheme. The satisfaction is much more among the participants in Bhattendada HP. However, the participants from Chapagaon HP had higher expectation on the level of care provided by the HP. It could be because the community in Chapagaon VDC has easier physical access to the higher-level health care because of the location. All of the participants wanted to continue the membership and highly recommend the scheme to be implemented in HP/SHP especially in the rural area. But, they also expressed that there are some people who don't understand the scheme and are not continuing the membership. There was observed limited participation from the general members of the scheme although the decision and management is done by the HPC and there are provisions to involve them.

The participants in both the HP were able and willing to pay the premium the current premium. They were willing to pay higher premium if the level of the services would be increased. The participants in Chapagaon HP had higher expectation on the level of services and were willing to pay for it. Therefore, since the participants in the scheme had good understanding of the scheme and were convinced of the benefits they receive, they were satisfied with the scheme and were willing to pay for it although they had limited involvement in it.



## **3.2. Lalitpur-scheme non-implemented area**

### **3.2.1. Lele VDC**

Lele VDC is located in the southern corner of the valley about 15 km from the ring road. The VDC is connected by an all season motorable road to a blacktopped road, which links to the main city in the valley.

The FGD was conducted in the Lele Primary Health Center (PHC) among eight participants from two wards. All of them were male household heads age ranging from 52 years to 70. One of the participants was illiterate and rests were simple literate. Six of them were farmers; one a shopkeeper and one had traditional sewing occupation. The PI conducted FGD for one hour and note was taken by Mr. Krishna Poudel, a public health worker.

In the introductory discussion, the participants mentioned their mixed type of health seeking behavior. Some of them said that they would practice traditional faith healing or do some home remedies for the first time when they fall sick. Few said that they would go to the PHC for basic health problems and then to hospital for bigger problems. They expressed the problem in getting the services that there would be no regular staff and no medicines were provided at the PHC. However, there was some improvement in the health service after having the PHC doctor for few months.

#### **Ability to pay**

Only two out of the eight participants had paid RS. 60-2000 outside the PHC for health care. Two of them had simple treatment at the PHC and the rest didn't have illness for the last six months.

All of the participants were willing to pay some amount of money for the health service at the local PHC. They referred to the LMIS in Chapagaon HP and were willing to pay for such scheme from RS.100-150 if the services are available at the local PHC. However, they had

higher expectation on the level of services such as x-ray, laboratory services at the local level. If these services would be available, they were willing to pay as high as 500 Rs. One of the participants said, it would be convenient to pay premium in installment basis and others also agreed on it.

Therefore, the participants were not satisfied with the current health care services in the PHC. They expected to improve the health care services at the PHC and were willing to pay the affordable price for the services. Although they had higher expectation on the level of services, they would pay the cost if the services would be available.

### **3.2.2. Chhampi VDC FGD**

Chhampi is a VDC located in the Southern edge of Kathmandu Valley about 15km from the Ring road. There is a graveled road to connect the VDC to the main road to the city. The VDC has a SHP as the local health institution.

There were twelve participants from four wards of the VDC. Ten of them were male and two female ages ranging from 31 years to 61 years. Eight of them were farmers; two jobholders in office and two had local shops for their livelihood. All the male participants were literate and one of the female was illiterate. The PI conducted the FGD for one and half-hour and the discussion were recorded.

In the introductory discussion, the participants expressed that they would utilize the local SHP very less. They said that very few services were available at the SHP, which would be open only for limited hours. They said, mostly had to go to private clinics or hospitals in the city for health services. All of the participants said that there is no regular staff, no medicines and essential services available at the SHP.

## **Ability to pay**

Majority of the participants said they had spent high amount of money for the health care of the families in the last six months. Eight out of twelve participants said they paid RS.700-12,000. for health care for the last six months. All of the participants were willing to pay for the services if they were made available locally. They also said that they had to spend much for the transportation to go the city and spend whole day to get there. One of the participants said, *“I have to live on daily wage. If the services are available locally, I will pay even my wage for the health care of my family”*. They also referred to the LMIS in Chapagaon HP and were willing to pay for such scheme if its run in the SHP provided the similar services would be available in the SHP.

### **3.2.3. Conclusion**

The participants from both the study areas mentioned that there are significantly lower proportion of people who are utilizing the local health services in the area due to unavailability of quality services. Instead, they are compelled to pay high cost for the health care of family outside. Though they are not satisfied with the local health services, they were willing to pay the price if the quality health care is available locally. They were highly motivated to practice the LMIS in the local health institution to avail the quality health care for the community.

### **3.3. Social health insurance**

Two FGDs were planned to conduct in the communities where the SHI was implemented. However, only one FGD could be conducted in Sundarpur VDC of Morang District. Because of the practical problem of communication, another FGD in Chakraghati VDC in Sunsari District with women cooperative could not be conducted on the planned date and was left.

### **3.3.1. Sundarpur VDC FGD**

Sundarpur is one of the VDCs in Morang District in eastern Nepal. The VDC, intersected by the Mahendra Highway, is accessible with road and transportation. The VDC comprises of 3215 households in total.

This is the first VDC where the BPKIHS started SHI in 1999 (2057 BS.). The SHI is implemented in collaboration of the VDC by the BPKIHS. The registration and collection of SHI premium is done by the VDC and an agreement is made between the VDC and the BPKIHS. The poor and marginalized five families from each wards esp. the Dalits are insured with one-third contribution from the VDC, one third from the BPKIHS and one third from the members themselves for the first year. On the second year, the contribution from the VDC and the BPKIHS is decreased to one-fifth respectively and the third year, they have to pay the full premium on their own.

There were twelve participants from three wards of the VDC. Exactly half of the participants were male and half female. They were the household heads the age ranging from a 28 to 55 years. Eight out of twelve participants were from the farming occupation, two were the jobholders, and two had small business for living.

The PI himself conducted the FGD for about one and half-hour using the FGD guideline and the discussion was recorded.

#### **a. Knowledge**

From the discussion, the participants showed good level of knowledge about the scheme. They had good understanding why they had enrolled in the scheme, its benefits and general policies.

Most of the participants mentioned that the SHI saved them from the financial risk while having health services. Other participants agreed and added that they would not have money on

hand all the time to pay for health care expenses. In such situation, the SHI really help them to get treatment.

Most of the participants agree that it was a good benefit to have unlimited consultation in the scheme when they needed. Fast process for treatment at the hospital, health care for the whole family esp. for children were other benefits expressed by the participants.

Eleven of the participants were aware on premium rate, benefit packages, and ceilings of the scheme as well as the time for renewal. One of the participants who enrolled in the scheme for the first time had some confusion on some of the policies in the scheme. In average, the participants had good level of knowledge on the scheme.

## **b. Satisfaction**

Most of the participants were generally satisfied with the scheme since they had access to the health care services in the BPKIHS hospital. However, they also had some comments to the health care providers to improve.

Ten participants out of twelve generally expressed their satisfaction with the scheme. They had feeling that the scheme has provided them good access to the hospital services with much lower expenses than the private services. So far, they are getting effective treatment. However, one of the participants was strongly against the scheme and said, “ *I don’t like the scheme because they don’t provide the needful treatment when emergency. My mother was returned to home from emergency with just simple treatment. Therefore, they would not respond well when emergency. They would just provide some relief treatment*”, a 28-year-old man expressed. He said he even left the membership now. One or two others also had similar problem during emergency before. Some of the participants also expressed the problem of communication with the doctors due to language barrier. The doctors would speak either English or Hindi, which the participants would not understand. Few of them also commented on the improper behavior of the nurses in the hospital. Some of the participants felt problems to walk to various buildings in the process to get treatment. They also had comment for the Anti-Rabies

vaccine for not being included in the benefit packages. Sometimes they were asked to buy medicines outside which were not available in the hospital and not reimbursed. Some of them even had feeling that the treatment package is decreased than before.

Despite they had some comments; most of the participants were continuing the scheme. One participant joined and one left the scheme this year. They do want to continue the scheme in future and recommended to replicate in other areas.

### **c. Participation**

The SHI was initiated by the BPKIHS and is managed by it. Necessary inputs were taken from the respective community people on the process to develop the scheme. However, the participants do not feel that they have active participation in the scheme.

All of the participants said that the decision about SHI is done by the BPKIHS but some of participants mentioned that the VDC representatives were involved in developing or decision making process by the BPKIHS. Almost all of the participants said that they do not have any participation in terms of management or decision making process of the scheme. One of the lady participants said that there was a VDC level insurance committee formed by the ward representatives to discuss about the SHI in the VDC. BPKIHS representatives also attended the discussion before but now she didn't know exactly whether it was functioning or not. Another participant said that he didn't know about the existence of the committee. Moreover, none of the participants had participated in such discussion so far.

Some of the participants had some comments to communicate but didn't have way to do so. One of the female participants mentioned that the hospital staff asked her about her feed back about the services. Therefore, most of the participants feel that they have not participated in the decision-making and management of the SHI.

#### **d. Ability to pay**

All of the participants mentioned that the premium was affordable. They were happy to pay the present premium for the given benefit. However, more than half of the participants expressed that the coverage would decrease if the premium is increased. But some of the participants were willing to pay some additional premium if the packages would be increased such as the ceiling for the drugs.

Most of the participants had health care in the BPKIHS in the last year. Only for small treatments, they would visit the local private medical shops. They feel that the hospital is within easy reach for health care for them.

All of the participants could pay the premium with their savings. If they need some big amount urgently for the treatment, then they have to borrow money from others. They didn't have any comments on the timing for paying the premium. Therefore, it seemed that the participants were able to pay the current premium and some of them even would pay the higher premium if the benefit packages were increased.

#### **3.3.2. Conclusion**

In general there was good willingness to pay for the SHI among the participants. They had good understanding why they needed the SHI and the benefit packages provided. They were generally satisfied with the services provided. The participants expressed that they were able to pay the current premium.

However, the participants had some comments on specific areas such the emergency care and some other essential health care not being covered in the scheme, language of doctors to communicate to the patients to be improved and the various services should be arranged in a practical way for the convenience of the people.

Sundarpur VDC is an affluent rural community and is accessible place to the BPKIHS hospital. Therefore, they could afford the scheme and get access to the hospital as a local health institution. Because of that, they even didn't have any health service expectation from the local HP/SHP. However, they is complete bypassing of the local HP by the system and people have been directly linked to the tertiary level care at the hospital. Its natural for the people to expect health care within their affordability but the scheme has no link to the total health care system of the government.

### **3.4. Scheme non-implemented area**

#### **3.4.1. Panmara VDC, Sunsari District**

Panmara is one of the rural VDCs in Sunsari District about half an hour drive on the dry season motor able road from Dharan city. There is a local SHP functioning in the VDC.

The focus group discussion was conducted in the ward no. two of the VDC where twelve participants participated from two wards. Ten of the total participants were female who had role in household decision-making and two were male household heads. The FGD was conducted by the PI for one hour and note was taken by a local person after he was oriented about the task.

In the introductory discussion, it was found that there are very few services available at the local SHP. They had very low satisfaction and expectation from the local services. They had to go to Dharan for almost all health services either to the private services or to the BPKIHS.

#### **Ability to pay**

The participants were spending high amount of money for their family health care outside the local health institution. The participants said that they were spending RS.200-3000 for health services for their families. One of the participants said, “ *What to do, we get health problems, sometimes the adults and sometimes the children and have to get treatment whatever way or where ever we get it*”



The participants strongly expressed that if the essential services are available at the local SHP, they were willing to pay the cost. One of the female participants said, “ *We are spending so much money for the treatment of our family outside in the city. If the services are available here, why don’t we pay for it? Its takes us whole day to go to Dharan and its difficult to go there during the rainy season because the river get flooded*”. All of the participants agreed to her.

All of the participants said that they would be willing to pay the price for the health services if it’s available locally. One male participant said, “ *We are paying it now. If we are not get services without paying for it, we will pay for it*”. Some of them referred to the SHI and were willing to pay for such scheme if the treatment is available. However, two of the participants felt that the SHI was expensive. Therefore, in short, they were willing to pay the affordable price for the health services if the services are accessible.

### **3.4.2. Indrapur VDC, Morang District**

Indrapur is one of the VDCs in Morang. It’s an accessible rural community on both sides of the Mahendra High way. The VDC has a SHP and private clinics/medical shops are located in the bazaar area on the high way. There is no SHI implemented in the VDC. The FGD was conducted in ward no. 7 of the VDC. There were nine participants, all male from three wards in the discussion. Eight of the participants were the farmers and one had local business for living.

The participants expressed in the introductory discussion that they did have some traditional faith healing for simple illness for the first time when illness occurs. But most of the participants said that they would go to the private clinics available around most of the time and to bigger hospital when they had major illness. They said that private clinics provide quality health care locally when needed although it’s expensive. However, one of the participants said that it’s only for the ones who can afford. All of the participants said that they hardly visit the local SHP for health care except for very simple care such as vaccination for the children. They said, the SHP have short opening hours and services are not available when they need, the staff are not regular and no any essential drugs and equipments available in the SHP.

### **Ability to pay**

Seven out of nine participants said they were paying RS.200-1200 monthly for their family health care. Mostly, they were using the private health care services in the area. One of the participants said, *“If the outside treatment is available here in the local SHP, we would pay for it. But what to do, the facilities are not available here.”* Another participants added, *“The services for simple fracture, urine and stool test should be available here and we would be ready to pay”*. All of the participants said that if good health workers are available in the local SHP and essential health services are available, they would be willing to pay the price.

The participants were willing to pay the reasonable price for the essential health care. One of the participants said, *“We have paid the price of the services what we needed in the private clinics, therefore, we would pay it as long as we can when we need the services. But if we get the services locally, then it’s more beneficial because of the time and transportation cost”*. Therefore, all the participants were willing to pay the cost of the health services they needed if they are available locally.

### **3.4.3. Conclusion**

The people in the area where there are no any health insurance schemes are paying significant amount for their health services. People are paying higher expenditure for health care in the private services. These people are getting far less services from the government local health institutions than expected. People even have very low expectation from the government health institutions for the services.

However, people are willing to pay the cost of health care if they get the essential health services within their reach. People have feeling that health service could not be available without the price and they are willing to pay for it.

## **Part IV**

### **Conclusion and Recommendations**

#### **4.1. Conclusion**

In the LMIS, the participants have good knowledge of the scheme and have high-level satisfaction to the scheme since the essential health care services are available locally through the scheme. The people in the scheme think that the premium is affordable and they are willing to pay for the scheme. They highly recommend that the scheme should be replicated to the other rural health institutions. Although, there is limited participation from the general members of the scheme, the scheme has been able to strengthen the local HPs and has established the good referral in the health care system of the district.

The participants in the SHI have good knowledge of the scheme and are generally satisfied with the access to the health care services in the hospital through the scheme. They were able and willing to pay for the scheme. However, they have comments on the delivery of the services and benefit packages. There was observed no real participation from the community in the decision making process of the scheme. The people in the SHI implemented area have higher expectation on the level of the services and were also willing to pay for it. It may be due to the higher socio-economic status of the community.

The participants from the area where the schemes were not implemented were also able and willing to pay for the health care services. In these areas, the local health institutions are very under utilized and people are paying high expenses for health services outside. They expressed their willingness to pay if the health care services were made available locally.

#### **4.2. Recommendations:**

- People are willing to pay for the health insurance schemes if its affordable and quality health services are made available. Therefore, the schemes could be implemented in Nepal. The LMIS is especially appropriate for the primary health care level.
- The health insurance cannot be thought in isolation. Proper organization of the appropriate level of health services is a pre-requisite for implementing the health services. Therefore, organization of the health services should be well thought before implementing the schemes in the country.
- The health institutions where the schemes are implemented need to be linked to the appropriate level of health care system for referral so that it would function in proper system.
- Awareness about the health insurance scheme is vitally important at the community level so that people understand the benefits of the scheme. Therefore, promotional activities should be organized about the scheme to encourage people to get enrolled.
- Participation of the members of the scheme is important to make them feel ownership. The system and mechanism should also be developed to ensure that the voices of the members would be recognized and heard.

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**Annex-1**  
**FGD Summary Table**

QN.	LMIS	SHI
K1	<ul style="list-style-type: none"> <li>• To avoid the risk of high treatment cost, it provides a relief in the cost of the treatment</li> <li>• Maintain drugs supply at the HP</li> <li>• Prevent from high treatment cost at private clinics/medical shops</li> <li>• Ensures health care for the family</li> </ul>	<ul style="list-style-type: none"> <li>• The scheme saves from the financial risks when treatment is necessary</li> <li>• The scheme for the health care of the whole family when needed</li> </ul>
K2	<ul style="list-style-type: none"> <li>• Essential health care at the local HP</li> <li>• Essential health care available free of cost at the HP</li> <li>• Treatment at low cost</li> <li>• Appropriate referral services for bigger health problems</li> <li>• Referral when emergency</li> <li>• Any members of H/H can access the services</li> <li>• Saves transportation cost</li> </ul>	<ul style="list-style-type: none"> <li>• The scheme covers unlimited times of visit for treatment</li> <li>• The treatment is cheaper in case they need to visit frequently</li> <li>•</li> </ul>
K3	<ul style="list-style-type: none"> <li>• It provides a relief on the treatment cost when needed</li> <li>• Its beneficial esp. for the low income people</li> <li>• Discount in referral services</li> </ul>	<ul style="list-style-type: none"> <li>• No need to worry for the treatment of the children</li> <li>• They would not have money to pay for treatment every time, the scheme helps them in this situation</li> <li>•</li> </ul>
K4	<ul style="list-style-type: none"> <li>• MIS renewal from Shrawan 1</li> <li>• Higher premium for delayed enrollment</li> <li>• Updated on the rate of the premium in the respective HP</li> </ul>	<ul style="list-style-type: none"> <li>• Most of the participants know about the premium and when it lasts</li> <li>• They also knew the ceiling for treatment in the scheme</li> </ul>

QN	LMIS	SHI
Sat.1	<ul style="list-style-type: none"> <li>• Most of the participants were very satisfied with the scheme because they are getting essential health care at the local HP in low cost</li> <li>• In Chapagaon, satisfaction was moderate</li> </ul>	<ul style="list-style-type: none"> <li>• Most of the participants satisfied with the scheme, few women very satisfied</li> <li>• One of the participants strongly against the scheme and gave up the membership</li> <li>• Participants comments to improve: problem of language with the doctors, bad treatment from the nurses, inconvenient to walk various buildings, no coverage of anti-rabies vaccines and occasionally asked to buy medicines outside and not reimbursed</li> </ul>
Sat.2	<ul style="list-style-type: none"> <li>• No need to go far away for essential health services or to go to private clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Big financial discount for the treatment of family and much cheaper than the private clinics</li> <li>• Sometimes, asked to buy some medicines and not reimbursed</li> <li>• The ceiling of the drugs is limited</li> </ul>
Sat.3	<ul style="list-style-type: none"> <li>• They feel that most people are regular in the scheme</li> <li>• Most of the participants had renewed their enrollment</li> </ul>	<ul style="list-style-type: none"> <li>• One of the participants was strongly unsatisfied because there was no proper response in emergency situation and dropped the scheme</li> <li>• But another participant joined the scheme this year</li> </ul>
Sat.4	<ul style="list-style-type: none"> <li>• All of the participants strongly feel the need to continue the scheme</li> <li>• No medicines and treatment would be available if the scheme not there</li> <li>• Even staff are recruited in Bhattedanda from the scheme</li> <li>• They cannot bear the high treatment cost in other places</li> </ul>	<ul style="list-style-type: none"> <li>• Most of the participants want to continue the scheme</li> <li>• Big relief in the treatment cost compared to the private clinics esp. in the bigger health problem</li> </ul>

Sat.5	<ul style="list-style-type: none"> <li>• All of the participants recommend the scheme to be implemented in other HP/SHPs</li> <li>• Treatment could be locally available since the cost of drugs can be covered through the scheme</li> <li>• The scheme fit for rural community where no hospital or private clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Recommended to implement the scheme in other places</li> </ul>
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QN.	LMIS	SHI
Part.1	<ul style="list-style-type: none"> <li>• Participants are aware that the decision for the scheme is made by the HC</li> <li>• But the participants in Chapagaon think that the decision comes from CDHP and people are not involved in the decision making</li> </ul>	<ul style="list-style-type: none"> <li>• The most of the participants think and are aware that decision is made by the BPKIHS</li> <li>• The VDC representatives are involved in the decision making process</li> </ul>
Part.2	<ul style="list-style-type: none"> <li>• Providing comments and enrolled in the scheme</li> </ul>	<ul style="list-style-type: none"> <li>• The participants get enrolled in the scheme and share it with other community people about it</li> </ul>
Part.3	<ul style="list-style-type: none"> <li>• The community people are involved in the annual gathering</li> <li>• Input communicated through the FCHVs and HP staff</li> <li>• People also can demand gathering for communicating input</li> </ul>	<ul style="list-style-type: none"> <li>• There is a VDC level committee to discuss and share the comments on the scheme but most of the members were not aware of the committee</li> <li>• One of the participants shared that she was asked feed back at the hospital about the services</li> </ul>
Part.4	<ul style="list-style-type: none"> <li>• Comments are heard sometimes but not always</li> <li>• Some of the participants suggest to involve people more in the process</li> </ul>	<ul style="list-style-type: none"> <li>• The participants were not sure the comments were heard because there is not much change in the system and services</li> </ul>



<b>QN.</b>	<b>LMIS</b>	<b>SHI</b>
Ablpay1	Most of the participants said the premium is cheap	The premium is affordable for all the participants
Ablpay.2	Most of them willing to increase the premium up to double if the level of treatment and drugs increased, few wanted to increase the premium very for the indoor services However, few of them didn't agree to increase the premium and some wanted to increase gradually	Less willing to pay if the premium is increased Suspects of decreasing the coverage in case the premium is increased Few participants willing to pay increased premium if the ceiling of the OPD drugs increased
Ablpay.3	Some of them had higher treatment out of HP and spent significant amount of money last year	
Ablpay.4	Most of them can make it from their savings if it's a small amount but for the big amount and sudden need, then they have to borrow or take loan from others	Most of them make the expenses from their saving and occasionally had to borrow from others or sell the things
Ablpay.5	The participants used to in the given timing of MIS but Mangshir could be relatively better	No specific timing mentioned

## **Annex-2**

### **FGD Guideline (For health insurance implemented community)**

#### **Introductory question**

What do you think of the health insurance scheme implemented in your HP/institution?

#### **Knowledge assessment**

1. Why is the health insurance scheme needed?
2. What are the benefits you get from the scheme?
3. Does it minimize you from the financial risks born by the ill health? How?
4. When do the time for enrolling/renewing the scheme open and close?

#### **Satisfaction Assessment**

5. How much are you satisfied with the health insurance scheme? Why?
6. Do you think the insurance scheme is useful for the health service of your family?
7. Have you ever dropped out form the insurance scheme? If so why?
8. Do you think the scheme should be continued in future? Why?
9. Do you recommend that insurance to be implemented in other HPs or institution? Why?

#### **Participation assessment**

10. Who makes the decision for the health insurance scheme?
11. What is your participation in the management of the scheme?
12. How do you communicate your opinion/comments about the scheme to the concerned authority
13. Is your comment heard?

#### **Ability to pay Assessment**

14. What do you think the insurance premium? High or low or OK?
15. If the premium were increased, would you be willing to pay? In what conditions? How much?
16. How much did you spend for the health care of your family last six month?
17. How do you manage your medical expenses?
18. What should be the arrangement for paying the scheme conveniently?

**FGD Guideline**  
**(For the scheme non-implemented community)**

**Introductory question**

1. What do you do if you/family members are sick?
2. How much health service do you get from the local health institution?
3. Are you satisfied with the health services available? If not why?
4. What should be improved if you are not satisfied with the current services?

**Ability to pay**

5. How much did you spend for you/family healthcare in the last six-month?
6. Will you be willing to pay for the health services in the local health institution? If not, what condition?
7. How much will be willing to pay?

**Annex-3**  
**FGD Participants List**

**Bhattedanda FGD Participants**

SN	Participant Name	Age/Gender	Ward No.	Occupation
1.	Gyan Bdr Sinjali	40/m.	8	Agriculture
2.	Tekar Nath Timalsina	44/m	8	Jobholder
3.	Ganga Psd. Ghimire	35/m	5	Agriculture
4.	Arjun Bdr.Karki	50 /m	8	Agriculture
6.	Ram Sharan Chaurel	35/m	8	Agriculture
7.	Kapil Bdr.Khadka	64	5	Agriculture
8.	Sitaram Chaurel	33/m	8	Teacher
9.	Pot Psd. Chaurel	53/m	5	Jobholder
10.	Guru Psd.Gautam	36/m	8	Business
11.	Indra Psd. Chaurel	55/m	5	Agriculture

**Chapagaon FGD Participants**

SN	Participant Name	Age/Gender	Ward No.	Occupation
1.	Gopal Maharjan	62/m	9	Agriculture
2.	Min Lal Deshar	50/m	3	Agriculture
3.	Prem Bdr.Nagarkoti	60/m	6	Jobholder
4.	Ram Bdr Deshar	58/m	3	Agriculture
5.	Shanta Lal Deshar	64/m	3	Agriculture
6.	Buddhi Bdr.Deshar	45/m	3	Agriculture
7.	Krishna Gopal Shrestha	33/m	4	Jobholder
8.	Rina Tamang	30/fe	2	Housewife

**Lele FGD Participants**

SN	Participant Name	Age/Gender	Ward No.	Occupation
1.	Dal Bdr.Bhandari	56/m	1	Agriculture
2.	Dhruba Bdr. Thapa	63/m	3	Agriculture
3.	Nar Bdr. Dangol	56/m	3	Business
4.	Dhruba Bdr. Shrestha	50/m	3	Agriculture
5.	Saila Nepali	57/m	3	Sewing
6.	Buddhi Bdr. Dayali	51/m	1	Agriculture
7.	Hari Dangol	52/m	1	Agriculture
8.	Siddhi Bdr. Dangol	58/m	1	Agriculture

### Chhampi FGD Participants

SN	Participant Name	Age/gender	Ward no.	Occupation
1.	Matiram Bista	46/m	5	Jobholder
2.	Yagya KC	43/m	2	Business
3.	Bala Ram Bista	52/m	5	Agriculture
4.	Damodar Thapa	61/m	6	Agriculture
5.	Narayan Bdr. Bista	46/m	2	Agriculture
6.	Hari Psd.Pyakurel	50/m	5	Jobholder
7.	Jitu Mijar	31/m	6	Agriculture
8.	Udhav Kumar Pande	44/m	5	Agriculture
9.	Krishna Kumari Bista	40/f	2	Agriculture
10.	Pashupati Bista	54/f	2	Agriculture
11.	Radheshyam Thapa	37/m	6	Jobholder
12.	Deepak Thapa	43/m	6	Business

### Sundarpur FGD Participants

SN	Participant Name	Age/gender	Ward No.	Occupation
1.	Yub Raj Giri	35/m	1	Jobholder
2.	Lekhnath Bhandari	45/m	9	Business
3.	Narayan Psd.Ghimire	34/m	9	Agriculture
4.	Naramaya Rai	45/f	9	Jobholder
5.	Purna Maya Rai	48/f	9	Business
6.	Rudra Dahal	31/m	9	Agriculture
7.	Kishori Nepal	32/f	9	Jobholder
8.	Krishna Kumari Dahal	43/f	1	Agriculture
9.	Maiya Parajuli	34/f	9	Agriculture
10.	Narayani Bhandari	35/f	9	Agriculture
11.	Komal Psd. Ghimire	51/m	9	Agriculture
12.	Ganga Psd.Ghimire	48/m	9	Agriculture

### Indrapur FGD Participants

SN	Participant Name	Age/gender	Ward no.	Occupation
1.	Teknath Subedi	56/m	5	Agriculture
2.	Mekh Bdr.Karki	45/m	5	Agriculture
3.	Laxman Subedi	50/m	5	Agriculture
4.	Rajik Miya	51/m	4	Agriculture
5.	Kwaish Miya	58/m	4	Masonry
6.	Balav Mandal	42/m	5	Agriculture
7.	Dilli Psd. Darji	34/m	5	Sewing
8.	Hem Bdr.Subedi	45/m	5	Agriculture
9.	Mukti Nath Adhikari	38/m	5	Business

### Panmara FGD Participants

SN	Participant Name	Age/gender	Ward no.	Occupation
1.	Bhumi Raj Dhakal	55/m	2	Agriculture
2.	Parbati Acharya	57/f	2	Agriculture
3.	Indira Niraula	45/f	3	Agriculture
4.	Ganga Chaulagain	34/f	2	Agriculture
5.	Sabitra Subedi	37/f	2	Agriculture
6.	Narayan Niraula	60/m	2	Agriculture
7.	Januka Acharya	36/f	2	Agriculture
8.	Ambika Acharya	35/f	2	Jobholder
9.	Pasbi Rai	46/f	2	Agriculture
10.	Deepa Upreti	32/f	3	Agriculture
11.	Devi Chaulagain	51/f	3	Agriculture
12.	Chandra Kumari Pulami	57/f	3	Agriculture