

Community Health Insurance in Nepal

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Health System Development

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Abbreviations

- HMOs: Health Maintenance Organizations ()
- US: United States
- CBHI: Community Based Health Insurance
- NGOs: Non-Governmental Organizations
- CHI: Community Health Insurance
- WHO: World Health Organization
- ILO: International Labor Organization
- STEP: Strategies and Tools against Social Exclusion and Poverty
- SHI: Social Health Insurance
- SCHIP: State Children's Health Insurance Program
- MDG: Millennium Development Goal
- GDP: Gross Domestic Product
- STDs: Sexually transmitted diseases
- OOP: Out of Pocket
- WHS: World Health Survey
- BPKIHS: Biseshwor Prasad Koirala Institute of Health Sciences
- I/NGOs: International Non-Governmental Organizations
- PHECT: Public Health Concern Trust
- KMH: Kathmandu Model Hospital
- GEFONT: General Federation of Nepalese Trade Unions
- USA: United States of America
- MIA: Micro Insurance Academy
- MFI: Microfinance Institutions
- VDC: Village Development Committee
- MIS: Management Information System

Introduction

The term **health insurance** is generally used to describe a form of insurance that provides coverage for health-related needs. It pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies, or from group employer-sponsored plan. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. The type of health care covered by your health insurance plan depends on the type of coverage and the amount you pay for the premium. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government. By estimating the overall risk of healthcare expenses, a routine finance structure (such as a monthly premium or annual tax) can be developed, ensuring that money is available to pay for the healthcare benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan

Background

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, "accident insurance" began to be available, which operated much like modern *disability* insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance. Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the US by 1866, but the industry consolidated rapidly soon thereafter. The first employer sponsored group disability policy was issued in 1911.

Before the development of medical expense insurance, patients were expected to pay all other health care costs out of their own pockets, under what is known as the fee-for-service business model. During the middle to late 20th century, traditional disability insurance

evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case. Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations. The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II.

The states in most developing countries have not been able to fulfill health care needs of their poor population. Shrinking budgetary support for health care services, inefficiency in public health provision, an unacceptable low quality of public health services, and the resultant imposition of user charges are reflective of the state's inability to meet health care needs of the poor. In the last decade the "health care crisis" led to the emergence of many community-based health insurance schemes (CBHI) in different regions of developing countries, particularly in sub-Saharan Africa. The decentralization process unleashed in these countries to empower lower layers of government and the local community further fueled their emergence. Neither the state nor the market is effective in providing health insurance to low-income people in rural and informal sectors. Indeed, most of the CBHI schemes have either been initiated by the health providers i.e., missionary hospitals, or tend to be set around the providers themselves. Thus, the potential benefit of these schemes is seen not just in terms of mobilization of resources but also in the improvement and organization of health care services

Community Health Insurance:

A Community-Based Health Insurance Scheme (CBHIs) is any program managed and operated by a community-based organization, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. These are local initiatives that build on traditional coping mechanisms to provide small scale health insurance products specially designed to meet the needs of low income households. They are voluntary schemes, and are typically based on concepts of mutual aid and social solidarity. They are designed to assist those in the rural and informal sector for whom other forms of health insurance are not as well-suited. Beneficiaries are associated with, or involved in the management of community-based schemes, at least in the choice of

the health services it covers. It is voluntary in nature, formed on the basis of an ethic of mutual aid, and covers a variety of benefit packages.

CBHIs can be initiated by health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can be owned and run by any of these organizations. They may be organized around geographic entities (villages, cities), professional bodies (i.e. cooperatives or trade unions) or around health care facilities. They strengthen the demand for health care in poor rural areas, and enable low-income communities to articulate their own healthcare needs. As a risk- management instrument, CBHIs can play a major role in smoothing household expenditure patterns. They also allow households to limit social pressure on their own resources by establishing a pre-payment mechanism for healthcare outlays (Preker et. al. 2001, and 2004).

Many community finance schemes have evolved in the context of severe economic constraints, political instability, and lack of good governance. Usually government taxation capacity is weak, formal mechanisms of social protection for vulnerable populations absent, and government oversight of the informal health sector lacking. In such difficult contexts, community involvement in financing health care provides a critical first step towards improved access to health care by the poor and social protection against the cost of illness.

Community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. The World Health Report 2000, for example, noted that prepayment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes (World Health Organization 2000).

WHO defines CHI as “any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management.” CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events. They are generally targeted at low-income populations, and the nature of the ‘communities’ around which they have evolved is quite diverse: from people living in the same town or district, to members of work cooperative or micro-finance groups. Often, the schemes are initiated by a hospital, and

targeted at residents of the surrounding area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory. CHI includes:

- provides enrollees with a “medical home”;
- offers some form of care management that enhances early detection of medical problems, promotes preventive care, and reduces inappropriate utilization of emergency and inpatient services;
- gives providers some incentives to serve patients who cannot pay for services; and
- promotes the dignity of enrollees.

CBHIs are called by many different names, including: micro-insurance, community health finance organizations, mutual health insurance schemes, pre-payment insurance organizations, voluntary informal sector health insurance, mutual health organizations associations, community health finance organizations, and community self-financing health organizations. There is little to distinguish one from another, except that some terms are more commonly used in one part of the world than another.

In context to Nepal, there are various types of micro health insurance (CHI) are running under various programs. The Government is actively fostering the development of these health insurance systems. In a recent ILO round table discussion, former Minister for Health, Dr. Upendra Devkota declared that "access to health services is a right of all citizens. No one should be barred from health services due to a lack of treatment, low income or poverty. It is a shame that people have to beg for health care, as it is their birthright". Whether in the form of a health cooperative, a health post or so-called social health insurance; all these initiatives offer health insurance at the grassroots, with a genuine interest in providing affordable health care. When properly managed, health micro-insurance schemes carry enormous potential for transforming the lives of the excluded.

The concept of health insurance has been highlighted in the first and second Long-Term Health Plans, Nepal Health Sector Strategy Programme etc. Both the First (1976-1996) and the Second Plans (1997-2017), and ninth plan has underlined the importance of health insurance scheme in the country (NHP, 1991) and emphasis has been given to develop health insurance schemes in the country.

In Nepal, ILO/STEP is working with local partners to develop health micro-insurance that will improve access to health care for workers in the informal economy. The ILO's shows

how health micro-insurance helps pool risks and resources of community groups to provide health protection to all members against financial consequences of the various risks. Community-based initiatives are providing a gateway to health care for the poor and excluded. The ILO's continuous promotion of social protection in health has encouraged organizations, from the grassroots to the government, to launch innovative health micro-insurance schemes. The ILO is technically supporting the policy and programming health insurance initiatives taken up by the Government, and encouraging the connection between national level policies and local initiatives. Government, trade-unions and NGOs act as partners in the provision and as advocates for the extension of social protection. And their collaborative work as providers and promoters is paving the way for extending health care to poor and disadvantaged groups in Nepal.

The holistic approach taken by the different actors in Nepal gives health micro-insurance schemes the chance of remaining viable and sustainable in the long term. This well-conceived micro-insurance scheme which instills responsibility at the health posts has become a model in Nepal.

The Ministry of Health and Population intends to initiate alternative financing schemes such as community and social health insurance schemes as a means to supplement the government health sector financing source. SHI is a mechanism for financing and purchasing / delivering health care to workers in the formal sector regulated by the government. Currently there are no such schemes in Nepal, though a small number of agencies provide medical benefit packages, including membership of private insurance schemes, to their employees. CHI schemes are attractive as they provide the opportunity to link the activities into local management processes. MOHP is considering working closely with different CHI schemes and using them to provide information for developing an approach for wider replication elsewhere in Nepal.

The US Census Bureau broadly classifies health insurance coverage as either Private (non-government) coverage or Government-sponsored coverage.

Private Health Insurance

Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

Employment-based plans:

Employment-based health insurance is coverage offered through one's own employment or a relative's. It may be offered by an employer or by a union.

Own Employment-based plans:

Own employment-based health insurance is coverage offered through one's own employment and only the policyholder is covered by the plan.

Direct-purchase plans:

Direct-purchase health insurance is coverage through a plan purchased by an individual from a private company.

Government Health Insurance:

Government health insurance includes plans funded by governments as the federal, state, or local level. The major categories of government health insurance are Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), military health care, state plans, and the Indian Health Service.

Medicare

Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.

Medicaid

Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.

SCHIP

SCHIP, the State Children's Health Insurance Program, is a program administered at the state level, providing health care to low-income children whose parents do not qualify for Medicaid.

State-specific plan:

some states have their own health insurance programs for low-income uninsured individuals.

These health plans may be known by different names in different states.

DEFINITIONS OF HEALTH INSURANCE TERMS

- **Premium:** The amount the policy-holder or his sponsor (e.g. an employer) pays to the health plan each month to purchase health coverage.
- **Deductible:** The amount that the insured must pay out-of-pocket before the health insurer pays its share. For example, a policy-holder might have to pay a \$500 deductible per year, before any of their health care is covered by the health insurer. It may take several doctor's visits or prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care.
- **Copayment:** The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a \$45 copayment for a doctor's visit, or to obtain a prescription. A copayment must be paid each time a particular service is obtained.
- **Coinsurance:** Instead of, or in addition to, paying a fixed amount up front (a copayment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.
- **Out-of-pocket maximums:** Similar to coverage limits, except that in this case, the insured person's payment obligation ends when they reach the out-of-pocket maximum, and the health company pays all further covered costs. Out-of-pocket maximums can be limited to a specific benefit category (such as prescription drugs) or can apply to all coverage provided during a specific benefit year.
- **Capitation:** An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.

Statement of the problem

The socioeconomic conditions of Nepal, a rural, agricultural economy with low human development and presence of endemic poverty, have made the health sector a priority for sustained economic development. Equitable access to quality health care to meet the needs of the poor and reduction in poverty by achieving Millennium Development Goal (MDG) is the key concerns of the health policy.

The problem of financing of the health sector is a matter of serious concern to the government since there are indications of scarcity of resources in general. The incremental increase in per capita expenditure of the Ministry of Health and Population (MoHP) over the past decade has averaged about one per cent only – this is far below the WHO-recommended target of 5% of GDP spent on health. There is indication that the level of health expenditure will continue to be low with a scarcity of public resources in general, which may have a sharp impact on health expenditure, as it will be unable to meet the growing demands of the people. More than 40% of the population lives below the poverty line. Its ranking in terms of Human Development Indicators is low as Health Indicators are still poor. Likewise complications at childbirth, nutritional disorders and endemic diseases such as malaria, tuberculosis, leprosy, STDs, vector-borne diseases continue to prevail. New emerging health problem requires high technology(beyond the capacity of government) and high cost(beyond the capacity of poor people) that point to the need for a large investment in health even to reach the norm of South Asian countries in the context of a significant health financing gap in Nepal.

This health financing gap has been met largely by **out-of pocket** (OOP) expenditure; for example Hotchkiss et al. (1998), in their 1995/96 estimation, find that nearly **three quarters of health expenditure are borne by households**. This information along with the low level of public health expenditure, suggest that HMG has not been able to effectively meet the health financing demand of the country. This inability of public expenditure for meeting the general health expenditure of the population underlines the **need for alternative health care financing mechanisms**.

Literature review

One of the ways that poor communities manage health risks, in combination with publicly financed health care services, are community-based health insurance schemes (CBHIs). These are small scale, voluntary health insurance programs, organized and managed in a participatory manner. They are designed to be simple and affordable, and to draw on resources of social solidarity and cohesion to overcome problems of small risk pools, moral hazard, fraud, exclusion and cost-escalation. Less than 10 percent of the informal sector population in the developing nations has health coverage from a CBHI, but the number of such schemes is growing rapidly. On average, CBHIs recover between quarters to a half of health service costs. As a social protection device, they have been shown to be effective in reducing out-of-pocket payments of their members, and in improving access to health services. (*Steven R. Tabor, 2005*)

Community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism such as social health insurance in Europe and Japan. Social health insurance in these countries, in fact, evolved from a conglomeration of small 'community' health insurance schemes. Historically, during the peak of the industrial revolution workers' unions developed insurance mechanisms which were eventually transformed. Community health insurance programmes in India offer valuable lessons for policy-makers. (*N DEVADASAN, WIMVANDAMME, BARTCRIEL, 2004*)

Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor. In poor environments, insurance programs can work: Members of mutual health organizations (CHI) have a higher probability of using hospitalization services than nonmembers and pay substantially less when they need care. Furthermore, the analysis revealed that while the schemes achieved to attract poor people, the poorest of the poor remained excluded. (*JOHANNES P. J UUTTING, 2003*)

The paper identifies five co-operative models in health care. A) A primary care co-operative is formed by members in particular communities to provide quality medical, dental, allied health and home-based services with an emphasis upon continuity and integration of care. B) A community hospital co-operative is formed by members in particular communities to maintain or introduce a local or community hospital service. C) A health services and products purchasing co-operative is a co-

operative which aggregates the purchase of health services and and/or insurance products to obtain benefits for members. D) A health insurance co-operative provides insurance products for its members (individuals and/or organizations). E) An integrated provision and insurance co-operative integrates the purchasing and provision of services in the form of pre-paid health care packages, or managed care arrangements. (*Vern Hughes, 2003*)

Health policy makers are faced with competing alternatives, and for systems of health care financing. The choice of financing method should mobilize resources for health care and provide financial protection. This review systematically assesses the evidence of the extent to which community-based health insurance is a viable option for low-income countries in mobilizing resources and providing financial protection. There is strong evidence that community-based health insurance provides some financial protection by reducing out-of-pocket spending. There is evidence of moderate strength that such schemes improve cost-recovery. The main policy implication of the review is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing. (*Björn Ekman, 2004*)

In low-income countries, only two percent of WHS (world health survey) respondents with voluntary insurance belong to the lowest income quintile, suggesting very low CHI penetration among the poor. Yet according to the WHS, medicines are the largest reported component of out-of-pocket payments for healthcare in these countries (median 41.7%) and this proportion is inversely associated with income quintile. Publications have mentioned over a thousand CHI schemes in 19 low-income countries, usually without in-depth description of the type, extent, or adequacy of medicines coverage. Evidence from the literature is scarce about how coverage affects medicines utilization or how schemes use cost-containment tools like co-payments and formularies. On the other hand, interviews found that medicines may represent up to 80% of CHI expenditures. (*Catherine E Vialle-Valentin, Dennis Ross-Degnan, Joseph Ntaganira, and Anita K Wagner, 2008*)

Purpose of the study

General objective:

- To study the various model of community health insurance in Nepal.

Specific objective:

- To study the community hospital based insurance scheme in Nepal.
- To study the community, health-post based insurance scheme in Nepal.
- To study the co-operative health insurance scheme in Nepal.

METHODS AND MATERIALS

3.1 Study duration: The study was carried out from March 12 2009 to April 13, 2009.

3.2 Study design: Descriptive study

3.3 Data collection procedure/process: review of publications and books, surfing of web sites related to health insurance was the procedure of data collection for the study.

2.8 Data processing and analysis: It was done by MS-Word

3.5 Limitations of the study: the study was limited to models of community health insurance in Nepal.

Findings:

Community, Hospital-based health insurance:

Health care costs, and those for inpatient care in particular, pose a barrier to seeking health care, and cost be a major cause of impoverishment, particularly among the poor. The largest micro-insurance scheme in Nepal is run by a regional hospital in the foothills of Eastern Nepal. Dr. Narayan Kumar, Hospital Director, the founder and visionary behind this scheme, learned the principles of health insurance at a joint ILO/STEP and ILO/Training Centre course in Turin, five years ago. Inspired by the innovative concept, in 2000 he set up a Community Health Insurance Scheme at the B.P. Koirala Institute of Health Sciences (BPKIHS) for the people of Dharan and neighboring districts. BP Koirala Institute of Health Sciences (BPKIHS) has introduced CHI scheme in 2000 as an alternative health care financing mechanism to the community people of Sunsari and Morang districts. In the beginning small area was elected as a pilot project to launch the scheme. A major objective of CHI is to reduce poverty caused by paying for health care and to prevent already vulnerable families from falling into deeper poverty when facing health problems. The premium for urban areas is four times higher than rural areas. The service package includes free consultations and investigations in Out- and In-patient Departments, free hospital beds and medicines and operation charges beyond certain limit. The entire premium, contributions from VDC etc. go to hospital. The income shows surplus, but does not include expenditures borne for manpower, equipment costs etc.

The scheme is now marketed by more than 30 Village Development Committees, municipalities, schools and colleges, socio-cultural organizations and other local community groups, as well as I/NGOs. These organizations represent 18,000 members, and BPKIHS has the largest membership of any insurance scheme in Nepal, covering both the formal and informal economy. A total of 26 organizations with 19799 populations are at present in CHI scheme. Sixteen rural based organizations with 14,047 populations and 10 urban based organizations with 5752 people are the beneficiaries in this scheme. BPKIHS CHI Scheme is the outcome of the visionary thinking on social solidarity and as an alternative health care financing mechanism to the community. BPKIHS is mobilizing people's organizations and is offering health services through its health insurance scheme at subsidized expenses.

Co-operative health insurance:

At the local level, **PHECT** (Public Health Concern Trust) created a cooperative structure in order to encourage the involvement of the local community which comprised of several families and membership (family as a unit) is voluntary. In 1992, a group of doctors wishing to offer their services to the poor established a small clinic in the village of Tikathali. It was an experiment to learn how best to provide health services. A year later, PHECT Nepal founded the 'Kathmandu Model Hospital' aiming to make it a referral centre for their target community. At present, about 1,000 families are benefiting from the scheme and the membership has remained more or less stable since the beginning. Today, under PHECT's umbrella, there are five health cooperatives and one Health Information and Service Centre that provide health micro-insurance to the community through local clinics.

The various cooperative health insurance schemes running in Nepal:

- Tikathali Women's cooperative
- Seti Devi Health Cooperative
- Bikalpa Cooperative of Kirtipur
- Highway Health Cooperative in Dhading
- Sahaj Cooperative in Nawalparasi
- GFONT health cooperative

Co-operative health insurance provides two type of premium:

- I. Rs.400/person/year and a discount of 70% in the referral cases.
- II. Rs.300/person/year and a discount of 30% in the referral cases.

Each of the cooperatives have their own clinic and provide primary treatment services and referrals for Kathmandu Model Hospital (KMH) with the exception of dental and medicines. Fifty per cent of total collections go to KMH. Subsidy is provided to the poor on referral cases. There is coverage for 2 038 persons from 438 households.

The **GEFONT** (General Federation of Nepalese Trade Unions) has also begun to reach out to workers in the informal economy by promoting community-based health insurance. One of

the largest trade-unions in Nepal, GEFONT is dedicated to the rights, welfare and dignity of workers from different economic sectors, such as carpet, textiles, tourism, transportation, rickshaw pulling, agriculture, public and civil construction. GEFONT has been running a comprehensive welfare fund for transport workers since the early 1970's, and has recently acknowledged the call for health protection from all its constituents. In 2000, a health cooperative was founded as the first step towards a workers' cooperative movement. The health cooperative aims to provide affordable health care and clinical services to its members. The insured members of this Kathmandu-based health cooperative are referred to the hospital founded by PHECT. GEFONT has a dream to extend health protection to all its workers within the next five years. A nation-wide campaign carries the slogan, "All for one, and one for all", and through cooperative action their dream is materializing. With technical support of the ILO, GEFONT is now forming workers' health cooperatives across the country to carry out programmes related to micro-insurance.

MIA (Micro Insurance Academy) and Save the Children (USA) have created a consortium to introduce micro insurance to resource-poor communities in Nepal. The MIA and Save the Children signed last April (2008), to launch community-based micro insurance project in Nepal, which will provide health, life and property insurance. The unique feature of this project is the intensive involvement of local communities in designing the micro insurance products and in operating the insurance system at grassroots level. In July, the consortium organized consultations on micro insurance with leading NGOs and microfinance institutions (MFI) in Nepal. In the course of these consultations, the NGOs & MFIs decided to jointly establish the Nepalese Micro insurance Coalition. Save the Children and the Micro Insurance Academy will jointly provide technical and other support to this coalition, with the view to enabling more than one million persons from poor communities in Nepal to launch their own micro insurance scheme.

Over the past year, the Micro Insurance Academy (MIA) had been developing and testing innovative training tools for developing capacity to implement micro insurance programs. The MIA provides its services to community-based schemes through a series of successive steps, each additional module building on previous learning to create desirable, sustainable, and cost-effective micro insurance units. The MIA has developed a comprehensive set of training materials, delivered through 9 modules. The full set of modules provides communities with a complete understanding of the benefits that community-based micro health insurance schemes can bring. They also provide communities with the tools necessary

to democratically and transparently govern and successfully maintain a health insurance scheme.

Community, health post-based health insurance:

The oldest micro-insurance scheme in Nepal started with the establishment of local health posts by the **United Mission to Nepal**. Over 27 years ago, the community health development programme of United Missions to Nepal founded the "Lalitpur Medical Insurance Scheme". United Missions to Nepal managed to set up a viable scheme for the habitants of villages in and around Kathmandu. The Lalitpur Medical Insurance Scheme mainly covers the costs of essential drugs supplied to the health posts. Under this scheme, beneficiaries pay an annual premium to receive free essential drugs and a range of promotional and preventive health care at nominal fees. For serious illnesses, the health posts have a provision to refer patients to Patan Hospital in Lalitpur district.

Chapagaun Teaching Health Post, is currently owned by the local government, governed by the community, and managed by a Nepali Christian organization called Shanti Nepal (Peace for Nepal). The health post offers integrated primary health care services, including mental health care and dental services. The poor and lower middle class and those marginalized by society are the major beneficiaries of the health post services. While the well-trained and conscientious staff members provide basic curative care and preventive services, they also work with community groups and schools to raise awareness of health issues. Furthermore, Chapagaun Teaching Health Post serves as a source of training for paramedical and nursing students, as well as local midwives and healers. The health insurance system developed at this facility is a model for the country, and has been replicated in other health posts as well.

Discussion

Till date, health insurance in Nepal has not been commercialized and there is no any government health insurance scheme. Nepal does not have the long history of health insurance. Only the micro health insurance (CHI) scheme is existing in Nepal which is only specified to a certain target population. A small number of agencies provide medical benefit packages, including membership of private insurance schemes, to their employees.

The community based health insurance scheme provide health services at subsidized rate which help people to avail with health facilities who otherwise would have been left vulnerable because of their penetrating health need as the cost of health services is beyond the reach of poor people. The services provided by cooperative health insurance is similar to the services provided by the various models of cooperative health insurance (*Vern Hughes, 2003*). After 2000, GEFONT is now forming workers' health cooperatives across the country to carry out programmes related to micro-insurance which can be a factor of greater motivation of the workers as well as improves the health of the workers. As the workers become healthy the productivity also increases. And also the financial burden of cost can also be reduced.

As our findings shows that community health insurance scheme mainly focused the poor and the coverage of scheme is high among the poor which is just opposite of the study (*Catherine E Vialle-Valentin, Anita K Wagner, 2008*) in low income countries where there is low penetration of the CHI among poor.

In community, hospital-based health insurance scheme the entire premium, contributions from VDC etc. go to hospital(BPKIHS) and in community, health post based insurance premium fifty per cent of total collections go to KMH which shows the profit motive rather than the service motive(like as money for health services). The MIA (Micro Insurance Academy) and Save the Children (USA) approach to introduce micro insurance to resource-poor communities with the involvement of local communities can be a way to expand health insurance up to grassroots level as well as increasing understanding of health insurance.

There is huge gap between premium collection and expenditures. The expenditures are more and this may be due to knowledge - do gap in the program. If conditions are unsuitable, CHI can lead to higher costs of care, inefficient allocation of health care resources, inequitable provision and dissatisfied patients. It can also be more difficult to realize the potential advantages of CHI in future. The future challenges confronting the scheme are to give the

continuity and sustainability of the program to its catchments areas with a shift in program operation mechanism. Hence Nepal has a long way to go..... (Better coverage of health insurance).

The success of Chapagaun teaching health post local governance

Conclusion

Community health insurance (CHI) has been a possible means of: improving access to health care among the poor; and protecting the poor from impoverishment resulting from medical expenditures. The different models of community health insurance scheme are providing services to the people mainly the excluded groups. Health insurance is also being provided by cooperatives in various places.

Although health insurance is only specified to small areas and to the target population (poor) but the success is really appreciable, in terms of care seeking behavior of the poor as well as the appropriate utilization of the medicines. Also the success of various community health insurance could be a lesson for the government of Nepal to expand public health insurance scheme. The approach of MIA (Micro Insurance Academy) and Save the Children (USA) to introduce micro insurance can be a better way to expand health insurance.

The government of Nepal is intended to initiate health insurance as an alternate source of health financing. MOH is considering working closely with different CHI schemes and using them to provide information for developing an approach for wider replication elsewhere in Nepal. However, CHIs may still play a role in those countries or regions like Nepal where coverage cannot be ensured in a short period of time by the alternatives.

Based on the study we make the following recommendations:

- People's active involvement is required, which will further provide a sense of ownership in the scheme amongst the people.
- Government should be seen to guide CHIs in the direction of a national system of universal coverage and financial protection.
- Government should make an effective policy on health insurance.
- More awareness among the community.
- Government, and its development partners, can support the growth of CBHIs by ensuring that there is a satisfactory supply of appropriate health services, by subsidizing start-up costs and the premium costs of the poor
- Government should monitor the basic performance of each CHIs, track progress across the different schemes through time, and perform comparative analysis.
- An effective MIS that monitors the programme closely and makes midterm corrections where necessary.

