A Case Study on the Insurance Scheme of the Public Health Concern Trust (PHECT) Nepal

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Executive Summary

The Public Health Concern Trust (phect-NEPAL) is a non-profit organization established in 1991 with an objective of creating a sustainable health care system for the excluded section of the population. It is one of the pioneers in introducing the concept of health savings at the community level, through health services centres.

In June 1992, phect-Nepal established an Insurance Scheme called the Community Health Insurance Scheme. Since then the Scheme has been providing both curative and awareness raising health services in 8 Village Development Committees, namely, Tikathali, Lamatar, Setidevi, Siddhipur, Harisiddhi, Layaku, Wasbang and Bhandar. Each are managed by a Local Coordination Committee (LCC), which is responsible for running the health centre, creating awareness, and collecting premiums for financial support of the Schemes. The community clinics are run by Health Assistants. The Health Assistants are supported, at least twice a week, by visiting doctors from Kathmandu Model Hospital.

The Kathmandu Model Hospital provides referral services to the members of the Scheme. The hospital has an inpatient capacity of 50 beds and an ambulance service. Its office facilities are equipped with computers, photocopy machines, telephone connections, Internet and E-mail. The Hospital has its self-owned premises. The health centres located at the community level do not have their own buildings. However, almost all of them are connected to telephone facilities.

The LCCs formed in each VDC consist of 12-15 members in their Executive Body (EB). The EB is required to be comprised of at least one-fourth female members. All members of the EB work as volunteers with the responsibilities such as: the management of clinic activities, day-to-day operation of the pharmacy, collection of premiums, and their allocations, enhancing memberships, and the dissemination of information.

Before the implementation of the Insurance Scheme, a baseline survey was conducted. The Scheme was initiated without any other formal pre-feasibility and feasibility studies. A general agreement was set up between the beneficiaries and phect-NEPAL regarding coverage of health services and the methods of contribution collection. This process did not involve much elaboration of the legal formalities. The administration and management system of the Insurance Scheme relies more on the good faith of the health care provider and the cooperation of members, than on any formalized legal statutes. Both parties are making themselves equally responsible in complying with the clauses of the agreement.

Membership to the Insurance Scheme is open to all interested families regardless of age group, sex, health risk, religion, caste, ethnicity and income status. Membership status is given to the household head,followed by other members in the family as eligible beneficiaries, upon payment of the premiums. Average size of the beneficiary households is 6, ranging from 4 members at the lowest and 21 members at the highest.

Individual households have to apply for membership by submitting an application. A contract is then signed between the health service centre and the members concerned. In this contract, the member needs to commit their contribution of premiums, while the health service centre, on the other hand, makes commitments for providing access to health services at a subsidized rate.

Almost all members are semi-urban residents. Around 84 percent hold agriculture as their major occupation. Most of them have a family income of Rs. 10,000.- to Rs. 15,000.- per annum. Around 65 percent of the members in the Insurance Scheme area are literate (significantly high as compared to the national rate). Hardly 12 percent have passed the School Leaving Certificate and above. The male female ratio of the literates is around 90:45.

Nearly 45 percent of the households have access to a piped water supply, while the remaining others rely on natural streams and wells. The people have access to a post office, schools, electricity and telephone facilities. Around 96 percent have either permanent or temporary latrines built on their household premises.

The Insurance Scheme requires all members to deposit 25 paisa per day (50 paisa in the case of some Schemes) as their contribution. In return, they receive subsidized (50 percent) health services (e.g., general medicine, hospitalization, surgery and gyne-obstetrical investigation). The rate of premium is determined in view of member's affordability rather than from the standpoint of recovering cost against the benefits offered. Compared to the benefits offered, the premiums raised are small.

All contributions are paid in the cash form. Options are provided to pay the premiums in lump sum or in instalments depending upon the member's choice. According to the records maintained by the Insurance Schemes, the majority of the members are paying lump sum with an exception of some poor families who pay in 2 instalments.

Fifty percent of the collected premium is used for the management of health services at the local level, while the other half is forwarded to the Kathmandu Model Hospital, as members' contribution.

The Insurance Scheme covers around 19 percent of the total population (i.e., 135 out of 700 households) of different VDCs of its area. The total number of persons served was recorded at around 35,000 in June 1999. The majority of the beneficiaries were between the age group 19 to 65 years. The male-female ratio of the beneficiaries was 98:66.

Under the referral support arrangements, Kathmandu Model Hospital has been providing outpatient care and hospital treatment services for the members at a discount rate of 50 percent. The services cover both diagnostic and curative support. Among the diagnostic services, pathological and hematological investigations, and the radiological tests are covered. In the curative services, general medicine, surgeries (general surgery, plastic surgery, neuro-surgery, and orthopaedic surgery), gynecological treatments, ear, nose and throat treatments, dermatology and sexually transmitted diseases are included. Other services include: oral health/ dental services, acupuncture and physiotherapy.

At the initial stage, phect-NEPAL did not fix any limits on the benefits offered to the members and therefore, the members could avail the health services of their needs as offered by the clinic and Kathmandu Model Hospital free of charge. After a few months of operation, these services were made available at a subsidized payment rate of 50 percent. In the initial stage, the services offered were mostly curative (covering general medicine, hospitalization and surgery). At present, emphasis is on the preventive measures.

The Insurance Scheme has been extending services to both members and non-members. The non-members do not get subsidy on the services except for medical counselling.

The members need to present their membership card at the health centre to access health services. For obtaining treatment from Kathmandu Model Hospital, the same membership card, together with the referral sheet should be submitted.

Turnover of members has been more or less balanced because of the almost equal number of outgoing and incoming members in the range of 10-15 households per year. The members who do not continue to pay their contribution, and do not participate in the cooperative savings activities, are suspended from membership as decided by the Local Coordination Committee.

There are no variations in the service facilities provided to each of the members, and all are treated equally. Efforts are made to reach the socially and economically less developed communities as far as possible.

Some preventive activities covered by the Insurance Scheme are: sanitation, health literacy, ensuring access to drinking water and toilet construction. Similarly, immunization, vitamin-A, polio and iron tablets distribution are also conducted.

The amount spent by the Hospital on subsidized services is more than the amount of revenues contributed by the premiums paid by the beneficiaries. The Insurance Scheme still needs to struggle hard for full cost recovery and to create reserve funds for future use.

The total amount of subsidy accessed by the members for their health service benefits stood at around Rs. 50,000.- in 1998. This decreased to almost half and even less in the subsequent year (Rs. 17,898.-) because of declined access to services.

During the initial stage of establishment, phect-NEPAL paid the staff salaries of the health service centre clinics. Now, this is the community's responsibility. Since most of the staff are working as volunteers, the operational cost burden of the Insurance Scheme is smaller than what it could have been.

A committee formed of two members (President or Vice-President and the Treasurer) decides the expenditures by line items. The Treasurer handles petty cash. Registers are maintained for memberships and their contributions, including services offered and premium overdue. All payments made by the members are acknowledged by issuing receipts against the amount obtained.

The General Assembly meetings are regularly organized. The attendance of the meetings is more than 80 percent of the members are present every time. Other meetings are held as needed.

The Insurance Scheme has been confronted with the challenge of traditional beliefs influencing the health practices in the community. Some families believe that the sickness can only be treated by the traditional healers and cannot be treated through modern medical practices. Some even interpret that most of their illness have roots in their past deeds. With the introduction of Insurance Scheme, such superstitions are declining as indicated by the reduced number of patients approaching Dhamis and Jhankris, the traditional healers.

The Insurance Scheme has been useful in providing access to health services for people who would have been otherwise excluded. In the context of the Alma Ata Declaration (i.e., health for all by the year 2000) followed by Nepal, and the emphasis laid by the Ninth Development Plan (1997-2002), the Government is gradually moving towards the privatization of the health services. The efforts made by phect-Nepal with the Insurance Scheme to date is assisting with gradually moving towards this direction.

At present, the contribution of members is small when compared to the cost of subsidized treatment. Any cost explosion in future might challenge the sustainability of the Insurance Scheme. A diversification of new sources of revenue generation is needed. In the meantime, the challenge ahead is to turn the “subsidy-based” approach into a “cost-recovery” approach.

The Insurance Scheme has no provision for addressing epidemics, should they occur. For the diversification of services, phect-NEPAL has been trying to involve other sister organizations into the health support process. Realizing the importance of a health insurance scheme for the poor people with low income, some VDCs have already been supporting the Insurance Scheme. In order to increase the number of members, phect-Nepal has made an attempt to involve GEFONT (a federation of trade unions, which consists of more than 300,000 members) as a member in 1999.

Besides providing treatment to the patients, the Insurance Scheme has also attempted to bring both perceptual and behavioural changes among people living in the disadvantaged communities. Their awareness of health issues has been increased together with the knowledge of the advantages of generating savings for investment on future health care needs. However, it is not yet free from problems such as limited awareness of people in the community about the advantages of joining health care schemes, lack of interest for savings and reluctance to contribute advances on the future benefits (e.g., some new entrants joined the Insurance Scheme only when one of their family members was ill).

Phect-Nepal has been regularly monitoring the performance of the Insurance Scheme. In order to increase the management competency of health services centre staff, it has occasionally organized training and orientation programs for them. Some Insurance Schemes have already been registered as a Health Cooperative to institutionalize the process formally. It is expected that this kind of institutionalization process would help the Insurance Schemes gain needed strengths for self-reliance in the future.

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Abbreviations and Conversion Rate

AIDOS	An Italian Association for Women in Development
CHDP	Community Health Development Program
CHIS	Community Health Insurance Scheme
CMR	Child Mortality Rate
DPHO	District Public Health Organization
EB	Executive Body
EC/UNFPA	European Community United Nations Fund for Population
ENT	Ear, Nose and Throat
GEFONT	General Federation of Nepalese Trade Union
HISC	Health Information and Service Centre
HMG/N	His Majesty's Government of Nepal
IMR	Infant Mortality Rate
JNCFA	Japan-Nepal Cultural and Friendship Association
LCC	Local Coordination Committee
LHC	Local Health Conscientizers
MMR	Maternal Mortality Rate
NGO	Non-Governmental Organization
phect-NEPAL	Public Health Concern Trust, Nepal
RHI	Reproductive Health Initiative
SWC/N	Social Welfare Council, Nepal
VDC	Village Development Committee

Conversion Rate

1 US Dollar equals to NRs. 78.35 (May 2002)

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I. A DESCRIPTION OF THE COMMUNITY HEALTH INSURANCE SCHEME

Established as a non-governmental organization in 1991, the Public Health Concern Trust (phect-NEPAL) is a non-profit making entity. It is registered at the Kathmandu District Administration Office and affiliated with the Social Welfare Council/Nepal (SWC/N) since February 1993. The Ministry of Health has granted permission for its operation in the health sector.

1.1 Objectives

Principal objective of phect-NEPAL is to create a sustainable health care scheme based on the principles of people's participation, with the goal of achieving better health services to a greater number of the poorer section of the population. Specific objectives are:

- To launch community health development activities either independently or in coordination with other government health institutions and NGOs.
- To seek ways for providing sustainable health services to the needy.
- To facilitate/encourage the establishment of health cooperative models in the community.
- To engage in the research work concerning community health and any other field of health science.
- To run a central model hospital, which will serve as the referral hospital for the community (which also will be open for others as a centre for training health professionals in the phect-NEPAL's spirit; a place for research and academic activities).
- To implement the idea of integrating curative service with preventive medicine.
- To establish coordination with local health authorities and other NGOs to launch various health activities.
- To create a small model of non-commercial, sustainable, non-governmental health care scheme, which could be replicated by other organizations.

1.2 Support Agencies for phect-NEPAL

At the initial stage, phect-NEPAL received partial support from the Japan Nepal Cultural and Friendship Association (JNCFA). This support was useful during the time of establishment of Kathmandu Model Hospital. The Kathmandu Model Hospital is one of the activities of phect-NEPAL, governed by its Executive Board.

From February 1999, the phect-NEPAL initiated a project in the Kirtipur Municipality on Reproductive Health in partnership with the Italian Association for Women in Development (AIDOS) with the funding assistance of EC / UNFPA.

The phect-NEPAL is also one of the partner NGOs implementing a Reproductive Health Initiative (RHI) program funded by the EC / UNFPA in Nepal. It collaborates with the District Public Health Office (DPHO) for health related activities. It regularly participates in various interaction programs and meetings related to health issues. The phect-NEPAL has been working in collaboration with the local health posts and sub-health posts at the community level.

1.3 Community Level Health Services

The phect-NEPAL runs a Community Health Development Program (CHDP) in 8 areas (Table-1). Each of these areas has a Health Information and Service Centre, trained Local Health Conscientizers (LHC), one Health Assistant and a Pharmacy. Daily health services are rendered in the Health Information and Service Centre clinic by the Health Assistant, while a physician provides weekly services.

Table-1: Location of Health Information and Service Centres

Location	District	Date of Establishment
Tikathali VDC	Lalitpur	October 1992
Lamatar VDC	Lalitpur	December 1993
Setidevi VDC	Kathmandu	February 1994
Siddhipur VDC	Lalitpur	March 1994
Harisiddhi VDC	Lalitpur	March 1995
Layaku, Kirtipur	Kathmandu	March 1995
Wasbang, Lothar	Chitwan	February 1994
Bhandar	Ramechhap	March 1998

Source: phect-NEPAL, 2000

1.4 Central Level Health Services

Kathmandu Model Hospital located at Bagbazar provides curative services to the people coming from various places. This is also a place for accessing referral health care services for community members of the Health Information and Service Centres promoted by phect-NEPAL.

Historically, Kathmandu Model Hospital was established in 1993 as a referral clinic, which gradually evolved into an 18-bed hospital with basic facilities. In 1995, the hospital was upgraded to a 50-bed hospital with a maternity ward and other specialized services. Kathmandu Model Hospital extends both diagnostic and curative services:

a. Curative Services

General medicine
General surgery and plastic surgery
Neuro-surgery
Psychiatric
Orthopaedic surgery
Gynecology / Obstetric, Maternity and Neonatal
Paediatrics (Med. & Surgery)
Ear, Nose and Throat
Dermatology and sexually transmitted diseases

b. Diagnostic Services

Pathological and hematological investigations / histopathology
Radiological (General & Special)

c. Other Services

Oral Health /Dental
Acupuncture
Physiotherapy
Mother and Child Health clinic
Pharmacy

Operating with limited resources, the hospital is using best available methods of treatment. For example, the orthopedic surgeons are now using Elizarov type external fixators to treat difficult fractures. This is relatively new in the country and very few surgeons are using this method. Similarly, in the field of general surgery, 'minicholecystectomies' and 'lapcholecystectomies' are being performed.

The outpatient and in-patient departments of Kathmandu Model Hospital provided service to nearly 51 thousand patients in 1999.

Table-2: Services Extended to Patients in 1999

Service Unit	Number of Patients
Out Patient Department	48,564
In-Patient Department	2,251
Total	50815

Source: phect-NEPAL, 2000

The phect-NEPAL is served by a staff of 146, 90 percent of whom are located around the hospital.

Table-3: The phect-NEPAL's Staffing Strength

Location of Working Staff	Number of Staff
Hospital	131
Community	15
RHI Project, Kirtipur	18
Total	146

Source: phect-NEPAL, 2000

1.5 Phect-NEPAL's Establishment of a Community Health Insurance Scheme

Following its aim of providing health services to the people who are denied of any formal or informal access to health services, the phect-NEPAL has attempted to establish a sustainable health care system through its Health Insurance and Service Centres. These services are extended through its Community Health Development Program. This also covers the subsidized curative health services extended through the Kathmandu Model Hospital.

The phect-NEPAL is one of the pioneers in terms of introducing the concept of health savings at the community level through health cooperative movements. In June 1992, it established a Community Health Insurance Scheme. This Insurance Scheme was initially developed in the form of a cooperative, which mostly included people from the semi-urban areas. It was informally arranged between the health care providers and beneficiaries (without any formally binding legal statutes). The arrangement covered curative type of health services and awareness raising programs. The Community Health Insurance Scheme initially aimed to cultivate a health savings habit in the community. The community members collected money on a regular basis in the name of health insurance, but the money still remained in the community. It was not deposited at the Kathmandu Model Hospital until 1998. The fund collected before this period remains with the community as a "community reserve fund."

The Community Health Insurance Scheme now aims to provide access to better health services to the poorer community people. Together with increased access to health services, the self-ownership of the delivery programs is also promoted. The Scheme is open to provide the Scheme members with access to the Kathmandu Model Hospital as well. The members are mobilized through the cooperative society through which they deposit their premiums. The memberships are awarded to the household heads, including other family members. These memberships are limited to the Insurance Scheme level only because of the fact that phect-

NEPAL is governed by its own board members; an umbrella NGO covering the Scheme as one of its various activities.

The membership is open to any age group, sex, health risk, religion, caste, ethnicity and income status without restriction. To be a member, a person has to be a resident of the same community and cooperative. The Scheme is currently considering the possibility of restricting the number of persons in its membership size in the case of nucleus families. Another option would be to change the type of membership from family level to individual level.

Although the Insurance Scheme follows a strategy of equal opportunity and coverage of socially and economically less developed people, it is difficult to include the poorest of the poor. However, among those who access the health care services, nearly 90 percent are poor.

All insured families need to deposit a premium of 25 paisa per day as their contribution. In return, they receive pre-defined health services on a subsidized rate. These pre-defined health services cover – general medicine, hospitalization, surgery and gyne-obstetrical investigation. On each of the above-mentioned services, participating members receive 50 percent subsidy from the community clinic and Kathmandu Model Hospital. The members of the community collectively own the health clinic, with technical support from phect-NEPAL. The Kathmandu Model Hospital (under the authority of phect-NEPAL) acts as a health care provider in this process.

The Insurance Scheme is managed through the voluntary service of the Local Coordination Committee. The members of the Committee are made responsible for creating awareness among their fellow villagers, for increasing enrolments; they also collect periodic premiums and facilitate the mobilization of members, as and when necessary.

II. THE CONTEXT IN WHICH THE COMMUNITY HEALTH INSURANCE SCHEME OPERATES

This part describes various aspects of the Insurance Scheme including the context in which it operates. Major aspects covered include the demographic, economic and social environment, and information on the sanitary situation, national health policy, supply of health care and social protection services.

2.1 Demographic Aspects

The Insurance Scheme does not fix a pre-determined population size within the catchment area. So far, it has covered around 19 percent of the total population (i.e., 135 out of 700 households). The membership growth rate has remained stable. The number of persons served by the Insurance Scheme reached around 35,000 in the catchment by the end of June 1999.

A large number of beneficiaries represented the age group of 19 to 65 years.

Table-4: Percentage of Beneficiaries by Their Age Group

Age Group	Percent
0-5 Years	14.8
6-18 Years	29.8
19-65 Years	47.4
Above 65 Years	8.0
Overall	100.0

Source: Baseline Survey Report, 1992

The service ratio between men and women is 98:66 owing to the fact that women come to access the services only when they have no other alternative choices. However, in the case of males, they have a tendency of visiting the medical care centre even for relatively small health problems.

Average size of the beneficiary households is 6, ranging from 4 members at lowest and 21 members at the highest. The family size significantly varies according to the place of residence and caste group. For instance, Newar and Magar have higher family sizes compared to Brahmin and Chetris.

The extent of membership to the Insurance Scheme is affected by seasonal and periodic migrations. Even among the members, migration is one of the factors reducing access to

services (Health Insurance Feasibility Study, 1999). Most of the economically active members of the families have migrated out to the urban areas around Kathmandu Valley in search of work. The trend of in-migration in the target area is limited.

2.2 Economic Aspects

Around 84 percent inhabitants rely on agriculture as their main occupation, while 3 percent are engaged in the service sectors followed by 8 percent doing manual labour, and 5 percent in the business sector (Baseline Survey Report, 1992). For a majority of agricultural workers, a secondary occupation of manual labour is the major source of cash income, as the household products (crop and livestock) are too limited to send to the market for cash earnings. The cash income derived from the business and services sectors are also accessible to a limited number of persons. The majority of the households have an income of Rs. 10,000.- to Rs. 15,000.- per annum. The problem of such a low family income is associated with the individuals' low level of education, the lack of employment opportunities in the formal sectors, poor infrastructure development, and the lack of enterprising skills.

Given that the Insurance Scheme has been successful in benefiting the clients (who are present members), its utility need not be justified further. Based on this experience, phect-NEPAL is now looking for ways of reaching a greater number of poor with expanded coverage of the Insurance Scheme. In this context, it is also considering the possibility of subsidizing premiums to be paid by the poor from the reserve fund of the community.

2.3 Social Aspects

The baseline survey report reveals that around 65 percent of people in the target area are literate. This is a significantly higher figure over the national rate. Gender wise, around 90 percent of males were literate, compared to only 45 percent of females. Among the literate, the majority had attained a primary level of education, followed by the lower secondary and School Leaving Certificate level of education. Very few of them had intermediate and above.

Before implementation of the Insurance Scheme, the majority of the community people did not have any access to the health care at the village level. Now, they enjoy the privilege of a Health Information and Service Centre in their village, which has benefited to improve their health status.

Guthi is the most popular traditional organization in the community. Compared to other caste groups, this is a popular organization among Newaris from both cultural and mutual support perspectives. The family members of this system are informally insured of various socio-economic risks, primarily at the time of crisis. This also includes financial support for health activities in the case of serious illness of members. Nearly 80 percent of the beneficiaries are directly or indirectly linked with this and similar type of other traditional organizations. The Health Insurance Scheme was initially a completely new Scheme for the villagers, as this was initiated with specific purpose through a voluntary organization. This Scheme is now accepted and includes around 45 percent of the village people as members.

2.4 Sanitary Indicators

In understanding the health status of people, the life expectancy at birth, overall mortality rate, infant mortality rate (IMR), child mortality rate (CMR), maternal mortality rate (MMR) and morbidity are important indicators. Similarly, peoples' access to safe drinking water, personal hygiene and their trend of visiting health care centres are other important indicators. Information related to these indicators in the target area is presented below:

2.4.1 Mortality and Morbidity Status

Except for the life expectancy at birth, the target area was relatively better compared to the national figure in terms of various health indicators such as infant mortality rate, child mortality rate and maternal mortality rate. The overall mortality rate in the community was lower (8 per 1,000 mid-year population) than the national level (12 per 1,000 mid-year population). Similarly, the infant mortality rate was 71 per thousand population, whereas the national figure was 82. However, child mortality rate was just slightly lower than the national figure (i.e., 20 per 1,000 population of aged 0-4). The information on the maternal mortality rate was not available for the community. However, according to a guess estimate of the Insurance Scheme staff surveyed, it should also be lower than the national average. The life expectancy at birth was 59 years in the community as opposed to 56 years indicated by the national figure.

Gastro-intestinal problems and respiratory diseases were identified as two main causes of death of people in the community. Mainly children under the age of 5 years had the highest chances of being exposed to such diseases followed by the persons of 50 years and above. Other commonly prevalent diseases were: fever, typhoid, pneumonia, diarrhea and dysentery.

2.4.2 Water Supply and Sanitation

Natural stream (*Dhunge Dhara*) and piped water are the two major sources of drinking water (Base Line Survey Report, 1999) among the community members. Nearly 45 percent of them have access to a piped water supply, while others have to rely on natural stream and wells.
Around one-fourth of the total households in the village have provisions for latrine (permanent or temporary) facilities. The rest of the households use riverside, open fields or the road side as a public toilet, thus worsening the community environment. The situation has improved after 1995, as phect-NEPAL made people aware about the importance of permanent toilets for the prevention of diseases.

2.4.3 Trends on Visiting Health Care Centre

Because of regular services being provided by the Health Information and Services Centre there are great improvements to the health conditions of the villagers. Availability of such services nearby increased their frequency of visits for treatment. Though the information about the category of persons benefiting relatively more than the others is not available, the frequency of visits to the health care centre indicated that the persons who use the health care services have a higher level of awareness, and income.

2.5 National Health Policy

The Ninth Development Plan (1997-2002) of the government has emphasized the privatization of health care services. This means reduced allocation of grants to government hospitals and health care centres, and the number of private health care centres, have increased. However, such services from private clinics are accessible to only those who can afford them.

Inadequate health facilities offered by the government hospitals and health centres compounded with the higher rates charged by the private sector have excluded many poor people of the informal sector. With a view to provide health care services to a larger population, the concept of a Health Insurance Scheme has emerged as one solution. Such schemes not only intended to deliver services but also to provide ownership of the Scheme to the members.

Though some establishments catering to the need of excluded people of the informal sector have been initiated, the legal status for operation is still lacking. Despite such legal invisibility, the Insurance Scheme presented in this report has been contributing to better health services at community level. From the date of its establishment, phect-NEPAL has been trying its best to serve the poor. Frequent visits of doctors from the centre to village health centres has added value to the quality of services extended at the community level.

2.6 Supply of Health Care Services

Kathmandu Model Hospital provides both outpatient care and hospital treatment for the members of Health Insurance Scheme at a discount rate of 50 percent. As the clinics provide services at the community level, the patient visits Kathmandu Model Hospital only when his/her problem is referred as serious.

The clinics at the community are run by the Health Assistants. They are assisted through frequent visits (at least twice a week) of doctors from Kathmandu Model Hospital for a higher level of services. Presence of health service provisions in the community itself has reduced people's need to visit Kathmandu, particularly the ones who cannot afford higher treatment cost. However, they feel that the services being extended, at present, need to be enlarged for the coverage of wider problem areas.

The clinics follow a practice of forwarding complicated cases to Kathmandu Model Hospital only if they are found beyond the capacity of Community Health Centre to handle. The referral sheets are to be signed by the visiting doctor or Health Assistant. Except for emergency and obstetric cases, the members cannot obtain the benefit form Kathmandu Model Hospital without the referral document. If they are without a referral document and also the case is not emergency one, they will not be entitled to get special beneficiary privilege. All patients should access to the primary care services on their own, as this is not included in the benefit package issued by the Insurance Scheme.

2.7 Health Practices

Traditional beliefs have influence on the health practices in the communities. Consultation with the traditional healers is still common in many families. Some believe in the concept that sickness is to be treated by traditional healers and cannot be treated by modern medical

practices. To them, most illness are related to their past deeds and the mercy of god and not by any physical system disorder. However, with the establishment of Health Information and Services Centre, the number of patients visiting Dhamis and Jhankris are gradually decreasing. The patients who visit the traditional healers have a tendency to go for primary care treatment. If their treatment does not work, they visit the clinic for further treatment. Prior to the establishment of Health Information and Services Centre, the village had no other medical security system services offered. The only social security service in health provided was to the elderly persons, who got a government allowance of Rs. 100.-

III. IMPLEMENTATION OF THE HEALTH INSURANCE SCHEME

This part deals with how the Insurance Scheme was created, what measures were taken in its creation, and what obstacles were faced during the launching phase, and how they were overcome.

3.1 Launching of the Community Health Insurance Scheme

The concept of a Community Health Insurance Scheme was introduced to the community people initially in the form of health savings through the establishment of a Local Coordination Committee by phect-NEPAL in 1992. Principal objectives of the Scheme were to develop people's savings habit for health and increase access to health services. General agreement was set-up between the beneficiaries and phect-NEPAL regarding coverage of health services and methods of contributions collection. This process did not include much elaboration on legal formalities, as the legal statutes of the Scheme itself were not clarified.

All residents in the community were eligible for membership depending upon their voluntary interest on the Insurance Scheme. Up to 1997, Kathmandu Model Hospital provided services at subsidized rates without any contribution from the members. The contribution of the members remained in the community as the "reserve fund." From 2000, the membership process required deposit of the premium, of which half was used by the community for management of health services at the local level, while the other half was forwarded to Kathmandu Model Hospital as contributions. The services covered were: hospitalization, surgery, gyne-obstetrical investigation, general medicine, disease investigation and generic drugs.

Before implementing the Insurance Scheme, a baseline survey was conducted. This pointed out the need for an Insurance Scheme for those excluded people in the community. No other pre-feasibility or feasibility studies were carried out.

In the initial stage, the target group for the Insurance Scheme was not specified. People who were ready to deposit the premium and were affiliated with the cooperative society could become members. There was no restriction regarding target population by their age group, sex, health risk, income level, caste and ethnicity. The Insurance Scheme intended to cover poor people, and worked hard to bring them into the programme.

3.2 Phases of Implementation

3.2.1 Identifying Needs and Defining Objectives

Focusing on the Alma Ata Declaration (i.e., health for all by the year 2000), His Majesty's Government of Nepal (HMG/N) emphasized increased access of health services to the common people. The Ninth Development Plan underlined the importance of privatization of health services for wider coverage. This gave room to the mushrooming of private health centres in both urban and rural areas. Given that these services are expensive for the low-income people, they often cannot have access to such services. The shrink of services offered by the public sector has rather reduced the access of the poor to such services. As a solution against this situation, poor people are encouraged to save for future health investments in the areas where phect-NEPAL operate. Its vision is to ensure medical treatment for the poor despite their limited affordability. The concept was brought into operation as a collaborative Scheme between phect-NEPAL and people living in the community.

The principal objective of the Insurance Scheme is to establish a health cooperative hospital in the long run. Specific objectives related to this were:

- To develop savings habit for access to health services.
- To develop self-help habit through involvement in the cooperative society.
- To develop self-ownership on the health programs.
- To increase access of good quality health services among the low-affording high-risk groups.
- To ensure health security through the health cooperative.

3.2.2 Context and Financial Feasibility

As the Scheme was initiated without any formal pre-feasibility and feasibility studies, the information about the selective identification of the target population among many living in the community, their willingness for financial contribution, their opinion about the type of Insurance Scheme preferred and their priority about the health needs was lacking. The members are required to deposit 25 paisa per day / per person in the form of a premium. Of this, 50 percent is used locally for Health Information and Service Centre clinic management, while the other 50 percent is forwarded to the Kathmandu Model Hospital as a contribution to the Scheme. The rate of premium is determined in view of affordability from a majority of the poor, rather than from the standpoint of recovering cost against the benefits offered. Compared to the benefits offered, the premium raised is just nominal. The instalments of premiums collected by the different committees might differ from one another. However, the amount of contribution deposited to the Kathmandu Model Hospital is equal for all.

3.2.3 Target Population

Extending health care services to the needy and deprived is the major objective. Emphasis is given to reach a greater number of people living in a situation of poor health facilities. Accordingly, some semi-urban areas in the surroundings of Kathmandu valley were selected. The selection process stressed identification of areas with poor sanitary conditions and absence of health centres. In the first stage the identification of possible villages for the Insurance Scheme were targeted; the second stage criteria for the target group was that the person willing to become a member of the Scheme should be a resident of the selected community, and also have joined the cooperative society.

The majority of the people in the selected villages are involved in agriculture with their accompanying poor socio-economic condition. Hardly 12 percent of the people have received a School Leaving Certificate.

Due to the lack of a structured database, it is not possible to provide gender and age disaggregated statistics about the members. However, the discussions held with the Kathmandu Model Hospital staff indicated that the number of female members exceeds the number of male among the age group of 30 years and above. Similarly, there were more girl beneficiaries than boys in the case of those aged below 5 years.

The access to the Insurance Scheme was initially a totally new concept for the villagers. Many of whom had been deprived of access to such services, and had also never heard about the advantages of becoming a member of such a scheme. The idea came into the knowledge of many only after information about the Scheme was disseminated by phect-NEPAL through group meetings, Health Information and Service Centre activities and periodic publication of notice. Occasionally, the Insurance Scheme staff were mobilized to disseminate information about the advantages of becoming a member of the Insurance Scheme. This helped phect-NEPAL to attract a greater number of members into the Scheme.

3.2.4 Launching of Activities

The phect-NEPAL has been focusing on attracting greater involvement of community people into the Insurance Scheme with a view of identifying what kind of health services to offer. People were actively consulted and invited to come into an agreement with Kathmandu Model Hospital to contribute their premium and obtain the health benefits offered at a subsidized rate.

The membership offer was extended, from the first year of establishment of the Scheme, to a second year. A Local Coordination Committee was formed with the involvement of representatives from the community. This helped with the acceleration of Health Information and Service Centre activities. The Local Coordination Committee members took responsibility for collecting premiums, convincing villagers to become members and motivating them to assist in the promotion of Scheme activities.

To make the services easily accessible, clinics were established in the selected villages. Services offered by these clinics have had positive impact on the improvement of the health condition of the community people. Major emphasis of the clinic, at the initial stage of its operation, was on making community people aware of health concerns and providing primary

health care services. Attempt was made to treat the cases locally as much as possible. Only the complicated cases were referred to Kathmandu Model Hospital for further treatment.

3.2.5 Leadership and Decision-making

The phect-NEPAL took lead-role in initiating the Insurance Scheme. Among its various other functions, it has been continuously assisting with the operationalization of the Scheme. Decisions about the benefit coverage and selection of health care providers are made by phect-NEPAL in consultation with the Local Coordination Committee members, and other beneficiaries. The current members are also part of the decision-making process in matters related to the enrolment of new members, raising premiums (duration and methods of payment such as lump sum or instalment) and their management.

Services and Benefit Coverage: In the initial establishment stage of the Insurance Scheme, phect-NEPAL and Kathmandu Model Hospital did not fix any limits on the benefits to be offered to the members. All members could access the health services of their needs as offered by the clinic and Kathmandu Model Hospital free of charge on a charity basis. This also covered the pharmacy charges. These services were made available at a subsidized payment rate (50 percent) after some months of operation. In the initial stage, the services offered were mostly curative covering general medicine, medical counselling, hospitalization, surgery and medical check-up. Now the emphasis is on preventive measures as well.

Premium Collection and Fixing the Rate: The Local Coordination Committee members in consultation with other common members decide the collection and management of premiums under the guidelines of phect-NEPAL. Furthermore, they are made responsible to take decisions about fixing the rates, including the premium.

Membership and Coverage of other Beneficiaries: The Local Coordination Committee decides on the enrolment of members, and disseminates information about the advantages of joining the Insurance Scheme. They also promote and encourage members to cost-share their contributions when some members cannot pay their premiums.

Health Care Providers: The Kathmandu Model Hospital is the health care provider for the Insurance Scheme. Since the Scheme was initiated by the health care provider, the members had only limited decision-making roles in the management.They expressed their concerns and now they cooperate to make the system work.

3.3 Operation During the Initial Phase

3.3.1 Members and Other Beneficiaries

The Insurance Scheme covers the inhabitants of semi-urban areas, who become members on a voluntary basis. The,majority of the members contribute their share for the cooperative effort initiated. All memberships are counted on the basis of the number of the family units. When a household becomes a member, other persons of that household family are automatically included as members of the Scheme and are entitled to the services offered.

Although the Insurance Scheme has provisions to extend services both for the members and non-members, most of the service users are the members.

3.3.2 Benefits

A number of services were extended to the members and other beneficiaries from the start of the Scheme. Table-5 below shows the services covered:

Table-5: Services Covered by the Insurance Scheme During its First Term

Types of service covered	Type of Persons Covered	Coverage Limits /Co-Payment	Waiting Period	Compulsory Reference System
Non-programmed surgical interventions	M	50% of the total cost	Normal	Yes
Gyne-obstetrical interventions	M	50% of the total cost	Normal	Yes
Hospitalization	M	50% of the total cost	Normal	Yes
Programmed surgical interventions	M, NM	50% of the total cost for M and full payment for NM	Normal	Yes
General medicines	M	20% of the total charge	Normal	Yes
Specialized medicine	M	50% of the total cost	Normal	Yes
Laboratory / Radiology	M	50% of the total cost	Normal	Yes
Pharmacy	M	50% of the total cost	Normal	Yes
Medical counselling	M, NM	50% of the total cost	Normal	No

M = Members, NM = Non-members

Source: phect-NEPAL, 2000

For obtaining hospital services, the members need to follow a set of rules and regulations. The patients access services only with the referral document and the membership card, except in emergency situations. The non-members do not get subsidy on the services provided.

3.3.3 Financing

The Insurance Scheme is financed through joint contribution of members and by phect-NEPAL. A member with a family of less than 5 persons is required to deposit Rs. 100.- per year, and those with more than 5 persons have to pay Rs. 200.- per year. These contribution-rates do not vary according to age, sex, health status and income categories of the members. The prevailing rates are regularly revised and the current rate is Rs. 0.25 paisa per person per day. All contributions are paid in cash form. Options are provided to pay in lump sum or instalment basis depending upon the member's capacity.

During first year of operation, phect-NEPAL facilitated the management, including the collection of premiums, and the implementation of other administrative activities. The Local Coordination Committee partnership came into operation only in the second year.

3.3.4 Health Care Providers

The health care providers for the Insurance Scheme are located at community and central levels. At the community level, services are extended through a health centre, while at the central level Kathmandu Model Hospital provides the health services on referral basis.

3.3.5 Administration and Management

The administration and management of the Insurance Scheme rely more on the good faith of the health care provider and cooperation of members associated with its functions than any formal legal regulations. Structurally, the management system can be divided into two levels: community level, and centre level. At the community level, Local Coordination Committee members are responsible to manage the insurance activities such as Health Information and Service Centre clinic management, premium collection from the members, enrolment of new members, inform the community people about Insurance Scheme activities and update accounts. The phect-NEPAL Community Health Development Programme staff facilitates the health centres to perform their work more effectively and keep their accounts accurately. The phect-NEPAL,is also responsible for managing the system at centre level. It acts as a bridge between the Model Hospital and members. It is responsible for monitoring the quality of services, management and evaluation of the Scheme's performance, arrange training and organize meetings, as well as facilitating the community level activities as appropriate.

Statutes and Regulations: The Insurance Scheme started with and is still operating on a very basic form of internal regulations for the management of its activities. Rules are framed for the collection of premiums, their management, specification of the target groups and benefit coverage.

Information System: Some forms and formats (e.g., membership card and contribution register) were introduced for record keeping in the first year. The costs and benefit monitoring system was introduced in the second year. Introduction of well-maintained financial management tools (e.g., budget preparation, periodic allocations and preparation of balance

sheet) took some time to get in place, as people had to be trained for these skills at the community level. Until these trained persons were ready, most of the transactions were handled by phect-NEPAL directly.

Technical Assistance and Training: The Local Coordination Committee members and other committee members receive technical training about the Scheme through phect-NEPAL. Initial help extended was on proper implementation of savings and credit activities. This covered aspects like collection of contributions and their management. This intervention was useful in convincing common villagers about the need of health savings and how the Insurance Scheme could benefit them.

The phect-NEPAL also provided 2-5 days training program for the Local Coordination Committee members in the first year, the purpose being to develop their skills on accounting systems. Besides this, a number of other orientation programs and training were carried out on bookkeeping, maintaining financial records, inventory management and control.

IV. CHARACTERISTICS OF THE COMMUNITY HEALTH INSURANCE SCHEME

This part describes current operation of the Insurance Scheme.

4.1 Target Group and Beneficiaries

4.1.1 Target Group

All people living in the community irrespective of their age group, sex, health risk, income level, caste and ethnicity can join the Insurance Scheme. In 1998, the Scheme also included Trade Union members (e.g., GEFONT) into its target group.

General Characteristics of the Target Population: Almost all members covered as the target population are semi-urban residents. They have access to post office, schools, electricity and telephone facilities. Due to the lack of a database, information regarding their current age and sex distribution is not available. The literacy status of the members is relatively better, compared to the national average. Nearly 65 percent beneficiaries are literate. They can read, write and do basic arithmetic calculation. Male still dominate the literacy scenario. Agriculture is the most common occupation.

The majority of the community people are now in favour of maintaining good sanitary conditions. Around 96 percent have either permanent or temporary latrine facilities. This has stopped them from the need of visiting riverside and other open places for the toilet purposes. The improved sanitary conditions has had a created impact on improving health and reduction the frequency of illness. Indeed, the establishment of Health Insurance Scheme Centres in the villages has helped improve the health conditions. The health awareness has also increased among the villages significantly.

4.1.2 Categories of Beneficiaries

Any kind of people willing to pay their premium can become a member of the Insurance Scheme. The membership is neither compulsory nor automatic but voluntary. Membership is given to the family as one unit. There is no individual membership category. Once the family becomes a member of the Insurance Scheme, everyone living in the house from the same blood relations are eligible beneficiaries. The membership and beneficiary status is open to all age groups, sexes, income levels, health risks and caste groups. Eligibility for membership is limited to a nucleus family but not the joint ones. The phect-NEPAL is thinking of the possibility of limiting the beneficiary size under the prevailing family membership system. Discussion is also going on to consider the possibility of offering individual memberships.

To access health services, the members need to present their membership card at the health centre. To avail treatment from Kathmandu Model Hospital, the same document together with the referral sheet must be submitted. This requirement is exempted for emergency cases.

Under normal circumstances, any treatment accessed without the insurance card and referral sheets are not entitled to receive subsidies on payments, but health service can be obtained on a full fee paying condition. The membership card includes the names of all members living in the family for their identification during times of need.

4.1.3 Evolution of the Number of Beneficiaries

The number of beneficiaries has remained more or less stable in each Village Development Committee since the beginning. The turnover has been more or less balanced because of almost equal outgoing and incoming members in the range of 10-15 households.

Members who do not pay their contributions regularly and do not participate in the cooperative savings activities are subject to discontinue membership. The decision to retain or exclude any member from the Scheme is made by the Local Coordination Committee in their meeting.

During 1996-97, some health services were removed from the benefit coverage. Such reduced coverage also caused some members to leave the Scheme. Sometimes, members leave the group when they have access to other health facilities through their job. A few members have left the Scheme because the services do not match their expectations.

4.1.4 Target Group Penetration

Although, the Insurance Scheme has followed a strategy of reaching the socially and economically less developed community, it still needs to struggle hard to reach the poorest of the poor. Realizing this, the Scheme has planned to adopt effective measures for enhancing enrolment of the poor.

In this process, the Insurance Scheme needs to disseminate information to the poor along with the publicity of its vision. For the benefit of poor members, the Scheme has applied a provision for a grace period.

4.2 Benefits and Other Services Offered by the Insurance Scheme

4.2.1 Health Services

Currently, the members are entitled to a subsidy of 50 – 80 percent on the pre-defined health services (Re: Table-7). The pre-defined health services cover: medical counselling, general medical check up, surgery, hospitalization and gyne-obstetrical investigations. Due to the large number of patients, higher cost burden and some fraud cases on access to services, the disease investigation, radiology and pharmacy services were excluded from the benefit coverage list. The members can have access to subsidy on the specified health services only from the authorized health care provider (village clinic and Kathmandu Model Hospital). The current services covered are presented in Table-6 below.

Table-6: Health Services Covered

Types of service covered	Persons Covered	Compulsory Reference System
Gynee-obstetrical interventions	M	Yes
Medical hospitalization	M	Yes
General medical check- up	M	Yes
Medical counselling	M	No
Surgical treatment and medicine	M	Yes

M = Insurance Scheme members only

Source: phect-NEPAL, 2000

The Insurance Scheme does not have any regular provision for addressing epidemics and mass infections. However, informal attempts have been made to mitigate any sudden emergence of diseases.

Extent of Coverage: For the general medical check up 80 percent of the total cost is subsidized. For other services a 50 percent discount is given. The registration fee is not subject to subsidy. The beneficiaries have to cover the control over transportation, lodging and food.

The Health Insurance Scheme Centres have not only increased the health access of the people in the community but have also contributed to making them aware about the need for saving. The clinics have also reduced the frequency of travelling to health clinics in other places. Furthermore, they have increased health awareness and the importance of improving sanitation.

The information about health services in the community is extended through the cooperative members, health personnel and Local Coordination Committee members during the time of meetings. During the first term, the Scheme offered all the health services to its members as available with Kathmandu Model Hospital. The pharmacy cost of the members was also subsidized. Major health services offered at the subsidy rates applied to them now are as follows:

Table-7: Type of Services Offered and Subsidy Rates Applied

Services	Subsidy Rate
Medical counselling	50%
General medical check up	80%
Hospitalization	50%
Surgery	50%
Gyne-obstetrical investigation	50%

Source: phect-NEPAL, 2000

4.2.2 Payment of Benefits

The Kathmandu Model Hospital has been receiving around 50 percent of the premiums collected for its health care service provided. The rate of premium contributed by each member to Kathmandu Model Hospital is Rs. 0.25 paisa per day. The Kathmandu Model Hospital has a provision that any surplus amount left from this source (after deducting the amount of the subsidy) should be used for diversifying services. However, because of the small amount of contributions raised, the cost of subsidy is higher than the revenue. At present, the Kathmandu Model Hospital is extending part of its health care service on a charitable basis rather than in a cost recovery business manner. Since there is no surplus from the beneficiary contributions, there is no reserved fund nor early advance system.

4.2.3 Other Services Provided

Besides the medical services, phect-NEPAL also extends other services to its members. These services are:

Financing of Health Investment Services: All members of the Insurance Scheme are also members of the savings and credit group established in the village. Each of them saves his/her deposit for this group regularly. This is one of the major sources of loan for the members at times of need for financing their health investment. Some members have joined the 'Women's Group' for local development interactions. These groups are not directly linked with the Insurance Scheme.

Health Supply: Kathmandu Model Hospital facilitates the referral services, and since 1993, it has been providing curative services to members and non-members. As member's co-payment and service fees are major sources of finance for the direct medical offers, effort is made to balance the charges in view of affordability as well as a portion of cost recovery.

There is no discrimination between the members and non-members. However, due to the benefit of subsidies, the access is more attractive for members than others.

Both village health centres established in the communities and Kathmandu Model Hospital are effective in creating positive impact in the health conditions of people. The primary health care

services extended through the community level clinics and referral services provided by Kathmandu Model Hospital have made people feel insured against their health risks.

Prevention and Health Education: The Insurance Scheme has been promoting some preventive activities through its sanitation improvement program, and health awareness programs in the community. Within this process, health literacy classes, the improvement of a drinking water system, and toilet construction programs are operating. Indeed, immunization, vitamin-A, polio and iron tablets distribution programs are also conducted. These activities are linked with the objective of creating a healthy society. The phect-NEPAL has also tried to bring other sister organizations into the health support process. In this context, in 1998 around Rs. 125,000.- was invested from various sources for the health literacy classes.

4.3 Financing

4.3.1 Financial Support

The financial support consists of the contributions made by phect-NEPAL and contributions raised from the members and a few donations.

Member Contributions: As mentioned above, the major source of finance for the Scheme is member's contribution. At a daily contribution rate of Rs. 0.25 paisa per member, each member needs to pay Rs. 7.50 per month (in case of some Schemes the charge is Rs. 0.50 paisa per member thus amounting Rs. 15.- per month – e.g., Bikalpa at Kirtipur). These contributions are being shared by the community and Kathmandu Model Hospital equally (i.e., Rs. 3.75 each in the case of a premium of Rs. 7.50 collected and Rs. 7.50 for the collection of Rs. 15.- per month). In order to compensate the increased service cost of the Kathmandu Model Hospital, the revenue sharing arrangement was revised form 50 percent to 67 percent for the Hospital and 33 percent for the community. From this year onwards, the Hospital plans to receive full proportion of the premiums (100 percent) on account of its services.

As compared to the cost of services provided, the premiums charged to the members are still low, and they are maintained low in view of the benefit provided to poor who cannot afford larger sums.

The Local Coordination Committee members collect the contributions (premiums) bi-annually or annually in cash form. Some members find it difficult to pay this lump sum, as this payment period does not coincide with the seasonal income earning patterns of the members. For each collection of the premium receipts are given. The amount is also entered into the office register.

Up to 1998, all collected premiums were used by the Community Health Centre. After that, provision was made to share 50 percent of the premiums with Kathmandu Model Hospital. The rationale for sharing included the following reasons:

- To lower the financial burden (i.e., to lower the gap between income and expenditure)
- To ensure the sustainability of the Kathmandu Model Hospital's services for the beneficiaries
- To increase the sense of hospital management ownership among the beneficiaries

Despite change in the resource sharing structure, no change took place in the nature and quantity of benefits provided.

Membership Entry Fee: A person willing to join the Insurance Scheme pays an entry charge of Rs. 10.-

Financial Contributions and Donations from the Local Bodies: In some places, the local government body (Village Development Committee) provides Rs.1,000.- per month as its contribution to the Scheme. Sometimes, occasional donations are also received. Table-8 presents the contributions received by the Scheme in the past few years for different purposes.

Table-8: Financial Contribution Received from the Village Development Committees and other Local Bodies

Years	Purpose	Amount	Type of Support	Conditions
1998	HISC clinic management	Rs.10,000	Cash	Donation from Local bodies
1999	HISC management, Payment for the health personnel	Rs.12,000* + Donation	Cash and kind	Donation/Contribution from Local bodies/VDCs
2000	HISC management	Rs.12,000 + Donation	Cash and kind	Donation/Contribution from Local bodies/VDCs

Source: Progress Report, phect-NEPAL, 2000

4.3.2 Costs

The total amount of subsidy for the health service benefits accessed by the members stood at around Rs. 50,000.- in 1998. This decreased to almost half and even less in the subsequent years. Table-9 presents the total amount of subsidies paid to the beneficiaries in the past three years.

Table-9: Total Amount of Subsidies Paid for the Members Accessing Benefits of the Scheme

Year	Service Type*	Amount of Subsidies Paid
1997	-	-
1998	-	49,680.70
1999	-	31,205.25
2000	-	17,898.00 (up to November)

** Information on the amount of benefit paid by the service categories was not available.*

Source: phect-NEPAL, 2000

The office expenses incurred for the scheme is around Rs. 5,000.- per year. The Insurance Scheme allotted some money for training program, group meeting and promotional activities. However, the figures of actual spendings were not available.

The Scheme has no generated surplus allocation nor any reserve funds.

4.4 Health Care Providers

4.4.1 Health Care Providers Linked to the Insurance Scheme

The Kathmandu Model Hospital is an authorized health care provider. The beneficiaries are informed about Kathmandu Model Hospital's role and the types of services coverage through the Local Coordination Committee members and health staff working in the clinics. Information is also disseminated through occasional notice, brochure, meeting, training and Health Information and Service Centre clinic activities. Day to day counseling from the health centre is another method followed for information dissemination.

4.4.2 Relationship between the Health Care Provider and the Insurance Scheme

A general form of agreement drawn between the Insurance Scheme and the health care provider guide the coverage of subsidized health services, the sharing of contributions raised from members, and the terms and conditions of accessing benefits. Both the insurance

executive member and the health care provider are equally responsible for complying with the clauses of the agreement. The phect-NEPAL staff and Local Coordination Committee members monitor the quality of services through consultation with the beneficiaries.

Due to the lack of space, delivery of services has been disrupted a few times. Such problems were overcome in association with the services offered by other hospitals. In such a situation, the members did not receive any subsidy for the services obtained. The occurrence of such cases are rare.

In order to run the Insurance Scheme more effectively, meetings between the health care provider and the Insurance Scheme managers are held 3-4 times in a year. The meetings cover discussions about the quality of health services, benefits coverage, the enrolment of new members and better ways of raising premiums. The Scheme personnel and health care providers often consult beneficiaries to obtain suggestions on how to improve the management of the medical program. They listen to the beneficiaries' voices in an attempt to develop quality services. An evaluation of performance to-date has been planned. In this process, individual opinions related to the increased benefit coverage and inclusion of the poor into the Scheme will be considered.

4.4.3 Payment of Health Care Providers

The Katmandu Model Hospital, which also acts as the health care provider, receives direct cash payment in the form of premium contribution and service charges. The service charges are subsidized.

4.5 Insurance Scheme Administration and Management

4.5.1 Statutes and Regulations

The Insurance Scheme is connected with the Katmandu Model Hospital and runs on its good faith without any separate legislative statutes. Since the Scheme is operating on a trial basis to find out how it can best be sustained in the long run, registration has not yet received immediate attention. According to the phect-NEPAL staff, the issue of registration is being considered to make the Scheme stronger and more facilitative in its work.

For the operational purpose, the Scheme has developed some internal regulations. They are of the general type and are primarily concerned with the benefit coverage, the conditions for acquiring benefits, the eligibility for Scheme membership, and the responsibility of Local Coordination Committee members, as well as the rate of membership premium.

4.5.2 Management of the Community Health Insurance Scheme

At the community level, the Local Coordination Committee members manage the Scheme, while at the central level, it is the managed by phect-NEPAL.

The Local Coordination Committee formed in each Village Development Committee consists of 12-15 members as its executive bodies. Involvement of female members in these bodies is

compulsory (at least one-fourth of the total members should be female). All members work as volunteers for the Scheme. Their main responsibilities are:

- To manage Health Information and Service Centre clinic activities.
- To manage day-to-day operation of the community pharmacy.
- To collect and handle premiums.
- To encourage enrolment of new members .
- To inform the community people about Scheme activities.
- To maintain accounts of daily income and expenditure, and
- To revise membership card, as necessary.

The phect-NEPAL members are responsible for the overall management and monitoring of whole Scheme activities including quality of health services offered and benefits covered. They are also responsible for the evaluation of performance of the interventions and development of innovative measures for the promotion of the Scheme.

The Scheme does not have any salaried manpower for its daily operation. Also there is no provision for providing allowances to the working members.

4.5.3 Extent of Democratic and Cooperative Character of the Management System

During the time of general assembly, group meetings, discussions and training, all members are informed about the Insurance Scheme activities. These forums are used as a venue to explain the importance of the Insurance Scheme to the new members, including the dissemination of information on the various health services covered, the criteria required to obtain the Scheme benefits, and the importance of saving needs for future health investments.

Members Role for the Choice of Services Covered: Decision about the coverage of health services is primarily done by phect-NEPAL through a consultation process. Although the Scheme members are not allowed to decide the services; they are consulted to provide the best possible offer, in regards to the small financial contribution which they made.

Amount and Methods of Member's Contribution: Each member deposits 25 paisa per day as his/her contribution. They are responsible to pay the contribution regularly. Otherwise, their eligibility to receive the benefit is forfeited.

The members are given a choice of paying their contribution either in a lump sum or in instalments as per their convenience. The majority of the members pay in a lump sum, while others pay in 2 instalments. Those who decide to pay in instalments are usually from the poor sector of the population.

Choice of the Health Care Provider: The Kathmandu Model Hospital is the only authorized health care provider for the Insurance Scheme in the community. Beside Kathmandu Model Hospital, Scheme members do not approach the other health care centres for acquiring health services at a subsidized rate. Also, they cannot make their choices for the health care provider individually.

Selection of Officials: The members are responsible for selecting their Executive Board members as either volunteers or salaried staff. If salaried, they are also authorized to decide on the remuneration package. However, in practice, most of the officials are working as volunteers, except for the Health Information and Service Centre clinic staffs. The member-elected ones may also run as incumbents in the next election.

The members select Health Information and Service Centre clinic personnel and take decisions on the rate at which the salaries have to be paid. The phect-NEPAL pay the salary to the staff of the Health Information and Service Centre clinic in the initial stage; but now, paying their salary is the community's responsibility.

4.5.4 Financial Management

The health centres have maintained accounts either in the name of health clinic or Local Coordination Committee. A committee is formed to decide expenditure by the line items. The committee is formed of two members: President or Vice-President and the Treasurer. The Treasurer is responsible to handle petty cash. Most of the health centres have cash transaction of Rs. 7,000.- to Rs. 8,000.- for pharmacy management.

4.5.5 Information System Management

Information about Members, Contribution and Benefits:

The Insurance Scheme maintains a membership register, membership card and contribution register. Information is also maintained for enrolment of members, dropouts, services offered and premium overdue. The need of organizing the records better for analytical purpose has been recognized and is being considered.

Accounting Framework: All incomes and expenditures are recorded in a register. The phect-NEPAL feels the need for improving the existing system for classification of the nature of expenses.

Finding a skilled accountant with an interest in serving voluntarily has remained a major problem. The Local Coordination Committee insists to involve any educated member (up to School Leaving Certificate or higher) in the group as a Treasurer to entrust the responsibility of maintaining accounts.

The phect-NEPAL organized some courses with the objective of enhancing accounts keeping skills of the members. Whenever there is a need, the central level staff provide support to update and analyze the records including preparation of periodic statements.

Management Tools: The Insurance Scheme has realized the need for adopting some basic management tools. So for, the Scheme only uses a simple budget system.

Contracts are signed with the members for their contribution of premium and access to services. Standardized forms for membership has yet to be developed. At present, the membership requests are received in the form of general application, in which the requesting party specifies his/her interest. The contract is signed by the service provider and service users.

4.6 Control Functions

Petty Cash Control: Fifty percent of the premium collected is spent for the community pharmacy and Health Information and Service Centre clinic operations. The petty cash method is used for spending the money.

Accounting Control: Accounts maintained indicate monthly income and expenditure. The Local Coordination Committee members are responsible for regular update and maintenance.

Beneficiary's Status: Information maintained about the beneficiary contains membership size, place of residence, membership card number and date of membership. The beneficiaries who are registered receive more attention than the ones who are not registered.

Contribution by Members: Members' contribution is regularly recorded. A register is maintained for this purpose. All payments are acknowledged by giving receipt.

Medical Treatment: The Health Assistant and other regular staff working with the health centre are responsible for daily operation of the clinic. The doctors visiting from the centre twice a week provide backstopping services. Complicated cases are referred to Kathmandu Model Hospital.

4.7 Demarcation of Roles

The Insurance Scheme operates with the involvement of limited number of actors such as health centre staff, Local Coordination Committee members, Kathmandu Model Hospital health care providers and members' assembly. Their respective roles are clearly defined. The health centre staff and Kathmandu Model Hospital health care providers are involved in extending health services to the members, while the Local Coordination Committee members are involved in coordinating functions. They also facilitate the collection of contributions and provide assistance for smooth functioning of the Scheme.

There is no regularized provision of external health care providers except for the Kathmandu Model Hospital doctors who visit to the village centres twice a week. There is no provision of any insurance agents in the system as the Scheme is being run in the form of a cooperative society.

Insurance Scheme Organs: The General Assembly and Local Coordination Committee meeting are the two major decision making bodies. The General Assembly meeting discusses progress achieved throughout the year, income, expenditure and future plans. In this course, various other issues related to beneficiary claims, benefit coverage, expected role of health care providers, status of contribution, convenience of the contribution schedule, satisfaction towards covered services and emerging needs of the members are shared.

Regular group meeting are held 2-3 times in a month. These meetings focus on the agenda such as Health Information and Service Centre and community pharmacy management, selection of health personnel, rate and method of premium collection and management, updating of accounts and enrolment of members in the Scheme.

The Scheme provides day-to-day free counselling services both at central and community levels. The beneficiaries are informed about the importance of the Insurance Scheme together

with description of activities covered, health care provides extending services, need of savings for health investment and membership criteria.

Health Care Providers: Both health centres and the Kathmandu Model Hospital provide health care services to the members.

Volunteer doctors from the Kathmandu Model Hospital make their visit to the Health Information and Service Centre clinics as the external health care staff. The frequency of their visits is more or less fixed for at least twice a week. During this period, they provide general medical check services and refer the complex cases to Kathmandu Model Hospital.

The phect-NEPAL has a policy of consulting Local Coordination Committee members in defining roles and responsibilities of different actors.

4.8 Equipment and Infrastructure

Established in 1993, Kathmandu Model Hospital has been offering health care services as a central referral hospital for the Scheme. The hospital has an inpatient capacity of 50 beds with general and obstetrics emergencies and is equipped with an ambulance service. It is well-established among the public and is considered as a well-equipped hospital. Its office facilities are equipped with computers, photocopy machine, telephone connections, Internet and E-mail. The hospital owns its premises.

The health centres located at the community level do not have their own building. They possess no computer equipment nor vehicles, but most of them are connected to telephone facilities.

4.9 Relationship Between the Community Health Insurance Scheme and Other Actors

The Scheme is related in different ways to many other actors in terms of providing services to those who are excluded from the formal social security system in Nepal. The status of relations observed with respect to some organizations are as follows:

Table-10: Relationship between the Insurance Scheme and Other Actors

Actors	Relationship Status	Relations
Government organizations	Yes	Legal formalities
Village Development Committee	Yes	Funding support
Community	Yes	Health Information and Service Centre management
Social security providers	No	-

Source: phect-NEPAL, 2000

Some Village Development Committees are regularly funding for Health Information and Service Center clinic operation from 1998, while the local community bodies have provided donations occasionally. The community has no other public social security services established except for the security system covering old age population, which includes payment of Rs. 100.- per month.

Since 1999, the Insurance Scheme has involved GEFONT as its member. GEFONT is a federation of trade unions, which consists of more than 300,000 members. Most of them are poor workers at a high health risk. The main objective of establishing link with this organization is to open room for sustainability of the Scheme. When this cooperation further develops, the size of service to be provided by the Scheme will rise substantially. With greater number of members, phect-NEPAL hopes to make the Scheme sustainable.

4.10 Operation Indicators of the Insurance Scheme

Five Health Information and Service Centres have already been registered as Health Cooperatives, while others are in process. They are gradually gaining strengths for self-reliance in terms of management of health services at the local level.

The Insurance Scheme needs to establish some indicators to make its current position more clear. Aspects to be covered by such indicators might include: the number of members served as compared to the target, level of services accessed by the beneficiaries and non-beneficiaries, proportion of village people excluded and included by the Scheme, and the extent of costs recovered from the contributions raised. Therefore, the establishment of a database along these lines would be important for the Scheme.

4.11 Evaluation of the Insurance Scheme

Members' active role in evaluating the Scheme needs to be clarified. However, every member when they come for enrolment are told that they can put forward their observations about the quality of services and system management as they feel it necessary because of the mutually cooperative endeavour phect-NEPAL wants to promote.

General assembly meetings are organized regularly (3-4 times in a year). Attendance of members in these meetings is never less than 80 percent. Suggestions for effective performance are obtained during these meetings. The assembly meetings discuss current issues, emerging problems related to the management of Scheme, beneficiary needs and demands, future plans, awareness level of members about the activities of the scheme and members' contribution status.

The phect-NEPAL has the policy of entertaining members' suggestions related to services requests and claims. Suggestions can be submitted verbally or in writing as per the convenience of members. According to the phect-NEPAL staff, such occasional suggestions have helped the Scheme to improve.

V. VIEWS OF DIFFERENT ACTORS

This part covers views of different actors related to the scheme.

5.1 Beneficiary Point of View

The Insurance Scheme makes an effort to gather information about its impact through the general assembly meetings, group meetings and occasional interaction with members. The Local Coordination Committee members do the same to obtain feedback on their role. These interactions in different ways help to understand the level of satisfaction among the members. Though the members are not yet directly involved in the evaluation of the Scheme, they are providing regular feedback both verbally and in writing. Most of the members have expressed satisfaction with the Scheme's performance.

5.2 The Management's Point of View

The officials implementing the Insurance Scheme feel that continuation of the Scheme is possible only with the regular support of the community. Their expanded enrolment into the Scheme and regular contributions followed after that would provide a sound basis for the promoters to take the Scheme forward. With the establishment of Health Information and Service Centre clinics in the community patient pressure in the city has been reduced (including those served by Kathmandu Model Hospital. Awareness of people towards health and sanitation has increased. Some of the key factors leading to success of the Scheme are:

- Availability of quality health services at a lower price.
- Higher return of contributions paid.
- Existence of Health Information and Service Centre facilities at the community level.
- Increased relationship between health care personnel and beneficiaries.
- Increased enrolment of community people to the Scheme.
- Regular sharing of contributions for the health sector.

The difficulties associated with the Scheme, are stated as follows:

- Limited awareness of people about the Scheme.
- Poor saving attitude among the potential members.
- Lack of readiness to contribute for future access to health benefits.
- Poor knowledge of members about proper accounting systems.
- Limited coverage of health services.

Administration and Management: The administration and management system of the Scheme has gradually improved over the years. Arrangement of training and orientation programs for accounts keeping and day-to-day administration of the Scheme has increased the Scheme management competency of staff. The members have become more supportive of the administration and management of the Scheme. Awareness about the need for contribution has increased. The officials find understanding between different units of management satisfactory.
The Insurance Scheme is proud of its ability to mobilize volunteers. Given that most of the management staff are working voluntarily, the operational cost burden of the Scheme is smaller than it had to be.

Considering the potential for improvements, the officials felt that with additional office management training offered to the members, the operational system of the Scheme could be standardized further.

***Membership Experience*:** The members realize that the Insurance Scheme is for their benefit. But still there are others, who are not yet prepared to enrol. As the membership is focused only on those willing to join voluntarily, the promotional activities remain key for increasing the pool, Phect-NEPAL hopes that its open policy to integrate all age groups, sex, health risk persons and income strata, will encourage non-members to join through the demonstration effect of benefits accessed by current members.

The members feel that the benefit coverage needs to be expanded to attract more members. Some feel that most dropouts in membership have resulted from the availability of other alternatives than their poor economic condition causing discontinuation of contribution. According to them, some reasons for dissatisfaction towards the scheme were as follows:

- Lower coverage of benefits as compared to members' expectation.
- Relatively lower access of the poor (which has become a reason for suspecting unsafe situation for participation by other risk averse poor).
- Lack of monitoring of service quality by the members.

Some officials felt that the Scheme needs to understand reasons for dissatisfaction of those who leave.

Satisfied members who are continuing their affiliation with the Insurance Scheme point out the following:

- Access to health services at a lower price.
- Access to basic health services in the village.
- Good relation with the health care providers (Health Assistant and Doctors).
- Discrimination-free access to the members of all categories.

Potential for Increased Membership: Lack of willingness and affordability are two important reasons for non-participation. Some people still have difficulties to understand the Insurance Scheme concept and the benefits of joining. Trust building is one of the challenges to be encountered by the Scheme. Most of the new entrants join the Scheme only after one of their family members become ill.

5.3 Other Actors' Point of View

The Village Development Committees are positive towards the performance of health centres and their positive impact on the health condition of the local population. They have demonstrated their willingness to support effective operation of the scheme at the community level by providing funds.

The local authorities have realized that the Community Health Insurance Scheme is important for poor people with low income. They felt that besides treatment such programs could make people more aware about their health rights and enhance self-help attitude. In their view, good understanding among the community people, more information sharing and transparency in the management of the Scheme could accelerate efficient growth of the Scheme.

Most of them believed that replication of similar schemes to other areas would be important for improving the health status of the people in the country. They suggested that the Scheme should aim at wider coverage of both services as well as beneficiaries, penetrate towards poor as the target group, and increase frequency of doctors' visit to the Health Information and Service Center clinics.

5.4 Contribution Against the Benefits

The community people have benefited from the Insurance Scheme in many ways:

- Increased health awareness among the community people.
- Increase health access to members.
- Reduced morbidity cases.
- Ownership of community health services.
- Subsidized treatment opportunity.

The contribution received from members is significantly lower as compared to the amount spent for subsidized treatment benefits. In this sense, the Scheme is still more tilted towards providing charity than recovering the actual cost. In such a situation, any cost explosion in the future would become a major risk for sustainability of the Scheme unless some sources of increasing the revenue are identified. Therefore, the Scheme needs to explore possibilities of increasing the rate of contribution along with possible diversification of access to resources. One of the options being considered by the Scheme at present is the possibility of raising the contribution from "individuals" as the members of the Scheme than the "family" as a member unit. The Scheme has also mobilized cooperation of local government body (Village Development Committee) to strengthen its resource base. Some Village Development Committees have already given a grant to the health centre. This can be taken as a good example of the partnership between the needy local contributors at the community level (members) and local bodies concerned with social development.

5.5 Relation between Beneficiary and Health Care Providers

Beneficiaries: The relationship built between the beneficiaries and health care providers is quite strong. After implementation of the Insurance Scheme, the frequency of illness has been reduced among the members. Contribution of the Scheme lies not only on the curative treatments but also on the awareness it has raised about the primary health care.

Frequency of visit to the traditional healers has decreased. People going to them have instead switched to the health centre. Morbidity cases have decreased due to improved sanitation and greater access to services at times of need.

The Scheme informs its beneficiaries about the health service activities through the general assembly meetings, group meetings, Health Information and Service Centre clinic operation and counselling. Their opinion about the Scheme operation is sought occasionally. The members see the importance of such consultation for a good partnership.

Health Care Provider: All are treated equally for the health services. Besides providing treatment to the patients, the Scheme is trying to bring both perceptual and behavioural change to the beneficiaries. Their awareness of health issues has increased together with the need for generating savings for future health investment.

The health care provider is cautious about possible fraud cases. For example, two years back one patient came to Kathmandu Model Hospital for medical treatment with an insurance card. When the person died during the process of the medical investigation, it was then discovered that he was using the card of another person. After this event, phect-NEPAL decided to use photograph of the member in his/her membership card.

VI. CONCLUSION AND A FEW RECOMMENDATIONS

The phect-NEPAL has been mobilizing people and offering quality health services through its Community Health Insurance Scheme. This has helped people in the community, who were otherwise left out due to the lack of access to such facilities. Experience of the Scheme to-date is encouraging in that it has been able to continue its services, although it is being subsidized. The challenge ahead confronting phect-NEPAL is to sustain this momentum for a longer term. This may require a shift from a *"subsidy based"* approach to a *"cost recovery"* approach. This means transferring the ownership of the Scheme from phect-NEPAL into the hands of members. This is a challenging task against the reality of higher demand of services from the members against their limited financial contributions at present versus the phect-NEPAL's interest to reduce its financial burden. To deal with this problem, phect-NEPAL could embark on increasing sensitivity among the non-members regarding health and sanitation condition and morbidity cases so that more number of memberships could be attracted to join the insurance system. Similarly, the resource base could be diversified as much as possible. Monitoring of management system and maintaining transparency could be other areas, which would raise consciousness of the members for their self-help initiatives to manage the Scheme by themselves in the long run.

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