CHALLENGES FOR IMPLEMENTATION OF THE HEALTH INSURANCE PROGRAM IN NEPAL: IMPLEMENTER'S PERSPECTIVES

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Abstract

Introduction: The National Health Insurance Program is one of the most significant policy initiatives by the Nepal government. The program was started in 2016 as a pilot project in three districts with the objectives to reduce financial hardship, increase access and equality to quality health care, and as an approach to achieve Universal Health care (UHC) in Nepal. However, there are challenges and obstacles to implementing the insurance reform successfully, which should be identified to eliminate them hopefully. This study's main objective is to explore the challenges from the perspective of different levels of implementers. Further, it explored the solutions for these challenges.

Method and material: The study is qualitative, and ten key informants were purposively selected for in-depth interviews. They were the National Insurance Board staffs (6), health service providers (2), and enrolment assistants (2). The qualitative thematic analysis was used to generate different themes, categories, and sub-categories.

Results: Multiple interrelated challenges were drawn from the study. Poor educational awareness, promotion, and marketing, reimbursement delay, adverse selection, lack of trust, weak incentives, lack of coordination with the local authority and community mobilization, lack of human resources, poor quality health service, fraud, poor identification problems, lack of political support and overlapping of different government programs were the major challenges identified. Participants also reported some possible solutions to combat these implementation problems. Some of the major solution reported were increasing educational awareness, improving human resource management, adoption of online and digital sign-up methods, more appropriate salary and motivational support, political support, integrating the different program into the insurance scheme, early evaluation of service sites before implementing the scheme, and finally, legal regulation to control fraud and corruption. This study offers a theoretical elaboration of challenges between three actors (the Nepalese people, the health care providers, and the health insurance providers) and problems related to the institutional working environment.

Conclusion: The National Health Insurance Program is one of Nepal's most ambitious programs, ensuring its effective implementation is necessary. Multiple sectors like political parties, government program managers, stakeholders, and local authorities need to work better to make the national health insurance program successful.

Keywords: Health insurance program, voluntary health insurance, and low- and middle-income country, implementation challenges.

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Definition of terms

Health: According to the World Health Organization (WHO) 1946, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Health insurance: health insurance may be defined as a method to spread the financial risk related to healthcare needs among a more significant risk pool.

Health insurance program: HIP is a way where some health insurance program attempts to accomplishes Universal Health coverage (UHG) and helping people from falling into scarcity by terrible health expenditures due to health problems or accidents. It represents risk pooling with mutual support. This program is set up to tackle obstacles in health care and make sure everyone's equity to access, including deprived and underprivileged people (Health Insurance Board (HIB), 2021).

Implementation challenges: According to this study, implementation challenges are those problems and barriers present for implementing the NHIP, all difficulties faced by the health insurance implementers from the lower level to upper level in the insurance board of Nepal. Challenges can be either from the demand side or from the supply side or jointly together. Demand-side represents the factors related to the potential customers and insured people. The supply side represents the health system (hospital or Primary Health Care Center (PHCc) related, and health insurance agency-related factors).

Adverse selection problem: According to this study, the characteristic of adverse selection is when people in high health risk categories are more likely to buy health insurance than healthy and low-health risk people.

Moral hazard: Moral hazard is defined as the tendency of an individual to behave, once they are insured, in such a way that may increase the likelihood of the risk against which they have insured (Criel, 1998). According to this study, the moral hazard problem represents both problems related to the health service provider's behavior- such as over-prescription of drugs, unnecessary diagnostic test, taking extra money from patients or fraud; and client's behavior- such as over-consumption of medical service, using double insurance card.

Enrolment Assistant (EA): Enrolment assistants are those local registration helpers appointed to go door to door of Nepalese citizen's households for educational awareness and counseling about the program and help people sign up for the health insurance program.

Abbreviations and Acronyms

BPKIHS	BP Koirala Institute of Health Science
BS	Bikram Sumbat (official calendar of Nepal)
CBHI	Community- Based Health Insurance
CHF	Community Health Fund
CHI	Community Health Insurance
DoHS	Department of Health Service
DRG	Diagnose Related Group
FY	Fiscal Year
GDP	Gross Domestic Product
GoN	Government of Nepal
HDI	Human Development Index
HIB	Health Insurance Board
HIP	Health Insurance Program
HMIS	Health Management Information System
MoHP	Ministry of Health and Population
NHIP	National Health Insurance program
NHRC	Nepal Health Research Council
PHCc	Primary Health Care Center
UHG	Universal Health Coverage
UNDP	United Nations Development Program
WHO	World Health Organizations

Chapter I: Introduction and Background of Study

1.1 Introduction

This chapter contains a short introduction to Nepal's health system, a statement of the problems, the background of Nepal's health insurance program, and the research objectives.

1.1.1 Health, Health Care and Financial Protection

Nepal is a small country in the South Asia region surrounded by China and India (The World Bank, 2020). The Ministry of Health and Population (MoHP) is the head of the Nepal public health sector, responsible for overall policy development, planning, organizing, and coordinating all the country's health divisions. Over the decades, Nepal has made massive success towards achieving the major health goals. The mortality and morbidity related to vaccine-preventable diseases have declined remarkably through the expanded immunization program. Likewise, maternal mortality decreased with the help of a safe motherhood program, institutional delivery increased (63%), and delivery conducted by skilled birth attendants increased (60%). However, the percentage varied from place to place.

The constitution of Nepal 2007 announced basic healthcare free of charge for all Nepalese citizens from a 25-bed district hospital or primary health care center (PHCc). However, only 6.5% of hospitals are public hospitals recorded in HMIS under DoHS (Department of Health Services (DoHS), 2020).

The poverty alleviation program is adopted as a national strategic method and is implemented by the local, provincial, and central level in Nepal to identify the poor people. In the Fiscal year 2076/77, poverty measurement was done in 26 districts of Nepal, resulting in almost four hundred thousand households below the poverty line (Ministry of Finance, 2020).

The government of Nepal started a citizen service scheme (Bipanna Nagarik Kosh). That offers health benefits for Nepali people (deprived citizens) to treat serious health problems such as cancer, heart disease, severe head and spinal injury, Alzheimer's or Parkinson's disease and sickle cell anemia, etc. Out of the total national budget, only 2.59 percent of the budget has been allocated for the health sector (Department of Health Services (DoHS), 2020).

1.1.2 Problem statement and justification

Nepal government has taken steps to introduce a national health insurance program (HIP) in 2016 to ensure quality health services and reduce out-of-pocket expenditure. However, Following the first year of an act, the program covered just 5 % of its target population. The number of people enrolling in the Social Health Insurance program increased from 1.1 million at the end of the fiscal year (FY) 2016/17 to just 1.5 million at the end of the year 2018, which counts to about 8.3% of the catchment population in the targeted area (Department of Health Services (DoHS), 2019). In FY 2018/19, the enrolment number was about 1.6 million, which means 14% of coverage in the targeted area (Department of Health Services (DoHS), 2020). At the same time, five hundred seven thousand people dropped out of the program at the end of that year.

HIP had the vision to cover all the 77 districts within FY 2075/76 (2019/20). However, only 69 districts have launched the program until FY 2077/78 (2020/21). It is evident that HIP has not yet reached the targeted level of coverage, which poses a question on the program's sustainability. Since the health insurance scheme is voluntary, previous studies show that most people prone to disease were enrolled (Acharya, Devkota, & Wagle, 2019), which means sick people would register more often than healthy people. This cotests the purpose of sharing risk (Mishra, Khanal, Karki, Kallestrup, & Enemark, 2015). Thus, high enrolment and coverage are necessary for the program's growth and development, which is not happening so far.

If we look at the history of health insurance schemes in Nepal, many small health insurance schemes could not survive long due to very few studies on the challenges of implementing the schemes. It is important to conduct a study on challenges and probable solutions to ensure the survival and success of health insurance schemes at the implementation level. It is important to understand the perspective of key implementers of the program on the challenges and lay a foundation for appropriate solutions. Since implementers are in a more informed position than the general population, the probability that they give more informed views of the problems are higher. However, a few studies have investigated this issue, so that we can see a research gap here. Thus, this study aims to assess the challenges for the implementation of the HIP. We will distinguish various factors hindering the widespread coverage of the insurance through qualitative research, with interviews of experts and actors involved in implementing the health

insurance scheme. Going a step further, we will articulate recommendations to the Government of Nepal, the Health Insurance Board of Nepal, and future research based on the study's insights.

1.1.3 Health insurance in Nepal

Many states worldwide aim to achieve universal health coverage (UHC) irrespective of their economic status or lack of adequate infrastructure. In one corner, various countries like France and Japan have attained universal health coverage successfully. In another corner, low-income states such as Nepal are still trying to achieve universal health coverage (UHC)(Raut, 2015). Concerning this, the Government of Nepal (GoN) adopted the 'National Health Insurance program' as a strategy to monitor and ensure UHC and create a risk pooling mechanism, which could provide economic protection against health-related catastrophic expenditure for all Nepalese. The initial phases involved a sequence of pilot schemes in Kailali, Baglung, and Illam districts from 2016 (Acharya et al., 2019; Ghimire, Sapkota, & Poudyal, 2019).

The concept of the HIP is not new in the Nepalese health sector, as the non-profit organization has previously launched a medical insurance scheme in 1976 Bikram sambat (BS) as the "Lalitpur Medical Insurance Scheme," which was one of the initial insurance systems in Nepal. The BP Koirala Institute of Health Science (BPKIHS) in Dharan (2000) started health insurance for rural and urban people with the same assistance at different premium amounts. However, they could not expand the program due to the high cost and low premium collection (Ghimire, 2013).

HIP in Nepal is a voluntary program selecting family as a unit, established to enable people to get quality health care services and minimize financial hardship and shield people from the catastrophic payments due to severe accidents or diseases. The health insurance board (HIB) is the responsible body for carrying out HIP all over the country. It is an effort to prevent financial barriers to the use of services, especially for a disadvantaged group, to promote pre-payment and risk pooling, equitable economic mobilization, and move toward UHC. (Department of Health Services (DoHS), 2020).

1.1.4 Features of HIP

The health insurance act 2074 B.S. (2017 AD) (amendment in 2075 B.S.) of the Nepalese government regulates all the procedures related to Nepal's health insurance. According to this Act:

Table 1 Features of NHIP

Features of NHIP	Description
Project started	• April 2016
Unit of insurance	• Family of 5 members considered as a unit
Contribution	• Annually
Contribution amount	• Rs. 3500 (29.70 USD dollar)/ year/ Family up to 5 members, • Rs.700 (5.86 USD dollar) /person for an additional member,
Benefit ceiling	• Health care benefit ceiling Rs.1,00,000 (848.68 USD dollar) for a family of five, • Rs.20,000 (169.74 USD dollar) for every additional member,
Process	• Either local registration helper or directly through electronic registration in the insurance information management system maintained by the health insurance board, • Each member of the family gets a personal insurance card, • Insures must specify the first service point (Hospital or PHCc), which they will use primarily except for an emergency, • If the service provider cannot provide the necessary service, they need to recommend other facilities with proper recommendations, • The first service point should maintain appropriate information about the treatment involved and the cost incurred and pre-inform the patient about the probable cost before treatment, • To claim the reimbursement, the service provider should apply via the insurance information system (IMIS) and treatment documents. • The health insurance board evaluates and regulates the treatment procedure and it's cost and the medication.
Exemption and subsidies	• Special concessions for elderly citizens, citizens below the poverty line, and government employees
Medicine	• 928 types of medicine (70 free essential drugs, 25 Ayurvedic drugs, and 833 other medicine),

(Health Insurance Board (HIB), 2020).

1.1.5 Objectives of the study

General objective

To assess the challenges for implementation of the health insurance program (HIP) in Nepal from the implementer's perspectives.

Specific objectives

To identify the challenges as perceived by the implementers,

To identify their suggested solutions and recommendations to solve those challenges,

Chapter II: Literature Review

2.1 Introduction

A literature review was essential to investigate problems and challenges facing the Nepalese public health insurance system. I reviewed previous studies related to health insurance in Nepal and literature exploring national, voluntary health insurance systems in other low-and-middle-income countries.

Firstly, the motivation for the literature review was to understand what has already been investigated regarding my study topic. Secondly, it helps me pre-understand the problems, making it possible for me to ask relevant follow-up questions to the interviewees. Finally, to enhance my study's robustness, investigation if I had similar findings from the interviews, which have been reported in earlier studies. In other words, it aimed to support my study findings. Data on previous studies were collected from different peer-reviewed and grey literatures.

2.2 Methodology of Literature review

2.2.1 Source of information

All studies were systematically searched through online databases, such as PubMed, Google scholar, the Oslo-metropolitan university online search engine Oria, library learning center, and Oslo-Met library. Some of the studies were selected by my supervisor's suggestion and recommendation.

2.2.2 Search strategy

Key terms and inclusion criteria were used to gather literature. In the case of studies outside of Nepal: "National health insurance" AND "implementation problem" and "professional", "health insurance program" AND "implementation challenges," "voluntary health insurance" AND "low- and middle-income country." Only full articles in English were gathered.
In Nepal, a review of health insurance policy and similar relevant documents from Nepal was searched. Thus, Nepal health insurance policy and Health insurance act 2017 searched on the website of HIB, MoHP. Secondly, to gather information about the insurance program's situation and background, the website of WHO, World Bank, Nepal law commission, central bureau of

statistics, UNDP, and ministry of finance Nepal were searched. Key terms were as "national health insurance program" AND "Nepal," "health insurance" AND "implementation" AND "challenges" AND "Nepal," "social health security program" AND "Nepal," "health insurance policy" AND "Nepal", "voluntary health insurance" AND "Nepal" Only full articles in Nepali and English were selected.

2.3 Review of the studies outside of Nepal

2.3.1 Articles providing an overview of implementation problems

Two review articles were found that discussed problems in voluntary health insurance systems in low-to-middle income countries generally:

A systematic review has been performed to assess the "barriers and facilitators to implementation, uptake, and sustainability of community-based health insurance schemes in low- and middle-income countries" (Fadlallah et al., 2018). Researchers searched electronic databases and grey literature, including both qualitative and quantitative studies. The study differentiated challenges into an individual, interpersonal, community, and system-level factors to facilitate the implementation, uptake, and sustainability of community-based health insurance. The report found that awareness level, trust in scheme and managers, perceived service quality, and demographic characteristics were the main individual factors. Interpersonal factors were the family member enrolment, household dynamic, etc. Community-level factors were norms and culture, community influence. System-level factors were lack of staff motivation, less political support, poor administrative structure and management of the scheme, lack of qualified scheme manager and leaders, limited expertise and insufficient stakeholders' involvement, inappropriate benefit package formulation, an inadequate promotional campaign. These were significant challenges in the implementation, uptake, and sustainability of community-based health insurance schemes in low- and middle-income countries.

Another systematic review (Panda et al., 2015) was also conducted about factors influencing the uptake of voluntary and CBHI schemes in low- and middle-income countries. Altogether 54 articles were reviewed in this study. According to this study, factors found to be barrier for the

enrolment were cultural belief, inappropriate benefit package, a far distance of health facility, lack of trust in the scheme, and lack of policy framework. Whereas, adequate knowledge and understanding of the scheme, quality health services, having faith and trust in the scheme, good benefit package, appropriate payment mechanism, an effective unit of enrollment, affordable premium amount, health facility in the catchment area, and adequate policy regulation would increase the enrolment in health insurance schemes. (Panda et al., 2015).

2.3.2. Single country studies in Asian low and middle-income countries

Two studies were found that discussed problems and methods to run voluntary health insurance systems in Asian low-and middle-income countries generally:

A household survey was conducted in Lao Peoples' Democratic Republic (Lao PDR) using a case-comparison method among three thousand households. 'Achieving universal health coverage through voluntary health insurance: what can we learn from the experience of Lao PDR?': the 2013 study found more unhealthy people signed into the CBHI program leading to adverse selection problems. Most rich people did not prefer a health insurance scheme; instead, they went to private health care centers while getting sick. Low-quality service and a negative attitude towards the CBHI scheme seemed to be apparent. There was no subsidy plan for impoverished people, which showed poor people could not use the CBHI scheme (Alkenbrack, Jacobs, & Lindelow, 2013).

A case study conducted in India regarding 'health security for the rural poor? A case study of a health insurance scheme for rural farmers and peasants in India' from 2007 showed various methods to reduce the barriers to provide health care security to village people. The Yeshasvini Health insurance in Karnataka focused on giving local-level authorities and cooperatives initiatives to connect rural farmers. Mobilize rural members to sign up, provide effective self-financing designs, and increase access to health care facilities by including private health centers responsible for providing health care services. These acted as prerequisites for the insurance scheme to be successful (Kuruvilla & Liu, 2007).

2.3.3 Single country studies in low-and middle-income countries outside Asia

Two articles from Tanzania, Uganda investigating public voluntary health care schemes were selected. Four articles were selected from a voluntary scheme in Ghana, which had a different finding.

A study (2007) was conducted in Tanzania to explore the "factor influencing implementation of the community health fund." A qualitative method was used to gather information at the district level in 2 stages. In the first stage, a national-level document was reviewed, and interviews were taken, and in the second stage, district-level case studies with a high and low level of enrolment rate in each district were done. Also, in-depth interviews with district and ward level officials and community people were done. Stratified purposive sampling was used to select districts. The study found that unaffordable premium amounts, lack of quality health services, trust issues with CHF officials, lack of education and understanding to community people, rushed implementation of the program without pre-planning were significant factors causing implementation problems of CHF (Kamuzora & Gilson, 2007).

A case study in Uganda regarding the low enrollment of the Community Health Insurance (CHI) scheme, including its causes and policy implications (2007), was conducted. The study aimed to identify the underlying reasons for the limited success of CHI. The study reviewed the program's record, used semi-structured interviews with key-informants, and exit interviews with both insured and non-insured patients. The study found a lack of knowledge and understanding of the scheme, lack of trust, and lack of money to buy insurance from the people's side, lack of knowledge about the program, and inadequate policy guidelines to run the scheme were significant barriers for the scheme management and health service provider (Basaza, Criel, & Van der Stuyft, 2007).

A cross-sectional mixed-method study was conducted in Ghana (2016) regarding barriers and facilitators of enrolment in the NHIS. The study found that factors facilitating and enabling enrolment were influenced by the design and policy of NHIS; economic, political, and socio-cultural factors; client experience; frontline purchaser and implementation arrangement; and frontline providers and implementation arrangement (Agyepong et al., 2016).

An embedded case study design was carried out with an intention to provide in-depth understanding of political and economic challenges influencing the implementation of the national health insurance scheme in Ghana. A qualitative in-depth interview was done among thirty-three participants in four districts of Ghana (2 northern Ghana and 2 southern Ghana). A purposive sampling technique was used alongside stakeholders mapping and snowballing. The study found that political interference was a significant challenge. The economic challenges were low contributions from clients, moral hazard behavior, and fraud and abuse by the health care service site about reimbursement. The study concluded that both political and economic factors need to be managed effectively. Political stewardship is necessary for a national health insurance scheme, and political leaders should realize their responsibility regarding the scheme by constructed trust and confidence in the system (Fusheini, 2016).

A qualitative study about 'an exploration of moral hazard behaviors under the national health insurance scheme in northern Ghana' was conducted with focus group discussions and individual in-depth interviews in December 2009 and January 2010. Thematic analysis was performed. The study showed both health service provider and client of insurance abused scheme through a frequent visit to the health center, impersonate (pretend to be insured patients), faking sickness to get medicine for their non-insured friends and family, excessive service charge by the health service provider, excessive prescription of drugs, and charging extra money from insured people. These problems were reported as moral hazard problems. (Debpuur, Dalaba, Chatio, Adjuik, & Akweongo, 2015).

A mixed study (qualitative and quantitative) was conducted in Bolgatanga and Builsa district of Ghana about 'the national health insurance scheme: perception and experience of health care provider and client in two Ghana districts.' Two hundred insured and uninsured clients and fifteen in-dept interview were performed with health care providers and health insurance managers and eight focus group discussions were done with both insured and uninsured people. The study found various challenges such as increasing workload among health service providers, delay in reimbursement from the insurance agency, and difficulty operating hospitals' normal function without reimbursement. This study concluded that delay in payment resulted in the negative attitude of the service provider to insure (Dalinjong & Laar, 2012).

2.4 Review of studies in Nepal

Finally, literature related to the NHIP in Nepal was selected to find out what sort of research problems have been investigated by previous researchers. As well as to check if additional research needed to be done. Some studies were found that discussed the problems of voluntary public health insurance systems in Nepal.

An exploratory mixed-method (qualitative and quantitative study) was conducted in three districts of Nepal, i.e., Bardiya, Chitwan, and Gorkha, and participants selected purposively. The study's main aim was to identify the status and determinants of enrollment and dropout of health insurance in Nepal. For qualitative data, enrollment assistants were taken as a sample participant. Focus group discussion was done with the enrolment assistant. The study found out the enrolment dropout rate was higher than the enrolment coverage rate from 2016 to 2019. The insurance coverage's major challenges were lack of availability of medicine in health care centers, negative attitudes of the health care worker toward the insured population, long time to mature insurance card, and inadequate health benefits. The study concluded that there should be better coordination with the health insurance board and the health service site, re-examine the current health insurance policy and its current health care benefits package. It was also strengthening the enrollment assistant's skills to decrease the dropout rate and increase the enrolment rate (Ranabhat, Subedi, & Karn, 2020).

A cross-sectional study conducted in the Baglung and Kailali districts in Nepal in 2018. The aim of the study was to assess factors associated with enrolment in the health insurance program. A simple random technique was used to select 810 (enrolled and not-enrolled) households. The study showed nearly 75% of participants stated they were willing to pay enrollment fees. The study also showed that literate people were less likely to sign up, and chronically ill patients more likely to join the health insurance program (Acharya et al., 2019).

The systematic review study conducted regarding "social health insurance in Nepal: a health system departure toward the UHC." This paper highlighted issues, challenges, and its future perspective on its way to achieve UHC. This paper highlighted the current payment system of the health insurance, i.e., Diagnose-related group (DRG) payment is an administratively and technically complex method that would require robust information structure and sound auditing

capacity from the government side, as problems such as fraudulent claims may arise. It is a daunting task to ensure equal coverage of insurance programs throughout rural areas of Nepal. The insurance premium amount seems to be the major funding source of Nepal which might not be adequate (Pokharel & Silwal, 2018).

The Nepal Health Research council conducted mixed-method research (qualitative and quantitative study) to explore the "experiences and identifying the key challenges in implementing health insurance." The study was conducted in Kailali, Baglung, and Ilam with 54 key-informant interviews and 338 exit client interviews (half insured and half not-insured). The sampling technique was purposive for key-informants, and consecutive sampling was done for exit client interviews of the service user. The study reported that people with health insurance tended to opt for health service in the earlier stage of disease, leading to adverse selection problems. They also reported that the enthusiasm on people about the health insurance scheme had been reducing, which means retention of insurance is in danger. Inadequate availability of medicine, poor internet service, and complicated claim system was also mentioned as problems (NHRC, 2018).

A systematic study conducted in Nepal in 2015 regarding the national health insurance policy and its challenges for implementation also suggested various challenges for the health insurance program. The study highlighted health insurance program should learn from previous unsuccessful CBHI programs in Nepal. The study reported that the program should strengthen health care services, charge affordable premium payments, develop effective benefit packages, improve human resource and technological management, and careful policy planning. These would improve the health insurance reform (Mishra et al., 2015).

To sum up, based on the above, we can identify four "groups of actors" who in various ways are relevant for the take-up of a voluntary health insurance offer, and I have listed different pertinent factors in each category found from the study above.

1. **The citizens and their families (their perception of the system, level of trust, adverse selection, etc.)**

- Lack of awareness level and understanding, trust in scheme and managers,
- Non- insured did not want to enroll because of perceived low-quality service, lack of money to buy insurance, or due to poverty,
- Enthusiasm on people about health insurance scheme has been going down,
- More unhealthy people into the health insurance program (adverse selection problem),
- Client of insurance abused reform through a frequent visit to the health center,
- impersonate (pretending to be insurance clients), faking sickness to get medicine for their not insured friends and family,

2. The organization and capabilities of the health insurance system (agency related)

- [lack of] motivation of the staff of scheme and qualified scheme manager and leaders, and delay in having an insurance card,
- Limited expertise and poor stakeholders' involvement, inadequate promotional campaign,
- Inappropriate benefit package formulation, payment mechanism, payment amount,
- [lack of] health facility in the catchment area,
- [lack of] provision of logistic, proper infrastructure, poor internet, administrative structure and management of the scheme, and adequate policy regulation,
- [lack of] giving training to the staff and [lack of] stability of staff, [lack of] skill and trained human resources in the claim section,
- Fraud and abuse by the health care centers about reimbursement,
- Rushed implementation of the insurance program,
- Long activation cycle of insurance card

3. The organization and capabilities of the health care services (public and private) that insurance provides access to

- Low-quality service, medicine, Inadequate logistic and infrastructure and [lack of] human resources,
- Negative attitude towards clients,
- Inadequate fund and taking time for the claim refund, difficulty in operating hospitals normal function without refund,

- More service charge by the service provider, more prescription of drugs, and charging extra money from insured people,
- Increasing workload among health service provider leading to change in their behavior towards clients through negative attitude for insured people,

4. **The political environment, i.e., how politicians have set up, regulate and steer the health insurance system as well as health service delivery,**

- Less political support,
- Making political agenda of the program,

The above list provides a structure, or pre-understanding, of the problems likely to be experienced by the implementers I interviewed. With this in mind, in the next chapter III, I present the methodology behind my study of implementation problems.

Chapter III: Methodology

3.1 Introduction

This chapter describes the methodology of this study. A qualitative research design was performed for this study. The qualitative research method is one of the research methods where the researcher tries to understand the study participant's culture, faith, and manner, and how the study operates. This method emphasizes the meaning of an action; the participant's visions about the situation are always superior to the researcher. The researcher gets close to the study population to understand the natural world and societal truth from their action and words. Contextual understanding is essential in this method (Bryman, 2012).

3.1.1 Design

The descriptive qualitative method was applied to explore the research objectives.

3.1.2 Sampling technique

The non- probability purposive sampling technique was used to select participants from different health insurance program implement levels. They were from the central level, the provincial level, the district level, and the local or root level of the health insurance board. Besides, snowball sampling was used to select some participants, i.e., some respondents were obtained from the information given by the first respondent.

3.1.3 Data collection technique

Key informants were individually interviewed in-depth to identify the challenges they face during the implementation of the health insurance program. All the interviews were carried out using a semi-structured interview guide (Appendix 2). Semi-structured interviews can be placed somewhere between the end of the wholly structured and completely unstructured interviews, which allow exploring and, at the same time, maintain the track to keep the interviews in control (Bryman, 2012). Questions were asked according to the researcher's preference, did not follow an exact outline or question patterns, started randomly.

There was a variation on the wordings, exact word was not used to every participant. Few face-to-face interviews were done to gather information and experience. However, due to the COVID 19 pandemic, the same method was not possible. Therefore, some of the interviews were taken through the internet (zoom video call) by keeping social distancing in mind. All the interviews were audio-recorded after the participant's consent, which lasted from 30 minutes to 1 hour 15 minutes.

3.1.4 Sample size

Altogether ten participants were interviewed to understand their experiences regarding challenges for implementing health insurance scheme in Nepal.

Table 1 Participants of the study

S.N	Participants and their designations
1	Enrolment assistant 1 (local level)
2	Enrolment assistant 2 (local level)
3	District enrolment officer (district level)
4	Provincial coordinator (provincial level)
5	Health service provider 1 (public hospital)
6	Health service provider 2 (public hospital)
7	Claim reviewer (central level)
8	IT official (central level)
9	Information planning and communication official (central level)
10	HR official (central level)

All participants were implementers of the health insurance program in Nepal. From the root level, I selected an enrolment assistant. Since the Gandaki province office and the Kaski district office were same, I chose the enrollment officer and provincial or district coordinator. At the central level, I selected participants from the management branch processing claim on behalf of health service providers, human resource department, IT department, and Information, education and communication (IEC) section.

3.1.5 Study site

The study site was divided into different levels, i.e., national, provincial, district, and ward levels in Nepal. Nepal is a big country, so a multi-level sampling technique was used to divide places into smaller ones to conduct the study.

Level one: Nepal health insurance board
Level two: Gandaki province health insurance board
Level three: Kaski district health insurance board
Level four: Pokhara Municipality ward (local level) number 11 and 27 (Enrolment assistant)

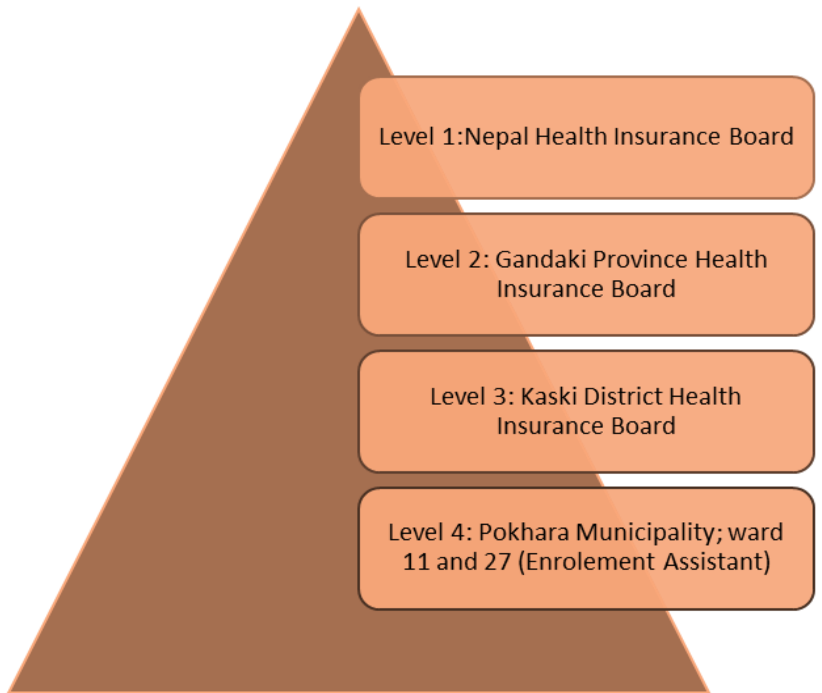


Figure 1 Level of the study site

3.1.6 Data sources

The majority of data were collected from primary data sources (participant's interviews). Data collected through face-to-face interviews in both natural and virtual settings. Secondary data were collected from the literature review.

3.1.7 Preparation of the interview guide

I prepared the list of questions that I thought to get information from the interview. The interview guide was developed after reviewing several literatures, which gave me profound ideas on probable questions to ask based on my research objectives. During the interview guide preparation, I constructed a certain number of questions related to the topics with a good following order. However, I altered questions during an actual interview. The interview guide was in Nepali to make it easier for the informants to express themselves freely without a language barrier. See interview guide in appendix 2.

3.1.8 Data management and analysis

All the interviews were audio-recorded, which helps to identify the repetitive words and sentences. It protects the researcher from the accusation that the researcher's point of view could have manipulated the analysis. It is essential that the participant does not get distracted by the researcher's focus on noting down answers to what is said. The recording was necessary to concentrate on the words and sentences spoken by the participant, and I could ask related proving questions (Bryman, 2012, p. 482). Firstly, all the recorded interviews were transcribed in Nepali, which took me nearly 3- 5 hours for each interview. After that, all the transcription were translated to English, which also took 3- 4 hours for each interview.

This qualitative data was analyzed by using the thematic analysis approach. It is the method of coding information from the dataset and generating themes. "The themes may be the manifest level, i.e., directly observable in the information or at the latent level, i.e., underlying the phenomenon" (Boyatzis, 1998, p. 4). Themes can be generated by the inductive approach from the pool of dataset or by the deductive approach from the preliminary theories or literature review (Boyatzis, 1998). When looking for the themes, the researcher needs to give emphasis on the repetitive words or sentences, participant's slang expression, an expression which never heard or seen before, some metaphoric and analogy term to describe something, naturally occurring shifts in the expression of speech such as nature of voice tone. As well as if a participant takes any pause during the speech and shows different forms of expression, that also needs to be considered. Careful examination of some "phrase" or words such as "if, because, rather than, as a result, etc.," missing data such as strategic use of silence also should be noted (Ryan & Bernard, 2003;

Bryman, 2012, p. 580). Thematic analysis is very flexible, and it has different phases outlined by (Braun and Clarke, 2006). Thus, I followed the following steps.

1. **Becoming familiar with the data:** In this phase, I familiarize myself with the data. Repetitive reading dominated this phase to generate the preliminary codes from the data set. After transcribing the data, I had to go repetitively through all the information in the transcribed and translated interview to generate initial coding.

2. **Developing codes**: After reading all the transcribed data set from the translated interviews, I generated initial codes related to the data. Especially those which had an interesting feature, meanings and which I thought I needed to analyse. Coding was done (appendix 5) manually through writing notes at the side of the sentences.

3. **Searching themes:** After generating different codes, I sorted different codes into specific potential themes. First, I combined all the codes into subcategories that had a similar feature. After creating a sub-category, a potential category had developed where all subcategories could fit into (appendix 4). With different categories and subcategories from the codes, developed potential themes helped to find out the challenges for implementing the health insurance program in Nepal.

4. **Reviewing themes:** In this phase, I investigated if the themes I generated represented an actual theme or not. I went through all the generated codes twice that I developed from the dataset if those fit perfectly into the sub-categories or categories. Some of the codes were removed from those themes, which did not fit in until I got satisfaction with the generated themes. I also developed a thematic map of analysis.

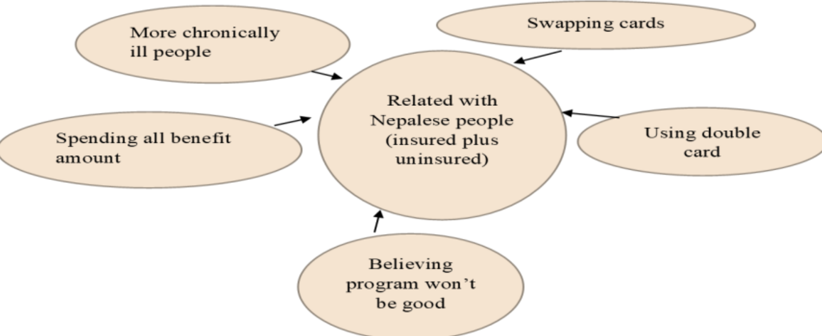


Figure 2 Example of initial thematic map

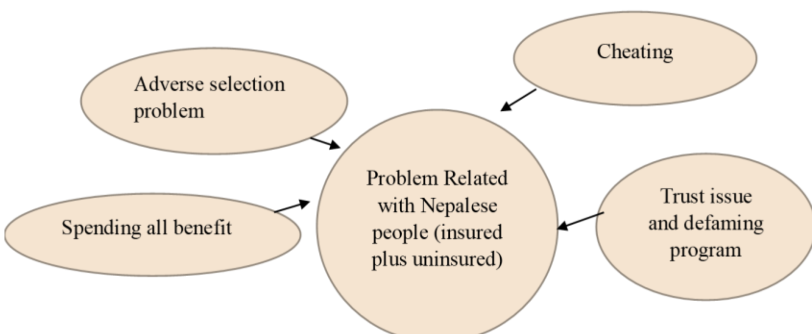


Figure 3 Example of revised and final thematic map

5. **Defining and naming themes:** In this phase, I refine and define all the themes and potential categories and subcategories within the data. I gave each theme a name and described them to capture the essence of each theme.

6. **Producing the report:** finally, after identifying all the themes, categories, and subcategories, the report was produced. As such, thematic analysis was carried out in six phases.

3.1.9 Trustworthiness of Study

To achieve the reliability and validity of this research, the trustworthiness of the study was measured in terms of credibility, transferability, dependability, and confirmability.

Credibility: Data and findings were shared with the participant to determine their accurate reflection of their answers.

Dependability: The researcher collected all the interviews.

Confirmability: All the results were extracted from the interviews given by the study participant. I have not introduced any potential bias and personal motivation to generate results from the interviews. Interpretation of the study was done based on participant responses.

Transferability: This study's findings will hopefully be applicable for future research in other settings. This study has provided details of the sample size, participants, methodology information so that future researchers can use this study as a reference.

3.1.10 Inclusion and Exclusion Criteria in the selection of the participant

Inclusion Criteria

Staffs of the health insurance board who are responsible for the implementation of the health insurance program,

Enrolment assistant from the ward level,

Exclusion Criteria

Staffs of health insurance board who are not responsible for the formal implementation of health insurance program. Such as, driver,

3.1.11 Ethical Approval and Consideration

Ethical matter occurs in every stage of any research. Thus, for ethical clearance, the study proposal and interview guideline were sent to the Norwegian Centre for Research Data (NSD) and the Nepal health research council (NHRC) for ethical approval. The proposal got approved by both ethical boards.

Before selecting any participant, an ethical approval letter from the NHRC and a formal request letter were sent to the official sites of the health insurance board. After their approval, I selected

participants who were present in the office. Informed consent was provided before the interview, and their formal sign was taken.

Participants were informed about the purpose of the study, method, and intention behind the use of research. They were made aware of their rights to refuse at any stage or withdraw from the interview, and their name kept anonymous.

Informed consent was in the English language (see appendix 1) since all the participants were official workers and could read and write in English. No personal questions were asked or issues related to private matters.

After recording the interviews, recordings were carefully stored on my laptop and phone. And transcribed data were stored in a locked drawer. The recording will be deleted after finishing the research project.

3.2 Limitation of the study

This study is subject to limitations. First, the study results could be affected by the purposive section of the sites and the limited number of participants, limiting the ability to generalize the results. Second, only participants from public health care facilities were selected, even though there were private health service providers available. Bringing in responses from the private health care centers would have been interesting and a suggestion worth pursuing in future research. Third, there was little available literature in Nepal related to the actual implementation of the health insurance scheme. Therefore, similar literature from other low- and middle-income countries was selected as part of the literature review. It is difficult to assess how relevant the findings from other low-and-middle income countries are relative to the Nepalese context, although, again, many problems appear similar. Finally, Due to the time limit, the study could not study more districts and different participants' responses. Thus, studies that can expand the number of sites and the number of implementers to interview would be worthwhile to undertake in the future.

Chapter IV: Results regarding perceived challenges

4.1 Introduction

This chapter includes the findings (perceived challenges) from the key informant interviews. To structure the presentation, we investigate problems related to the four groups of actors identified in the literature review and their relationship, as expressed by the various informants. Thus, we have structured the presentation concerning what our informants say about their perception of 1) Problems related to the relationship between Nepalese people (potential and actual buyers of insurance) and the national insurance system/agency; 2) Problems related to the relationship between the buyers of insurance and health care center or providers; 3) Problems Related to The Relationship Between the Insurance Board and service sites (Hospital and PHCc); 4) Problems related with the relationship between the insurance agency and political authorities, which have set up and oversee the system.

4.2 Conceptual framework, inspired by the literature review

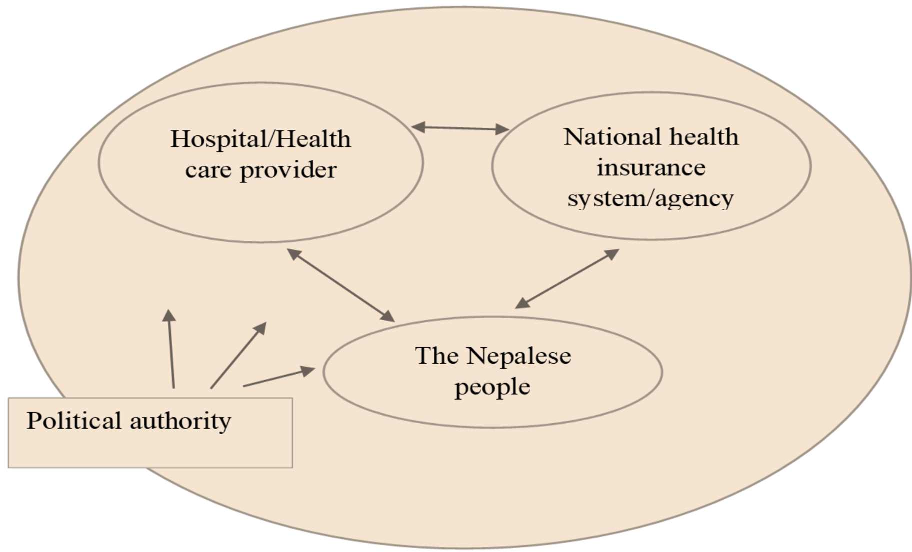


Figure 4 Conceptual framework, inspired by literature review

4.3 Problems related to the relationship between Nepalese people (potential and actual buyers of insurance) and the national insurance system/agency

In this category, we describe the problems mentioned by the participants concerning the relationship between the Nepalese people (both insured or uninsured) and the national health insurance board (HIB). The health insurance program was affected by the behavior of Nepalese citizens and the activities of the insured people. Also, problems related to the outreach efforts by the insurer to increase take-up of insurance.

4.3.1 Problems Related to how the Nepalese people perceive and act vis-à-vis the insurance system

My interviewees mentioned some significant problems when it comes to explaining why many people did not sign up for the program. They mentioned four major issues in particular: Trust issues and defaming program, Adverse selection problem, the mentality of people to spend all the benefit amount within the year they were insured and cheating which spilled over into reducing take-up from others, plus limited their renewal of the insurance. Let us elaborate the answers of the interviewees.

A. Trust Issue and the insurance system being defamed by People

According to informants, trust issue is one of the challenges for implementing health insurance program. Some participants said that people do not sign up because they do not trust the medicine provided by the government health care facility.

People think government hospitals provide cheaper medicine than private hospitals and believed government programs were not effective. Interviews also indicated that some people also spread negative news about the program.

".....But in the case of PHC and hospitals, there are huge problems in medicine, and we get many complaints from patients. There are problems in medicine. Sometimes same medicine has different brand names. Patients complain about medicine, and they say, "they are giving cheap medicine to us and do not give expensive one..."(IT head, 2020).

".....But the main problem in our country regarding insurance program is that people who are more educated are not attracted to the program than other with little education. The main

reason behind that is their mentality. They think this program will not be good......... people who do not sign for insurance, who doesn't even go to get services they talk rubbish about program......"(Provincial coordinator, 2020)

B. Adverse Selection Problem

Adverse selection (which means someone with high health risk sign up) is one of the challenges argued by the health insurance implementers. Some participants mentioned that most people in the health insurance program are those with chronic diseases which need more care and services, and they require more reimbursement.

"*..... Among them mostly there are people who have a chronic disease, who needs regular medicine, who must follow medical service regularly, who really needs, who needs regular treatment, we must spend on them. As long as we do not cover everyone in insurance, there will not be sustainability....."(District enrolment officer, 2020)*

".... mostly people with the disease. Today's trend is people who have a chronic disease, and they have to use more medicine, people with Diabetics, hypertension. These kinds of people from all the classes, if they are from a higher level, middle level, or even poor people, are more attracted to the insurance program. and they are also getting extreme benefits by utilizing insurance service..." (Provincial coordinator, 2020)

"*.....main enroll number is chronic disease person. As long as we do not include all the citizen, this program will not be successful...." (Claim reviewer, 2020)*

C. Mentality to Spend All Benefit Amount

Nepal government is giving health insurance services that comprise benefits up to Rs. 1 lakh (848.68 USD dollar) by just collecting Rs. 3500 (29.70 USD dollar) as a premium amount. However, in Nepal, according to HR official, many people think that if they pay a premium amount of 3500, they should utilize all the benefit amount within the year so that the benefit amount will not "go wasted."

"......Because they think their cycle is almost ending and they have not spent their benefit money, they want to spend that. "if I have money, I will spend that at any cost.......Insured people think they paid their premium money so they can spend all benefit amount........Insured people have a mentality to spend all the money if they pay 3500 premium amounts......" (HR official, 2020)

D. Cheating

Cheating from the insured people was another major problem described by the participant. Insured people try to get more benefit by applying the act of dishonesty. Participant said that citizens were abusing the insurance program through different methods such as having double insurance cards with them. When they finish the benefit amount from one card, they could use another card. They also claimed that people swapped their cards with their friends and other people.

".......Citizen also cheating. They have 2/2 card and use another person's card. If they are friends and brothers, then they use each other's card. These kinds of cases are also more....."(IT official, 2020)

4.3.2 Problems Related to the Outreach Effort to the Nepalese people by the health insurer

Above, we have listed four problems mentioned by our respondents concerning how people in Nepal (actual and potential members) perceive and act toward the insurance system.

In the following, we have categorized the response of our interviewees with regards to the outreach effort by the insurance provider into five factors: those related to how enrolment assistants (i.e., those responsible for getting new members to sign up and old members to renew their membership) are paid; those related to lack of human resources; lack of educational awareness, promotion, and publicity; lack of coordination with local authorities and community organizations; and finally related to maturation of insurance card.

A. Payment and incentives of the enrolment assistant

Incentives of the enrolment assistant (EA) seemed a little unsatisfactory disclosed by the participants. EAs said that they did not get logistics support; they should get them by themselves, and they reported a delay in providing incentives. They mentioned that if they had some monthly salary instead of incentive percentages, they would do their job more efficiently.

Moreover, since they were not getting any monthly salary, they did not think they should go to every house for the awareness about the insurance program. They did not consider themselves responsible for that activity which stopped people from having an educational understanding and eventually led to low sign-up. Furthermore, when the health insurance board delayed the payment of EAs, that also created challenges in collecting filled insurance forms and entering data. The EAs reported they did not reach the health insurance board with collected filled insurance forms from citizens because it was not easy for them to go without payment since some lived far from the office. So, the EAs would not intentionally reach the office with collected form, affecting data entry in the system and making a slow process.

"......oh no no,,, poor us...hehehe...ok look at us ... office does not even give us a pen. We must get everything by ourselves. Before they used to give us everything, including a pen. Now they only give us insurance forms. Mobile is not working. We must fix that by ourselves. We must call the insurer to tell them to renew their insurance. We do not get any recharge money from the office about this situation. They say they will provide that money in our account, but still, we do not have that............If we are sure about, we have a secured job then we would do our work more efficiently whether it's day or night......"(Enrolment assistant1, 2020)

".....But they do not even get that amount on time. They do not get incentives on time....."(HR official, 2020)

"........ if we do not have a monthly salary, then we do not have to reach every door to door. That is not our problem to reach every house...........there should be a monthly salary for us. If they give us just a percentage, then we do not have to come immediately with the forms, and also not possible for us. We did not get that percentage since last year Shrawan. When we do

not even get that percentage from last year, then how can we work........" (Enrolment assistant 2, 2020)

B. Related with the Actual Work Done to Outreach: Lack of Human Resource at Root Level

Outreaching people for the counseling or educational awareness about the insurance program and sign-up were also significant aspects of the insurance's high coverage. However, according to participants, there is mostly one EA in each ward (local community), which might not be enough for high-density areas. Even in some places, there was a vacant enrolment assistant post. Some participants reported that it was hard to select enrolment assistants in some wards because of a lack of proper qualifications. One participant also mentioned that people do not recognize EA and clams not seeing EA in their locality. People had to look for an enrolment assistant to sign up.

".....In the initial days in our regulation, we selected 1 for 1000 households, and if it's 1001, we could select 2 people. This was mentioned in work regulation, and we have practiced that. And after Act, we select only one in each ward. in someplace where there is more density population it might be difficult......" (Information planning and communication official 2020)

"......But of course, EA does not go door to door in someplace with high density....."(Information planning and communication official, 2020)

"....In the present situation, in some district, there are vacant post because of lack of qualification, no +2 pass, if there is FCHV but not SLC passed or qualification less......" (Claim reviewer, 2020)

".....But in some districts, people ask us if the program has been launched or not, and we say 'yes, it's already launched' and they say 'your enrolment assistant did not come yet, we have not seen them.' so this is also challenging for health insurance board to solve this weakness....." (IT official, 2020)

C. Lack of Educational Awareness, Promotion, And Publicity

For increased educational awareness about the health insurance program, the government had recruited EAs and tried to share understanding through radio, TV, newspaper, and social networking sites. However, a participant from the IT department reported that all those methods were still not sufficient. Many people still did not know about the program.

The district enrolment officer mentioned that health insurance authorities were dependent on the EAs and radio for promotion and publicity, but they could not provide education to mass. There was a lack of educational awareness in some rural places because enrolment assistants can't reach there, and people from rural areas didn't even have a radio to learn about the insurance program.

".... umm for the advertisement of health insurance, we talk about it in every review meeting and make videos and put-on videos. If we launch in some districts, then we use FM and radio to do so. Next, we make videos and put that on Facebook or social media to do publicity. Even so, many people in the launched district do not know about it. Still, it has not reached to ground level....." (IT official, 2020)

"..we select enrolment assistant and send them to the community, we do promotion through Radio and TV, which is not enough ....our program is really rigid so we could not gather all the people at the same place and provide them education. We tried to do it at the beginning, but now we are unable to provide education to them. Also, that because of the lack of human resources. But I do not think we are still able to gather mass and provide them information. So in my opinion, we are mostly dependent on the Enrolment assistant. Along with Radio, TV, and news....." (District enrolment officer, 2020)

"....To provide health education, it's tough to reach people in the very rural areas. Someplace also does not have FM radio services..." (Provincial coordinator, 2020)

D. Lack of Coordination with Local Authority or Community Mobilization

Coordination among local level authority and mobilization community lacked in this program, according to interviews. Participant also disclosed that the program would not be successful until

they give the program's initiative to the local community, which would help increase coverage of enrollment of the program.

"....In my opinion, what I think is our target should be that we should give our program's ownership to local bodies. But it is not happening. If we can mobilize them, if we make compulsory for all the municipality, we will get wide coverage. If we do this all around the country, then there will be huge coverage. Otherwise, it is not possible..." (HR official, 2020)

E. Long maturation of insurance card

The participant revealed that the activation of the insurance card is three months. People have to wait for at least three months from when they sign up to the insurance system to enjoy health insurance services. This distracted people from signing up for a health insurance program. Due to the timeline, EAs were not able to convince people to get into the program.

".....For example if someone does insurance in Bishak (first month of Nepali calendar), then he has to wait three months to get the services. So this period is very long...." (Enrolment assistant2, 2020)

"......yes, that one is also another issues, because of the time length people also do not want to get insured, difficult for us, because they expect if they sign up today then, they think, they can have services from tomorrow..." (Enrolment assistant1, 2020)

4.4 Problems related to the relationship between buyers of insurance and health care centers/health care providers

Let us now focus on the relationship between the Nepalese people and the health care providers, presented in Figure 4 above. We can categorize the response of our respondents into two sub-group or problems: those problems related to how people perceive the treatment they receive from the health care providers which have agreements with the health insurance system (i.e., treat insured members of the public); and problems related to how the health care providers perceive customers that have insurance.

4.4.1 Problems Related to how insured members perceive health care providers

A. Pressurized Service Providers

Insured people creating work pressure on health service providers was mentioned as a problem by informants. Once people get an insurance card, they want more treatment and lab investigations even if they do not have severe health problems. Insured clients asked for the listed lab investigation from the list of the insurance benefit, which could be costly. Which suggested that would increase the unnecessary cost for the insurance board. Insured patients often requested a referral for private hospitals, even when the first service site could provide health services.

The health service provider from the primary health care center said that insured patients came to the health service site with minor sickness. Still, they wished for all the investigation available in the hospital, which could cost a lot even though they did not need that, and put pressure on the service provider to do what they wanted. This creates another challenge for health service providers to answer inquires by the health insurance board about unnecessary tests.

Furthermore, IT official mentioned that when participants realized they have not been sick the whole year and their annual membership will expire soon, they demand to do all body check-ups, which means costly screening.

".......Nowadays, what we got to know that, patients themselves make all the test list and such MRI test, CT scan, they ask doctors to do that even though that's unnecessary..........So it's just that, even though doctors are not ready to give all the treatment to the patient without their need, they are pressurized by the patient........"(District enrolment officer, 2020)

".....Nowadays, people with simple fever also want to go to medical college...." (Provincial coordinator, 2020)

"...........And also, when they signed up for this health facility for the service. They want to refer to another facility even though we can provide service to them.......... If I have to talk about the challenge, then when patients come to the hospital with minor cases, they want to get more lab investigation. And we must do that, and when we do that, the insurance board asks about that and cannot give them answers. This is also one of our challenges. Patients are asking by themselves. They come with just a minor problem and ask for more lab tests. They always want to do expensive lab test......" (Health service provider1, 2020)

"........ Hehehe (laughing), it's like this, I did insurance, but I did not get sick. And I have 1 lakh balance in my insurance. Ok then, what should I do? I should do a whole body checkup. They must finish that money. 1 time we can do that per year. You know. But here, money has not finished, so I want to do a whole body checkup. Giving pressure to hospital for referring. So, these kinds of things are a lot here........" (IT official, 2020)

B. Lack of Health Facility / Far from Catchment Area

Some of the interviews pointed out that most health facilities, especially in rural areas, are very far from people's spaces. In some places, health service sites are so far that people have to carry their patients to reach the hospital, which took nearly one week because there was no simple primary health center in their community. So, people usually do not sign up for insurance in this kind of place because there is no health center or the health center is far from their residential area.

Furthermore, the District enrolment officer also reported that it was complicated for enrolment assistants to convince people to sign up for health insurance because there was no health service center near people's residential areas, which caused low enrolment in the rural place. Not only low enrolment but also dropout was high according to the provincial coordinator.

".....But in most of the places because of geographical, health service institution is far.............But 1/2 years ago, I reached Dolpa (rural district), and there is just one district hospital in Dolpa. To go to the hospital, there was one patient, okay? It took seven days to carry him to come. That's the situation. There is no PHC neither anything. They have to come

to headquarter from a far place. So, at that place, it doesn't matter if insurance come or not........." (Information planning and communication official, 2020)

"......people from Annapurna, Ghandruk (rural place) do not come here for treatment. do they? You tell. If they have their own health site in their catchment area, there would be more enrolment. Also, it would be some relief for the enrolment assistant to ask to sign up for insurance because they have a health facility in their area. That would be a strong point for them to convince people. Yes, because of distance service site there is low coverage......" (District enrolment officer, 2020)

"........for rural people, service site is almost 2 to 3 hours far from their home. So, they could not get access to health services, and they do not renew their cards........"(Provincial coordinator, 2020)

C. Lack of Competent Human Resources

After launching the health insurance program, the health service sites' workload increased; from documentation and diagnosis to treatment, they were supposed to get extra working staff. However, according to the health service provider administration was not hiring additional staff. The workload had been increasing, but staffs were the same amount as its initial implementation stage. The technical workforce who can solve the problems regarding insurance claims and documentation was also lacking.

Similarly, the health service provider reported that he is the only technical human resource in the office while the hospital runs 24-hour service. There was a problem when he would not be at the hospital or went home after finishing his shift. He also mentioned that lab x-ray or lab services had not been used due to a lack of competent staff. A sufficient number of physicians was also lacking, and the upper-level administrative department was not doing anything. Not only that, but a necessary post of health staffs was also vacant.

".... because of this health insurance program, it increased our workload, but as compared to previous work, we staffs are in the same amount as before. They should hire more staff, but we have less staff..." (Health service provider1, 2020)

"...umm we have laptops and internet, but we have very few technical manpower..........there is a lot of problems with technical manpower in the office. Insurance also has 24-hour service, but I am the only technical manpower...........the office has some of the materials provided by the health insurance board, but they have not been able to operate due to lack of sufficient manpower and I do not think the upper body is interested in the operation for example for x-ray machine has been given by insurance board for x-ray service but has not been able to operate. One time there were 4 to 5 doctors, but now there is only one. It has been 1 year since the lab services were used. The post of staff nurse is vacant. ...." (Health service provider2, 2020)

D. Lack of Quality Medicine

Scarcity of medicine was another problem raised by the health insurance program implementers. One EA said that whenever they went to renew insured people's cards, they got lots of complaints about the lack of medicine in local health facilities or provincial hospitals. According to the District enrolment officer, local authorities or external stakeholders blamed the health insurance board for not having those medicine in the health service site. Mostly in government hospitals or primary health care centers, both IT and HR officials argued that there was no adequate medicine stock for insured people.

"......when we go there for the renew, they say" I went to get some treatment, but I didn't get medicine even though I pay a premium, I could not use any services, we lost our money ".... hehehe okay?........"(Enrolment assistant1, 2020)

"Not only in the local health facility but also provincial health facility does not have adequate medicine, resulting in the insurance board getting more blames. So when services are inadequate, the stakeholders blames our program, which makes our work difficult....."(District enrolment officer, 2020)

"... in case of government... there is a complaint of lack of medicine...." (HR official, 2020)

".....the problem comes where that government PHC or hospital has more problems. There is no medicine for the patients which they need. Main is, problems is in the government hospitals....." (IT official, 2020)

4.4.2 Problems Related to how the service site (Hospital and PHCc) treat insurance members

Now let us report the problems which is our informants reported regarding how the service sites such as Hospitals and PHCc treat insurance members while providing health insurance services to them. We have categories the responses of our interview into five factors as below:

A. Negligence and negative attitude to Insured People

Having a negative attitude toward insured people was one of the problems created by the health service provider revealed by interviews. Sometimes when insured people go to the health service site for treatment, they get neglected by the health service providers. They were subjected to a negative attitude or rude talk after they know patients are insured people. Some interviews also claimed service providers gave more priority to other patients than insured patients.

".......Different attitudes for the insured people and uninsured people. Rudely talk lack of medicine. My in-laws are also insured. But when I tell them to get service from the service site. They do not go. Instead, they go to a private hospital. Why? They say, "they ask us if I was from insurance" (different attitude) ...... They do not give priority to insured people......." (HR official, 2020)

"...But in review, I found because of not getting quality services and then even if they go to the hospital with a card then they get negligence......" (Information, planning and communication official, 2020)

B. Unnecessary Test and Medicine

According to HR official, making unnecessary lab investigations and medication was another challenge. Their client got medicine which was not the listed medicine from the board but different companies, causing extra cost. Also, some health service providers did not follow ethical norms by prescribing unnecessary tests.

" .....in private. They make unnecessary tests, and they give more amount of medicine..........We found complaints such as our service point do not give these medicines to our insured people who are in need by saying they do not have these medicine with them. Instead, they give medicine from another company.........On the other hand, doctors think they will earn money for the hospital, so they abuse it. If I have to say in one line, I would say ethical standards are absent. They do not follow norms. ...." (HR official, 2020)

C. Medical Person Doesn't Stay in Service Center

Interviews revealed that, especially in Nepal's rural places, the service sites are very far from the catchment area. People must walk for days, and when people finally go there, they see no doctor in the facility. The HR official reported that doctors in the government hospital did not always stay in their working shift.

"...... For example, people from Dolpa and Rukum, must walk for three days just to get health service. Not even one doctor sits there. They need to spend all day to get services.........We have our first contact point is government hospitals. What is the standard of those hospitals? What kinds of government health services? The medical person does not stay in those hospitals. These kinds of activities are happening......" (HR official, 2020)

D. Taking Money from Insured People

Taking money from insured people was also reported as a challenge argued by some participants. According to the HR official, sometimes the hospital collected money from the insured people. Similarly, the claim reviewer argued that when some patients do some big clinical operation, the hospital sometimes collected money from insured patients and at the same time claimed reimbursement from the insurance board.

"....we have an agreement with them on some amount of money, but they claim more money than that agreement amount also in someplace they collect money from the insured people....." (HR official, 2020)

".....Sometimes hospital claims some person did the big operation and along with that they also ask money from patient....."(Claim reviewer, 2020)

E. Delay in Services

Delay in treatment and health care service was one of the significant challenges mentioned by informants. People might have to wait for the long queue in the hospital with no place to sit and relax in the hospital. People had to go through several procedures and delayed lab tests, often taking a day.

"......process of treatment is slower, go there and come there. Patients are already weak, and again they send patients to several places. and also they have to wait for a long line.....".(Enrolment assistant2, 2020)

"....And people complaint about the queue in the hospitals. They say," its been 2 hours. We are still in the line..........They also complain about the time of lab services. They say" it has been 1 hour. I gave my blood to the lab. I am still waiting for the lab report"....it takes 2,3,4 hours... (Provincial coordinator,2020)

"......They need to spend all day to get services....." (HR official, 2020)

4.5 Problems Related to The Relationship Between the Insurance Board and service sites (Hospital and PHCc)

Let us now discuss the relationship between the government health insurance agency and the health care service provider. Here, the responses of our participants are categorized into two sub-groups. Those are related to how hospitals or PHCc process claims sent to the insurance board and how the insurance board deals with claim reimbursement. Let us take a brief look below.

4.5.1 Related to how hospital process claims sent to the insurance agency

A. Poor documentation

Poor documentation from the hospital to claim reimbursement is another problem reported. Service providers must upload all the documents related to the patient's treatment to get reimbursement, and with a lack of adequate system in place, it is often delayed.

The HR official of the insurance board said, "*But if we see now then nearly 2 billion Rupees or more than 3 lakh claims has not been reimbursing and are still in pending. Why is this happening? this is happening because the hospital does not provide documents on time, adequate document submission....*"

B. Fake Claim, Double Claim

Additionally, the HR official reported fake or double claims at the health insurance board. Usually, the health service site is supposed to claim a standard agreement amount for each treatment cost, which they tend not to follow, and sometimes double claims are made, making it challenging to detect fraud.

".... next thing, regarding a test, we have an agreement with them on some amount of money, but they claim more money than that agreement amount........." (HR official,2020)

".........in some cases, we think it is not good, documents must be fake because they claim same patient's double/double time on the same date. That is not possible. So, in that case, we made highlighting for the reviewer team. So, they will know when they see that one patient has a double/ double claim on the same date. And they decide if they want to accept or reject. Even after that, it's challenging to detect fraud carefully........" (IT official,2020)

***C.* Bribing, Corruption**

Both the claim reviewer and IT official reported that bribing and corruption were significant challenges the implementers faced. They believed that private and public health facilities try to

ask for more reimbursement or give a green signal for the false claim. However, the Claim reviewer claimed that they refused to pass those kinds of documents (false claim documents) and never been trapped in those kinds of influence by them.

A IT official also claimed to refuse a bribe from private health facilities. He believed that those kinds of problems were mainly in private health facilities.

".... yes there is some influence in working way. But the claim is the heart of health insurance. If we get influence, then this program will fail. That's why until now we are.......there are many health facilities both government and private, they are trying to influence us..........for example, now, Nepalese influence. hehehe...in the financial part or accountancies part in our board, they ask for more reimbursement. And even asked us to pass claim which do not have complete documents. But we do not pass incomplete documents. We reject incomplete, false claims and over claim also. But we are not trapped in influent yet..." (Claim reviewer, 2020)

"......Ummm when we go somewhere, it does not happen in the government PHC or district-level hospitals. Mainly, it comes from private. I have been told many times. "sir, I will manage something for you, please make my work, do something," and I said, "nothing is going to happen by saying to me, I do not see that part, I am not from the claim department" like this I ignore them. we get a lot from them. ..." (IT official, 2020)

4.5.2 Related to how the insurance agency deals with claim and reimbursement

A. Reimbursement delay

The health service provider reported that it took more time to get their reimbursement which caused a direct impact on their hospital financial structure and problems to stock medicine and the hospital equipment.

Similarly, the HR official claimed that they could not reimburse billions of Nepalese rupees to the health service facility. Daily, ten thousand claims come, but only 4 thousand claims could be reimbursed daily, according to IT official.

"...yeah... it takes more time, because of that hospital has to face problems in financial structure............. It will challenge service reliability during service provision. It is not always possible. How are we going to stock medicine, equipment? That is the challenges......" (Health service provider1, 2020)

"......But if we see now, nearly 2 billion Rupees or more than 3 lakh claims have not been reimbursed and are still pending. Why is this happening? This is happening because the hospital does not provide documents on time, adequate document submission, and fewer human recourses. Because of all these, we are unable to reimburse on time. When reimburse process gets delay then it directly affects insured people's health services which lead to more dropout...." (HR official, 2020)

"....If we talk about the claim, per day, we get 5/10 thousand claims from hospitals. And the staff in the claim section is medical doctors, pharmacy, altogether 14 people. They can look maximum per day is 4 thousand. Claims are pending daily...." (IT official, 2020)

B. Lack of human resources

The HR official claimed that staff was still the same numbers as before (the early stage of the insurance program). Most of the staff already left a job which caused claims pending. District enrolment officers were not in the amount of number as they were supposed to be, i.e., at least one at every 4 village municipality or 2 municipalities in the district. Still, there was only one at the district level. Even some district enrolment officers had to look after two districts.

Interview revealed, daily more than 10 thousand claims came from the health facility, but team members of claim review, which was just 14, could only review 4 thousand daily. That caused a pending reimbursement.

Furthermore, the district enrollment officer said it was difficult for them to handle all the work in the office because of the lack of enrollment officers.

".....The number of manpower is still the same now, where we have 65 launched districts and when we had 33/34 launched districts. Some also reigned. That's why It's very difficult. The reason behind the pending claim is also because of less manpower..........the enrolment officer is working in the district, somewhere there are 3 /4 somewhere 2/3, and somewhere one officer has to look after 2 districts..." (HR official, 2020)

"....and in district level we have enrolment officer. Based on our regulation, there should be one enrolment officer for at least 4 Gaunplaika or 2 municipalities. But now we have enrolment officer only at the district level ....If we talk about the claim per day, we get 5/10 thousand claims from hospitals. And the staff in the claim section is medical doctors, pharmacies, altogether 14 people. They can look maximum per day is 4 thousand. ...." (IT official, 2020)

"... because now we there has been increased in the district from 51 to 56 ... but we are still like 1 and 2 enrolment officers in the office. Here in the provincial office, we are just 4 officers. so that's why It's very difficult for us to enter data...." (District enrolment officer,2020)

C. Inadequate Board Committee, Regulation, Procedure

Some participants felt that the health insurance program didn't have any straightforward procedure or regulation to guide their work. For instance, there were only two legal documents, the insurance act and insurance regulation but not any guideline and procedure to the health insurance program, which indicates that health insurance board members are pretty confused about the program planning and implementation. According to them, the health insurance policy was not completed.

There is supposed to be a different committee and section for each insurance-related work, such as the claim committee, IT department section, medicine verification committee, account section, etc. Still, the insurance board didn't have any specific committee for a particular working department. Which eventually may lead to directionless work.

".......we need claim management committee, medicine verification committee but we do not have these kinds of the committee. We do not have any committee that gives us the right

direction and coordination to do actual work. And the second thing we do not have any guideline that shows how to regulate the program. That's why, because of this policy gap.........in insurance program we have only insurance act and regulation but not procedure and others thing.........Policy is not complete..." (HR official, 2020)

".....We have only Act and regulation as a legal document for health insurance. We do not have other regulations, procedures, finance procedures, directions. There is a lacking to carry out other section in insurance board..." (Claim reviewer, 2020)

D. Lack of Motivational Incentives/Salary

Lack of motivational incentives and wages are other significant problems discussed by the informant. According to some participants, their workload has been increased because of low human resources and not only during the official hour but during night times and holidays they had to work. They were waiting for some relief, motivational incentives to motivate their work, but they still didn't get any extra financial help.

"......we manpower in claim section work hard day and night. I mean, even it's Today; Saturday, I am looking at a claim to give program support. So, we work like this. But with our facility, It's not enough...." (Claim reviewer, 2020)

".....I said yesterday, Saturday, I was at the office from 10-6. These kinds of things, now the board is here, and we are hoping the board will do something. But now we only get that salary from the government. It's difficult now, but we need some motivation also......" (Information planning and communication official, 2020)

4.6 Problems related to the relationship between the insurance agency and the government programs and political authorities ultimately responsible for the implementation.

Above, we have presented all the problems between Nepalese people, service sites, and health insurance agencies. Now, let us look at the issues related to the relationship between the insurance

agency and the government programs and political authorities ultimately responsible for the implementation. We have categories four factors from our interviewees' responses, such as those related to the poor identification problems; political influence; launching program without preparation; and overlapping different government health programs. Again, let us take them in turn.

A. Poor Identification Problem

Some interviews revealed that the Nepal government gives free insurance services to ultra-poor people. Finding ultra-poor people is one of the government department's responsibilities. However, only 26 districts have got poverty cards for ultra-poor people out of 77 districts in Nepal. Problems arise when health insurance agencies try to enroll poor people from the district with no poverty card distribution. They cannot identify poor people, and poor people must pay for insurance or poor do not buy health insurance, contributing to low insurance coverage. Some participants believe that, because of unfinished ultra-poor people identification, it is difficult to increase enrolment.

B. Political Influence, low support

The politician's politics also causes problems for the proper implementation of health insurance program argued by some of this study's informants. According to the claim reviewer, the politician in the respected position does not do their job as required. In their speech, they always mention improving health insurance program through different approaches, but they do not imply that in practice. He also reported that those same politicians had their private hospital. According to him, politicians gave support to develop their private hospitals, which overshadows government hospitals.

According to some participants, hiring own people into the program also mentioned, and political tension between the staff inside the health insurance agency created negative vibes.

" ......And next thing politicians, as they include in their manifesto to make successful programs, their main responsibility is publicity, dedication, and policymaking. But in the present situation of Nepal, they say something but do another thing. In politics, we say Nepal government hospital, but the same politician has their own private hospitals. So, their focus is their

organization, and they overshadow the program. They speak one thing in practice, but they do not implement by being dedicated...........But here, politics is more. Politician wants to job, and staffs and physician want to do politics. The main sadness is here.....” (Claim reviewer, 2020)

“......when they hire enrolment assistant by ward chairperson, ward representative like that...they hire their own people...” (HR official, 2020)

“,,, according to me, ok lets dig inside story....hehehe..this is about the chairman and the director in the insurance board... or let’s talk about other staff of the boards... (sarcastic laugh hehehe)....there some people come from the political way and some come from examination (with skill and talent), and there is kinda war between them. So there is not good situation.....”(Enrolment assistant2, 2020)

C. launch of the program without preparation

Rushed implementation of health insurance program in particular districts were argued as one of the challenges mentioned by participants. HR official reported that they were supposed to be kept in mind about any health service site's standard and qualification before registering as primary service sites for insured people. However, in most of the cases, they just registered those without bothering to research on that. Similarly, the IT official also claimed that the health insurance agency selects health service sites haphazardly without pre-research.

Apart from lacking pre-research and analysis of health service sites, IT official reported they launch program without preparing an appropriate administrative office and needed staff in some districts. Thus, district enrolment officers from other nearest districts had to look after that district.

“....There should be standard norms and qualification of the health service provider organization but most of the cases this is not complete, but they are registered in this program which is the current situation...” (HR official, 2020)

"...almost all district has a program. The enrolment officer always asks when we are going to take forms. We do not have people to send from here. We have said that there should be proper infrastructure and adequate staff before implementing programs in any district. And then we start insurance. But it's not in practice.........some district there is no office, nothing.........Always on the spot. For example, the program has been implemented in Rasuwa and Udhayepur, today and tomorrow, whom to send there, one who is working in some district until they do not recruit enrolment officer for 3/ 4 months..." (IT official, 2020)

D. Overlapping with other different government programs

According to the HR official, different overlapping government programs were another challenge. For instance, basic free health care services, services for low-income family programs, social security funds. HR official and claim reviewer reported that other parallel programs were causing problems for implementing the insurance program. Ministry of health has a mother safety program that gives free health services during pregnancy, delivery, and postpartum. Similarly, for medical treatment for deprived citizens by the health ministry, people get free treatment and cash up to a hundred thousand Nepalese rupees to treat the same types of chronic diseases that the health insurance program covers. Thus, citizens believe that if they are getting free services without paying a premium, why would they want to sign up for health insurance.

Similarly, the HR official and claim reviewer claimed that Nepal's government declared free basic health care services. However, there is no standard format for those services to know. The health insurance board has been told not to cover charges for basic health services, but when people go to the hospital with some health problems that come under basic health care services, they have to pay to some health facilities. Those health facilities were abusing those kinds of resources or overlapping these services in this kind of situation.

".......There are more programs including mother safety program, services for poor family (BIPANNA PARIWAR) with kidney disease, heart disease, etc. they are getting service from government and insurance have these services. Insurance also gives free services for these kinds of 8 diseases for insured people. They are not implemented in a practical manner. It's overlapping...........Next, there is a difference between spoken words of constitution sectoral

plan and insurance specific policy and regulation. There is overlapping between them. For example, government has decided to give free basic health care but when people have simple headache, and they go to hospital then they say insurance does not include that services..." (HR official, 2020)

".....And all the scattered programs for example, mother safety program, which is operating by ministry of health. Programs related with the insurance are operated by many other health ministry, different board, or ministry. For example, social security fund, and staff reserve fund, and banks and insurance committee and different program by ministry of health are scattered...........It is needed to make standard format to know what basic health care is. Because basis heath care services are free in constitution. So health insurance is that concept which gives other types of medicine than basic health care. It has been decided whether the existing complex diseases can be cured with providing health insurance but there is a duplication now...." (Claim reviewer, 2020)

With the above analysis in mind, we can offer a specification of the framework presented in Figure 4, by making distinctions between problems related to the relationships between the three main actors involved in implementation (the Nepalese people, the health care providers, and the health insurance providers or agency), and problems related to the inner workings of these institutions. We illustrate this elaborated framework in Figure 5 below.

Figure 5 Analysis: Example of Categorization

Chapter V: Discussion (comparing the findings from problems reported in the literature review)

5.1 Introduction

This chapter presents a discussion of the significant findings (challenges) of the study related to results in the literature review, with a goal of making a "robustness check" of findings in this study as well as to discuss if the study has uncovered any new problems/barriers on effective implementation of voluntary health insurance, which no previous studies have looked at. By "robustness check," I mean to investigate if the problems mentioned by the respondent in this study are also reported in previous studies of implementation problems in voluntary, public (or public-sponsored) health insurance systems (conceptual framework in chapter II). To the extent similar problems are reported, this strengthens an assumption that our informants present valid, or at least widely shared, views of problems. To the extent they point to problems not mentioned in previous studies, these may still be valid points to make since such challenges may reflect idiosyncratic elements in the Nepalese context or limits in the literature review. Still, then there is also a possibility that the reported challenges "merely" reflect our respondents' original/idiosyncratic quirks.

This study found various challenging factors encountered by the implementers in multiple stages of implementation of health insurance scheme, rather than only factor hindering success. Nepal started NHIP in 2016, but health insurance coverage is still small, and many districts are still missing out. We discuss these challenges using the same conceptual framework as in figures 4 and 5.

5.1.1 Problems related to the relationship between the Nepalese people (potential and actual buyers of insurance) and the national insurance system/agency

The study covers the implementer's perspective on challenges regarding the national health insurance program. Our study found that most people enrolled in the program were chronically

ill, raising questions on the program's financial sustainability. Which directly indicates how adverse selection poses a threat to the program. This consistent with the findings of previous studies referred in the literature review, stating that ill patients and unhealthy households were attracted more towards the insurance scheme (Acharya et al., 2019; Alkenbrack et al., 2013). A previous study suggested that since Nepal has a voluntary government health insurance system that attracts more sick and unhealthy people instead of healthy people, it is pretty challenging to remove that problem precisely due to the program's voluntary nature (Mishra et al., 2015).

Our study found that the health insurance agency was dependent on enrollment assistants, TV, Radio, and Newspaper which was not sufficient to ensure widespread coverage that was required. Enrolment assistants were unable to reach all people and educate them about insurance programs, and the program lacked collaboration with local stakeholders and external partners, also confirmed by another study (Ranabhat et al., 2020).

Further, educated and prosperous are not as interested and more difficult to get to sign up than the uneducated and poor people. This was also highlighted by other studies (Alkenbrack et al., 2013; NHRC, 2018). Wealthy and middle-class people do not trust scheme officials, impacting enrolment into the program (Kamuzora & Gilson, 2007).

Lack of trust regarding HIP by the citizen stands out as another challenge for implementers. People tend to believe that the program will not be good and doubt the quality services from government health service sites. This finding parallels the referred study in India showed some people enroll in the scheme to go to private health centers as they do not trust government health initiatives (Kuruvilla & Liu, 2007). A qualitative study conducted in Ghana also showed people who could afford the cost of health expenditure prefers to go to private health care facilities rather than government health facilities. Even though their insurance card supports their expenses because of their negative perception of the quality of government health facilities (Agyepong et al., 2016).

The main idea of collecting premiums beforehand is to give financial support to those who need health care. However, my study reported, in Nepal, people believe that if they pay specific

premium amounts, they should utilize all the benefit amounts within the year. Therefore, they want to make full use of the money spent, which puts financial sustainability in danger. A previous study similarly showed insured people frequent visits to health facilities even with a minor problem, so they could fully use benefit on time (Debpuur et al., 2015). This study also reported some insured people's cheating behavior, such as using double cards or swapping insurance cards with other uninsured friends or family members. Other studies have reported client's cheating behavior, for instance, uninsured people getting a card of insured people to access health care (Dalinjong & Laar, 2012; Debpuur et al., 2015).

The long maturation timeline for the insurance card activation (3 months) was reported by one of the EAs as a challenge to convince people to sign up for the insurance. People get distracted and eliminate their attraction towards health insurance. This result is consistent with another study in Nepal referred to in the literature review (Ranabhat et al., 2020).

In this study, participants highlighted low incentives, payment delays, and instances where additional expenses of EA were not covered. Or, they did not get sufficient logistical supports on time, therefore losing their motivation towards work. This resulted in EA's behavior, like, not reaching every house for counseling and awareness. These findings correlate with the previous study (Ranabhat et al., 2020).

5.1.2 Problems related to the relationship between the buyers of insurance and health care centers or providers

According to some of our interviewees, patients did not get quality services and quality medicine from the health facility, eventually leading to low insurance coverage. This result is consistent with the finding from other studies (Alkenbrack et al., 2013; Kamuzora & Gilson, 2007; Mishra et al., 2015; Ranabhat et al., 2020).

Negative attitudes toward insured patients, like rude talk and lack of attention to insured people, and negligence from the health service provider, were another reported problem in our study. Previous studies similarly reported an attitude of health service providers that influences people's

enrollment in insurance program (Agyepong et al., 2016; Panda et al., 2015; Ranabhat et al., 2020).

Our study highlighted health worker's behavior such as prescribing different company drugs than listed medicines, not being available in the government service site during a working shift, doing unnecessary tests, and over-prescription. These again coincide with previous studies (Debpuur et al., 2015; Ranabhat et al., 2020). This study found the delay in health services from the health service sites as a reported problem by participants, which was also evident in previous studies (Agyepong et al., 2016; Ranabhat et al., 2020).

Our study found that enrolment assistants could not convince people to sign up for insurance because of distance to health facilities, leading to low enrollment and more dropout. A referred systematic review reported a similar result that the distance to health facilities is a reason for low enrolment into the health insurance scheme (Panda et al., 2015).

In Nepal, primary level health centers are the primary service site for insured patients. However, according to this study, insured patients may sometimes pressure doctors for referral to secondary or tertiary health service sites, even though primary health centers can treat or cure their problems, resulting in colossal expenditure and questioning the financial sustainability. A similar response was observed by another study where doctors were not handling the gatekeeping roles. People went to advanced health facility centers without visiting primary health service sites, leading to financial problems for the insurance system (Fusheini, 2016).

5.1.3 Problems Related to The Relationship Between the Insurance Board and The Hospitals

This study highlighted that not all hospitals provide adequate documents on time, eventually leading to more careful examination and time consumption, creating reimbursement delay problems.

We found that reimbursement delay by the health insurance board may impact hospitals' financial structure, including stock of medicine and equipment. A previous study also suggested that reimbursement delay caused difficulty to run the hospital and pharmacy (Dalinjong & Laar, 2012). Reimbursement delays also caused problems in health service provider's coping behavior towards the client (Agyepong et al., 2016).

Inadequate human resources in the board caused a delay in reimbursement. Some informants stated that human resources are still the same as the program's starting phase, which is problematic as the workload has increased since then. This result was similar to other work: low staffing in the districts creates implementation problems (Agyepong et al., 2016).

Main challenges to tackle the insurance implementation problem is: does the health insurance board have adequate insurance policies, regulation, and guidelines? Our study indicates that the health insurance program does not have an appropriate and enough regulatory framework for the health insurance program. Only the insurance act and insurance policy were available, which seemed insufficient for the scheme's normal function. Again, this result was similar to a previous study in Uganda (Basaza et al., 2007).

5.1.4 Problems related to the relationship between the insurance agency and the government programs and political authorities ultimately responsible for the system

Some informants argued there is a limited political commitment by the leaders in leading political positions. There is political nepotism in the form of recruiting own people regardless of their skill and capability. Political tensions between staff in the insurance agency were also reported, affecting the progress of the insurance program. A previous study also mentioned politicization and political interference as challenges for successful implementation (Fusheini, 2016). Likewise, coherent regulatory framework, procedure, and adequate expertise are key to successful implementation, which was lacking as by this study. This result is coinciding with the research done in Uganda (Basaza et al., 2007).

The Nepal government declared free health insurance enrolment for the ultra-poor people. However, poor people from only 26 districts have an ultra-poor card. This is a new insight into the relationship between delay in identifying poor people and challenges for the implementers to implement insurance programs, not reported in the previous studies we have referred to in chapter II. Thus, it is very challenging for health insurance implementers to identify poor people and enroll them in a health insurance program. Those people must pay a premium amount that is difficult for them, which leads to low coverage of insurance program.

Our study also reported rushed implementation of the insurance scheme without pre-preparation highlighted as significant challenges, which shows registering health service sites without researching Its quality and standard. A previous study also mentions this result (Kamuzora & Gilson, 2007).

The state has run various overlapping contributory programs with similar features as health insurance schemes. People can enjoy that kind of program without paying any premiums, which distracts people from joining health insurance schemes. Nepal's existing free health care policy creates confusion among health service providers and health insurance implementers about the standardized package. The government stated that the free health care policy package would be free for all the people and would not be charged by the health insurance program. However, some health facilities are abusing those policies and claiming that.

5.2 Conclusion of the discussion

Overall, we find most of the problems identified in the study to be consistent with the findings of previous studies referred to in chapter II. The problem of adverse selection arising by more likelihood of people with chronic conditions being interested in the program, the lack of trust in government initiative and services, unethical behavior of clients, and negative attitudes of service providers, technical problems such as maturation (waiting period) of the insurance card were identified as significant problems in our study. These findings were supported by the previous studies. Additionally, long-distance to health facilities, delay in reimbursement of expenses, lack of proper health insurance guidelines, and an overall lack of political support hindered the implementation of the program.

However, we also uncovered some issues that were not reported by previous studies found in the literature search, some of which might be unique to the Nepalese context. Primarily, the government has launched other programs targeting the poor and underprivileged, which overlaps the current health insurance scheme. Also, unfinished poor people identification and providing ultra-poor cards and delay in reimbursement caused by lack of proper documentation from hospitals may increase the dropout rate. Additionally, the problem such as lack of adequate EA (registration person) incentives were new problems unique to Nepal's health insurance program. However, we must stress that a more through literature review might reveal that these problems have been reported in (some) previous studies.

Chapter VI: Suggested Solutions/Recommendations from the interviewees

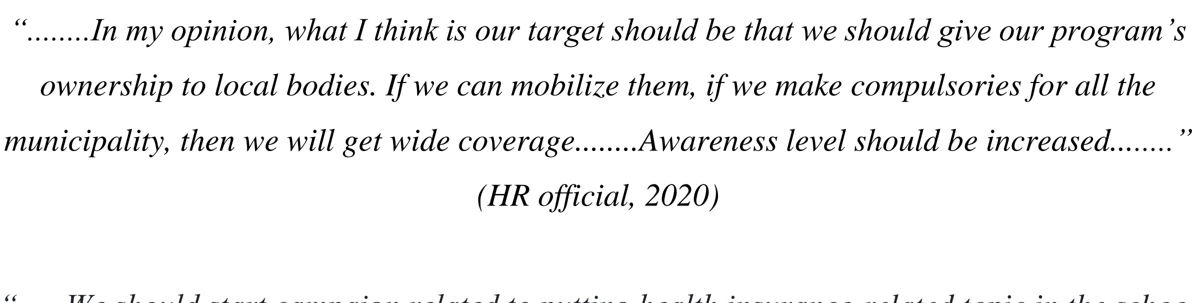
6.1 Introduction

Let us now turn the attention to our second theme, i.e., suggested solution and recommendation from the informants to solve the many listed challenges.

6.1.1 Problems related to the relationship between the Nepalese people (potential and actual buyers of insurance) and the national insurance system/agency

A. Educational Awareness and Community Mobilization

Some participants reported increasing educational awareness and publicity of the health insurance program, and community mobilization was a major solution. According to our informants, there should be more focus on promotion and giving ownership to the local authority compulsorily. Participant also suggested having a health insurance-related topic in the school curriculum, making people aware of the program.



"........In my opinion, what I think is our target should be that we should give our program's ownership to local bodies. If we can mobilize them, if we make compulsories for all the municipality, then we will get wide coverage........Awareness level should be increased........" *(HR official, 2020)*

"......We should start campaign related to putting health insurance-related topic in the school curriculum...." (provincial coordinator, 2020)

"......To increase this enrolment, we should focus on publicity..........Along with this, there should be quality and coordination with other stakeholders. Also, we should give more focus on publicity...." (claim reviewer, 2020)

B. Mandatory Health Insurance

The national health insurance program in Nepal is voluntary. However, an informant reported that making health insurance mandatory by the government would help overcome the problems and increase insurance coverage.

"......So now enrolment is voluntary base. Now our government should make this mandatory for example, just as born, health insurance should be one of the things for child after birth and he should be included in health insurance after his birth...." (Information planning and communication official, 2020)

C. Monthly Salary or Incentives to EA

Most of the participants claimed that enrolment assistants had inadequate incentives. Thus, participants suggested if EA got a monthly salary or adequate incentives that could cover anticipated costs according to their residential area, for instance, rural or urban, which would intensify their work.

".... In my view, there should be different incentives for a different assistant like, who are in rural place they should get more than in Tarai region where is more population density. In a rural area, they need to walk 2/3 days to reach another place. It supposed to be scientific...." (HR official, 2020)

"...If we are sure about, we have a secured job then we would do our work more efficiently whether its day or night. ..." (Enrolment assistant1, 2020)

".....if we get the job as a proper monthly job, or gives salary maybe just 7000 or 10000 per month, like fixed salary then we would be satisfied..." (Enrolment assistant2, 2020)

D. Quality Health Services

Providing quality health services from the health service site would be one of the best solutions for the problems listed above mentioned by the participants. Most people do not sign up for enrolment because of a lack of quality services from the health facility. Thus, quality service

provision would be the best decision to solve the challenges, argued by informants in the interviews.

".....to make health insurance success, quality of health service site need to good........".(Information planning and communication official, 2020)

".... Hospitals supposed to be neat and clean... ..." (Enrolment assistant1, 2020)

"......So first we have to point out the hospital and make them good. If that happens then we do not have to go house to house. Patients will come to us...." (IT official, 2020)

E. Online Method to Sign Up

Both IT official and HR official said to develop an online method to sign up for health insurance to solve that problem. People from every corner of the country could enroll in the health insurance program without EAs having to walk from door to door.

"....One online method need to be made from which anyone can do insurance from anywhere...." (IT official, 2020)

"....If we can bring that International standard and digital system here. Instead of going door to door, we can fill application form ourselves at home, and that will allow entry automatically and gets an update. That would be great. ...." (HR official, 2020)

6.1.2 Problems related to the relationship between the buyers of insurance and health care center or providers

A. Positive Attitude Toward Patients

An enrolment assistant reported that developing a positive attitude toward insured patients from the health service provider would solve citizens' hesitation to get services from health service sites. The health service provider should give proper attention and treat people with respect in the hospitals.

".....just like in private hospitals, doctors give good attention to the patients, when insured people go for treatment they should treat them with respect and attention. Hospital people should have a good attitude towards insured patients ..." (Enrolment assistant1, 2020)

B. More Service Site

The health services provider suggested there should be more establishment of service sites based on population density.

".....They should establish more health facility by being based on population density pressure...." (Health service provider2, 2020)

C. Quality Medicine

Many of the study's participants suggested increasing stock of quality medicine in the government's health facility would help overcome problems.

".....we get a lot of complaints about the medicine so simplify the logistic of medicine. ...." (Health service provider1, 2020)

".....hospital supposed to give them emergency services without delay. When they sign up for the insurance hospital should have medicine for them ..." (Enrolment assistant2, 2020)

".... But its real problems in medicine. If ministry control this, would be great. But nothing happens just because we say so. this should be controlled from the upper level. ...." (IT official, 2020)

D. Doctors should stay in hospitals

Information, planning, and communication official said to provide adequate motivational incentives to doctors to make them stay in the hospital. Also, the claim reviewer suggested that government make it mandatory for doctors to stay in the hospital during working shifts and stop them from going out.

".....not letting that health worker to go anywhere and giving some motivation to them from that health center and by making very good trustworthy and quality service provision...." (Information planning and communication official, 2020)

".... So government should make them mandatory to stay in their own respective place and need to stop them from going out.... (Claim reviewer, 2020)

6.1.3 Problems Related to The Relationship Between the Insurance Board and The Hospitals

A. Regular Monitoring, Training to Health Service Provider

Regular monitoring and adequate training to the health service providers regarding health services, and the reimbursement process, would limit problems such as fraud concerning claim processes.

".....To control fraud, there should be regular monitoring. Manage should be managed and give them training...." (HR official, 2020)

E. Legal Action for Fraud

Fraud, double claims, taking money from the insurance scheme was another reported problem that could be solved through good legal action from the insurance board.

".....When we found out fraud claim and when the hospital takes money from insured people, we have asked for compensation from them. First, we give them a warning. If that does not work, then we end our agreement contract. When they collect money from insured people, we asked them to return them...." (HR official, 2020)

B. Competent Human Resources

Due to low human resources, there were problems, such as the claim not being managed in time. Thus, the government should hire talented and skilled human resources in each section of the implementation of the health insurance program.

"........there would be fragrance in gold if people are here with related subjects and training. It would be great in IT if people are from same experience and background. Existing problem is lack of human resource. Claim does not mange in time is because of inadequate human resources. And, it would be better if there are competent human resources in concerned work. yes, work is going on, but it needs to make easier. So, to make easier not in just a claim department but in whole system there should be thematic expert, but I don't think there is enough......." (Information planning and communication official, 2020)

"......Human resources had to be provided in adequate number...." (HR official, 2020)

C. Adequate Motivational Incentives

Interviews revealed that participants were not satisfied with their salary and wanted additional motivational incentives according to their workload. Information planning and communication official suggested extra incentives to motivate their work and their government's salary.

".....But now we only get that salary by government. It's difficult now but we need some motivation also .... " (Information planning and communication official, 2020)

6.1.4 Problems related to the relationship between the insurance agency and the government programs and political authorities ultimately responsible for the system

A. Political support

One participant from the claim reviewer team reported that politician should take their responsibility, as they say in their manifestos, to increase publicity of the health insurance program and policymaking. A politician should also involve the topic of health insurance programs in their speech, which would increase the promotion of health insurance programs.

".....And next thing politician, as they include in their manifesto to make the successful program, so their main responsibility is to publicity, dedication, and policy-making..........At

least they should put 2 words about health insurance in their speech. But for the publicity, it would be helpful........" (Claim reviewer, 2020)

B. Pre- Planning Before Launching Program

According to the IT department participant, pre-planning the program before implementing it in any district would help overcome problems. According to him, whenever the insurance board tries to launch the program in a certain district, first they should make sure the district has adequate health facility centers, adequate infrastructure, quality services, medicine, and diagnostic facilities. There should be proper research before registering any health facility. There should also be pre-management of insufficient staff and the program's administrative department before launching the program.

".....what we can do about the hospital is before making any agreement we should carefully examine its infrastructure, what is happening in there, what kinds of services they have, about availability of services, how many medicines are available, what kinds of diagnosis the have, if patients come there or not. We should do analysis and research about that, and then we should move our work. that would be right............. If we are going to implement in some district, then before doing some management. Our thing is if we do some management before the start, then that would be easy. Always on the spot. For example, the program has been implemented in Rasuwa and Udhayepur, today and tomorrow, whom to send there?....."(IT official, 2020)

C. Integrated Different Government Program

Implementers have faced challenges such as various scattered government programs by the government of Nepal. Participants suggested that the government should standardize the basic health care services so that health facilities would not abuse those services. All the parallel Nepal's government health programs should be integrated and being handled by the same health insurance board.

".....Parallelly overlapping programs need to be integrated..."(HR official, 2020)

"......now we must go to the legal part where Government has declared basic health needs. Health ministry is its ministry. It is needed to make standard format to know what basic health care is..........health ministry should standardize standard treatment protocol and what is basic health services..........social security fund, and staff reserve fund, and banks and insurance committee and different program by ministry of health are scattered. Which need to integrate and handle by the health insurance board ...." (Claim reviewer, 2020)

Summing of the above finding: Conceptual framework elaborated

To sum up, the figure below 6 illustrates where the various reform suggestions can fit into an overall model of the relationship between the health insurance administration, the health care providers, and the Nepalese people and the government.

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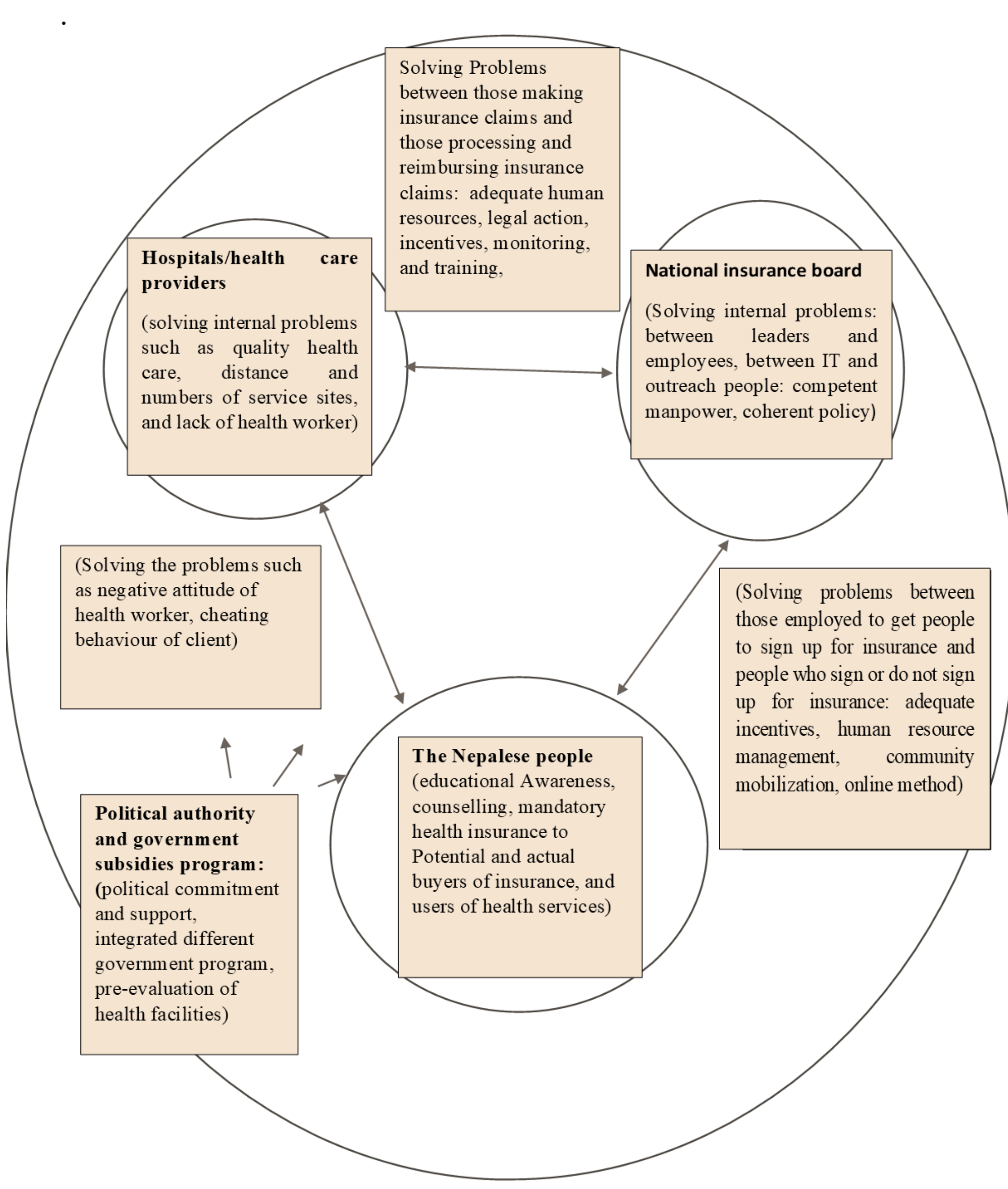

Figure 6 Conceptual framework elaborated (Solutions)

Chapter VII: Conclusion and Recommendations

8.1 Conclusion

Nepal's national voluntary HIP is a bold step to ensure quality access and equitable health, risk pooling and means to achieve UHC. However, as this study indicated, many challenges are limiting the success of the program. This study has aimed to identify the challenges faced by the implementers for the successful implementation of a voluntary, public health insurance program. This study has highlighted many interrelated challenges the actors face in implementing the insurance scheme based on qualitative analysis. The study found that limited educational awareness, limited promotion, limited community mobilization, limited human resource, and administrative management problems, as well as low incentives and salary to staff, lack of political support, lack of quality health services, overlapping government healthcare initiatives, adverse selection, and moral hazard problems as a major challenge. Success will require Constant scrutiny from political authority, from different administrative levels of the insurance agency, and from Health service sites of the health insurance program to improve implementation. This study has also given the informant an opportunity to suggest remedies, which should be seriously considered.

8.2 Recommendations for further studies

The HIP is essential for a low-income country like Nepal. If properly implemented, it will help increase access to health services, ensure quality health care, prevent financial hardship for those in need to utilize healthcare, remove catastrophic health expenditure, and help achieve Universal Health Coverage (UHC). Thus, several recommendations made by my informants are worth closer consideration. Let me end by listing which, in my opinion, are the most important that should merit further investigation by later studies:

Educational awareness, effective promotion, and adequate campaign should be conducted about the health insurance program through different means for the citizens, such as mass gathering, TV, radio, FM, newspapers, social networking sites, and starting topic of health insurance program in the school curriculum, and the eventual effect of such campaigns should be evaluated.

Regular door-to-door visits by the EAs for counseling and educational awareness should be intensified, and the importance of EAs for take-up should be evaluated.

Giving a more substantial role for local authorities and community mobilization should be done. For example, by providing some local government grants from the central government if they increase health insurance take-up among local citizens and evaluate if this leads to higher take-up.

The government should consider finalizing the ultra-poor identification program as soon as possible so that the poor would not have to be deprived of the insurance program because of poverty.

It is necessary to increase appropriate prior research and evaluation of the health service sites before registrations regarding hospital and PHCc 's standard, treatment procedure and charge, infrastructure, health staff, and emergency and out-patients services, surgery services, and distance from the citizen's catchment areas.

Before further implementing the scheme, the increased use of proper monitoring and evaluation teams should be considered to counter fraud and corruption, and effective legal actions and restrictions should be made.

Digital Applications that allow the citizen to sign up for HIP should be further developed so that people do not have to wait for EAs to come to their door and fill the form if they want to enroll right away.

The government should contemplate integrating all contributory health programs for people such as the mother safety program, medical treatment for deprived citizens (BIPANNA NAGARIC KOSH), a free health care service program, and the health insurance program.

Human resource management, adequate committee, and different branches should be further developed in the health insurance board to perform all types of health insurance-related activities.

Skilled and competent human resources should be hired, and sufficient incentives to the EA should be provided. This may imply covering anticipated travels, transportations, and logistic materials cost of EAs. Motivational incentives for extra working hours (such as a bonus) for administrative staffs along with salary should be provided.

The government of Nepal should consider strengthening the hospital and peripheral health care centers to provide quality health care and services, drug availability, infrastructure, human resources, etc.

Appropriate motivational support and adequate legislation should be developed for health workers so that they would stay in hospitals during working hours.

More research and studies should be performed to identify underlying problems regarding all the above topics.

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Appendix 1 Informed consent in English

Informed consent

Introduction and consent

Hello, Namaskar!

I am Binita Paudel, student of International social welfare and health policy program at Oslo Metropolitan University, Oslo, Norway. As a course requirement, I am doing research on "Challenges for the implementation of health insurance program in Nepal." I would like to ask you some questions related to how you perceived these challenges and what could be your suggestions and recommendation with regards to meet this challenge. Your cooperation will be highly appreciable. I would like to make a sound recording and take notes during our interview. you can refuse to answer any question at any time of the study. Your information and experience sharing will make my research successful.

The face-to-face interview will usually take 30-60 minutes to complete. Question will be related to only this topic, and no personal information will be asking. It is, of course, fully voluntary to participate. Whatever information you provide will be used for only this research purpose. All the sound recordings and notes will be kept in a safe place with a lock. After the project is finalized, all the sound recordings and notes will be deleted.

Are you ready to participate in this study?

Yes …...................

No.........................

Signature of interviewee...................

If you have any queries regarding this research, please contact me at binip45@gmail.com

Appendix 2 Interview guideline

Interview Guideline

1. Government of Nepal set the criteria for poor people that they can pay less amount of premium or do not have to pay the premium. How do you target poor people?
2. Do you think identifying poor people is the problem? How?
3. Could you please tell me about the reimbursement process to the health facility?
4. What are the problems you have faced to manage reimbursement?
5. What do you do in case of any DRG (diagnosis-related group) problems?
6. What are the methods you have applied to sign up for health insurance?
7. What do you do if benefits ceiling prices crossed the treatment? Do you think it would be a problem?
8. Program aims to carry out much of the insurance procedure online method. Do they possess the technological resources and capability to host a large number of insurance services to the user? Please clarify.
9. According to you, what is the reason behind the increasing amount of premium (from 2500 to 3500)? Please clarify.
10. Do you think you get enough wages for your working position?
11. Are there enough trained workers to supervise health insurance claims from the health facility? How do you divide work?
12. How do you perceive any external influence on your working way? (external stakeholders or political party).
13. How do you manage the consumer complaint about the program? Do you have any channel to connect with consumer complaints?
14. Still, we have very low coverage of the health insurance program. What is your opinion on this situation?
15. In your opinion, are there any other problems related to the implementation of the national health insurance program?
16. Could you please tell me how, in your opinion, these problems may be overcome and what is the suggestion you want to give to other staff of the program?

अन्तर्वार्ता दिशानिर्देश (In Nepali)

1. नेपाल सरकारले गरिब जनताका लागि मापदण्ड तय गर्दछ कि उनीहरूले कम प्रीमियम तिर्न सक्छन वा प्रीमियम तिर्नु पर्दैन। तपाईं गरिब मानिसहरूलाई कसरी लक्षित गर्नुहुन्छ?

2. के तपाई गरिब मानिसहरुको पहिचान समस्या हो जस्तो लाग्छ?

3.कृपया तपाई मलाई स्वास्थ्य सुविधा को लागि प्रतिपूर्ति प्रक्रिया को बारे मा बताउन सक्नुहुन्छ?

4. प्रतिपूर्ति व्यवस्थापन गर्न तपाईंले सामना गर्नुपरेका समस्याहरू के हुन्?

5. कुनै डीआरजी (निदान सम्बन्धित समूह) समस्या भएमा तपाईं के गर्नुहुन्छ?

6. स्वास्थ्य बीमाको लागि साइन अप गर्न तपाईंले प्रयोग गर्ने तरिकाहरू के हुन्?

7. फाइदा छतका मूल्यहरु ले उपचार पार गऱ्यो भने तपाई के गर्नुहुन्छ? के तपाईलाई लाग्छ कि यो समस्या हुनेछ?

8. प्रोग्रामले बीमा प्रक्रिया धेरै अनलाइन विधि पूरा गर्ने लक्ष्य राख्दछ, के तिनीहरूसँग टेक्नोलोजिकल रिसोर्सहरू र प्रयोगकर्तालाई बिमा सेवाको ठूलो संख्या होस्ट गर्ने क्षमता छ? कृपया स्पष्ट पार्नुहोस्।

9. तपाइँको अनुसार, प्रीमियमको मात्रा (2500 देखि 3500 सम्म) बढ्नुको कारण के हो? कृपया स्पष्ट पार्नुहोस्।

10. तपाईंलाई लाग्छ कि तपाईंले आफ्नो काम गर्ने स्थितिको लागि पर्याप्त पारिश्रमिक पाउनुहुन्छ?

11. स्वास्थ्य सेवाबाट स्वास्थ्य बीमा दाबी निगरानी गर्न पर्याप्त प्रशिक्षित कामदारहरू छन्? तपाईं कसरी काम विभाजन गर्नुहुन्छ?

12. तपाइँ तपाइँको काम गर्ने तरिकामा कुनै बाह्य प्रभाव कसरी देख्नुहुन्छ? (बाह्य सरोकारवालाहरु वा राजनीतिक पार्टी)।

13. तपाइँ कसरी प्रोग्रामरको बारेमा उपभोक्ता गुनासो व्यवस्थापन गर्नुहुन्छ? के तपाईंसँग उपभोक्ता उजूरी संग कनेक्ट गर्न कुनै च्यानल छ?

14. अझै पनि हामीसँग स्वास्थ्य बीमा कार्यक्रमको एक धेरै कम कभरेज छ। यस परिस्थितिमा तपाईंको राय के छ?

15. तपाईको रायमा राष्ट्रिय स्वास्थ्य बीमा कार्यक्रमको कार्यान्वयन सम्बन्धी अन्य समस्याहरु के के छन्?

16. के तपाई कृपया मलाई बताउन सक्नुहुन्छ कि कसरी तपाईको रायमा यी समस्याहरुबाट पार पाउन सकिन्छ र तपाईले कार्यक्रमका अन्य कर्मचारीहरुलाई दिन चाहानु भएको सुझाव के छ?

Appendix 3 Approval letter from Nepal Health Research Council (NHRC)

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 2279

28 April 2020

Ms. Binita Paudel
Principal Investigator
Oslo Metropolitan University
Norway

Ref: Approval of thesis proposal

Dear Ms. Paudel,

This is to certify that the following protocol and related documents have been reviewed and granted expedited from review by the Expedited Review Sub-Committee for implementation.

ERB Protocol Registration No.	291/2020 MT		**Sponsor Protocol No**	NA
Principal Investigator/s	Ms. Binita Paudel		**Sponsor Institution**	NA
Title	Challenges for the Implementation of the Health Insurance Program in Nepal, from the implementer's Perspectives			
Protocol Version No	Version 2.0		**Version Date**	3 April 2020
Other Documents	1. Data collection tools		**Risk Category**	Minimal risk
Expedited Review	Proposal	✓	**Duration of Approval** 28 April 2020 to 28 April 2021	**Frequency of continuing review**
	Amendment	☐		
	Re-submitted	☐		
	Meeting Date:	27 April 2020		
Total budget of research	**Self-Funded**			
Ethical review processing fee	**NRs 10,000.00**			

Investigator Responsibilities

- Any amendments shall be approved from the ERB before implementing them
- Submit progress report every 3 months

Tel: +977 1 4254220, Fax: +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.gov.np, E-mail: nhrc@nhrc.gov.np

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 2279

- Submit final report after completion of protocol procedures at the study site
- Report protocol deviation / violation within 7 days
- Comply with all relevant international and NHRC guidelines
- Abide by the principles of Good Clinical Practice and ethical conduct of the research

If you have any questions, please contact the Ethical Review M & E Section at NHRC.

Thanking you,

Dr. Pradip Gyanwali
Executive Chief
(Member-Secretary)

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Appendix 4 Tabular illustration of the theme, categories, and subcategories

Theme	Category	Subcategory
Challenges/ Suggested solution and recommendation	Problems related to the relationship between the Nepalese people (potential and actual buyers of insurance) and the national insurance system/agency.	Problems related to how the Nepalese people perceive and act vis-a-vis the insurance system. Problems related to the outreach effort to the Nepalese people by the health insurer.
	Problems related with the relationship between the buyers of insurance and health care center or providers.	Problems related to how insured members perceived health care providers. Problems related to how the service site (hospital and PHCc) treat insurance member.
	Problems related to the relationship between the insurance agency and the hospitals.	Problems related to how hospital process claims. Problems related to how the insurance agency deals with claim and reimbursement.
	Problems related with the relationship between the insurance agency and the government programs and political authorities ultimately responsible for the system.	Poverty identification problem. Low Political support. Government similar other problems. Launching program without preparation.

Appendix 5 Analysis (Example of Coding and Highlighting)

district there is no poverty identity card facility. For those we use our regular method to get sign up. So, we are unable to give insurance services for the actual poor people in this kind of district. Let's say identity gap.

Q: okay then let's talk about health insurance reimbursement and its process...could you please explain?

P: reimbursement is like this. We have our first service point. When people get insured then they get treatment according to their cycle. We can see that cycle in page. (4 months cycle). When insured people go to hospital then they go to government hospital which is primary service site and for referral they can go to Privet hospital. We have listed nearly 360 /62 different hospitals. When they receive services from those health facilities then health facility uploads those service utilization certificate in claim section of insurance board. They keep that in record. All this process is done by the technological software and through online method. According to their demand, our claim section team do verification of that documents. They check either these documents are correct or not. Only after verification they reimburse to the health facility. So yeah, process is this that. But if we see now then nearly 2 billion Rupees or more than 3 lakh claim has not been reimburse and are still in pending. Why this is happening? this is happening because hospital dose not provide documents on time, adequate document submission as well as we have fewer human recourses. Because of all these we are unable to reimburse on time. When reimburse process gets delay then it directly affects insured people's health services which leads to more dropout. this is the internal link.

Q: yes of course, this program is based on Triangle, if one has some problem than it will directly affect other aspect. Could you please explain other problems that you have faced to manage reimbursement? One you already said dropout rate increases others may be....

P: we can not solve claim on time and HR also has policy to case verify... again what kind of policy we have? We have only insurance act and regulation. There should be more regulation and committee... even in our insurance act, i think in article 17 , after completion of board member we can make other committee according to our need. We have that power. So we need claim management committee, medicine verification committee but we don't have these kinds of committee. We don't have any committee that gives us right direction and coordination to do exact work. and second thing we don't have any guideline that shows how to regulate program. thats why ...because of this policy gap... also we dont have proper resources. They dont provide proper documentation (hospitals), sometimes there is no access to server or internet. Thats why it slows overall process. When process gets slower than dropout increase. For example, i am insured person. When i go to health services to get services and dont get any satisfaction. Even i have to waste my entire day to get that. After that situation ultimately i would not renew my card. isn't it? So its like a chain circle.

Q: what are the problems that we have faced in any DRG?

P: umm for that we have listed 1163 types of medicine in health insurance program... no i think its 1133 types. So, we have these amounts of medicine in our program. all hospitals may not have all these medicines. We found complaint such as our service point don't give these medicines to our insured

Author	4 months cycle
Author	360/62 service site
Author	Reimbursement process
Author	Delay in reimburse.
Author	Hospitals negligence submission
Author	Few claim reviewer
Author	Unable to reimburse on time
Author	dropout
Author	Pending claim
Author	Inefficient policy
Author	Regulation act and committee
Author	Inadequate committee
Author	Policy gap
Author	Lack of resources
Author	No access to server
Author	Slow process
Author	Dissatisfaction with service
Author	Dropout
Author	1133 medicine
Author	Unavailability of listed medicine
Author	Complaint about medicine