A Case Study on Lalitpur Medical Insurance Scheme (LMIS), Nepal

• Working Paper •

2002

International Labour Office

ISBN 92-2-113184-X

ILO

A Case Study on Lalitpur Medical Insurance Scheme (LMIS), Nepal

---

This publication can be obtained, free of charge from:

Strategies and Tools against Social Exclusion and Poverty
ILO Social Security Policy and Development Branch
International Labour Office
4, route des Morillons
CH-1211 Geneva 22,
Switzerland
Tel: +41.22.799.65.44
Fax: +41.22.799.66.44
E-mail: step@ilo.org
http://www.ilo.org/step

Printed in Switzerland

Table of Contents

List of Tables

Acknowledgements

This report presents the United Mission in Nepal, as one of the pioneering institutions serving the poor informal sector workers to access quality health care services via a community-based health financing scheme. Attempt has been made to document the community-based health financing scheme with its operational modalities, hoping that its experience will prove useful for those, who are committed to identifying ways to promote the rights of the poor with access to quality health care services.

In the process of preparing this document various individuals extended their valuable support. The author, Dr. Lokendra Prasad Poudyal extends his appreciation to Ms. Ismène Stalpers, Ms. Evy Messell and Ms. Nita Neupane of the ILO for their valuable guidance to the study. He is also grateful to Dr. Thomas Koenig, Mr. Nawang Gurung, Ms. Subasha Shrestha and Mr. Arun Thapa of UMN Patan Hospital-Nepal, who readily answered queries and supplied valuable information about the scheme. Special thanks to Dr. Harding for sharing his comprehensive comments and suggestions on the case-study. Last but not least, Dr. Poudyal thanks Ms. Sunita Baidya and Mr. Narayan Babu Shrestha, who helped him in the collection and processing of information to bring the report to its present shape.

October 2001

Abbreviations and Conversion Rate

CDHP	Community Development and Health Project
CHP	Community Health Programme
DHO	District Health Office
HC	Health Clinic
HMG/N	His Majesty's Government of Nepal
HP	Health Post
IC	Insurance Card
IS	Insurance Scheme
LHPC	Local Health Post Committee
LMIS	Lalitpur Medical Insurance Scheme
MIS	Micro-insurance Scheme
MoH	Ministry of Health
NRs. / Rs.	Nepalese Rupees
PHC	Primary Health Care
UMN	United Mission in Nepal
VDC	Village Development Committee

Conversion Rate:

1 US Dollar equals to NRs. 75.10 (June 2001)

I. INTRODUCTION

The United Mission in Nepal (UMN) is a non-profit making organization providing health care services in Nepal. In 1976, under its Community Development and Health Project (CDHP) activities, it introduced a Microinsurance Scheme to the community people of the Lalitpur. The scheme was known as Lalitpur Medical Insurance Scheme (LMIS). The principal objective of the scheme was to facilitate people's access to health services. It aimed to cover the cost of the medical services, but not the expenses related to personnel, transport, or the maintenance of the community health posts and supplies.

The members of the scheme have been deriving benefits since the inception of the scheme. Presently, the scheme covers hospital care, general medicine, preventive care, gynae-obstetrical care, laboratory examination costs (limited) and radiology costs into its health services. In addition, the scheme activities are also directed towards improving sanitary condition and health awareness of the community people through health education activities.

II. SYNTHETIC DESCRIPTION OF THE HEALTH INSURANCE SYSTEM

The scheme covers mostly the rural areas of the Lalitpur district, which benefits people with access to health facilities and other development infrastructure. The covered areas are located in the vicinity of providing urban facilities.

Membership of the scheme is open to all of the local inhabitants irrespective of their age, caste, ethnicity, educational / income status and sex. The membership is of a *family type* and extends to all kinfolk living under one roof.

Currently, the number of member households of the target area covered by the Insurance Scheme, is around 4,240 with an average of 5 persons in each family. The membership data segregated by age and sex of the individuals is not available. Neither are the members categorized according to their other social and economic conditions. Available information reveals that more than 50 percent of them are living below the poverty line and almost all of them had no access to the social security system before participation in the scheme. The scheme also provides service opportunities to the people who live in the non-targeted village areas. The scheme emphasizes coverage of the poorest people as its major targeted beneficiary.

To run the scheme activities at the local level, four health posts have been established by the Community Development and Health Project (CDHP) at Ashrang, Bhattedanda, Chaughare and Gotikhel. Support was also provided to the already established government health post at Chapagaon. Services rendered through these health posts have contributed to the improvement of health conditions for the local people.

The health posts established under the scheme have employed a total of 34 staff for their day-to-day operation and management of activities. Among them, 7 are salaried staff and the rest (Health Committee Members) are volunteers (Table 1).

Table 1: Number of Staff Involved in the Management of IS in 2000

Type of Staff	Male	Female	Total
Salaried	4	3	7
Volunteer	25	2	27
Total	29	5	34

Source: LMIS, 2000

The scheme is collaboratively managed and operated by CDHP health post staff, central office staff and HP Committee staff. Except for their representation in the Health Post Committees, other members do not have opportunity to directly participate in the management of scheme.

The major source of income for financing the Insurance Scheme are members' contributions paid each year. Initially, the rate of premiums charged by different health posts, ranged between Rs. 12.- to Rs. 30.- during 1988-1989. Over the 25 years of running the LMIS, the rates have been revised at all health posts (Table 2).

Table 2: Annual Premiums Charged at Different Time Periods

Health Post	1988-1989	1993-1994	1996-1997	1999-2000
Ashrang	Rs. 30.-, Rs. 45.-, Rs. 60.- and Rs. 75.-	Rs. 35.-, Rs. 45.- and Rs. 120.-	Rs. 150.-	Rs 150,-
Chapagao	Rs. 30.-	Rs. 50.-	Rs. 50.-	Rs 100,-
Chaughare	Rs. 12.- and Rs. 15.-	Rs. 35.- and 45.-	-	Rs 100,-
Bhattedana	Rs. 25.-, Rs. 30.- and Rs. 50.-	Rs. 35.-, Rs. 45.-, Rs. 55.- and Rs. 65.-	Rs. 80.-, Rs. 90.- and Rs. 100.-	-
Gotikhel	Rs. 30.- and Rs. 40.-	Rs. 50.- and 75.-	-	-

Source: J. W. Richard Harding, Lalitpur Medical Insurance Scheme: A Status Report After Twenty Four Years, CDHP/UMN, 2000.

The Patan Hospital located at Lagankhel in Lalitpur acts as a referral hospital. Complex cases that are unmanageable at the health post level are referred to this hospital. The patients referred are entitled to receive health services from the hospital, and on subsidized rates from the UMN after paying their regular premiums.

Annual incomes of the health posts are different for different years. For example, the income of the Ashrang Health Post has increased in the recent years, while Chapagaon's has declined during the recent three year period (Table 3).

Table 3: Annual Income Contributed by Various Sources of Fund Raising

Year	Income* (in NRs. / US $)	
	Chapagaon	**Ashrang**
1997-1998	Rs. 105,803.- ($ 1,408.83)	Rs. 50,991.- ($ 678.97)
1998-1999	Rs. 99,000.- ($ 1,318.24)	Rs. 90,000.- ($1,198.40)
1999-2000	Rs. 69,230.- ($921.84)	Rs. 110,607.- ($1,472.80)

* Including Bank Interest

Source: LMIS, 2000

III. THE CONTEXT IN WHICH THE INSURANCE SYSTEM OPERATES

This part presents the context in which the Insurance Scheme (IS) has been operating. More specifically, it describes the demographic, social and economic aspects of the Insurance Scheme's Zone of Operation. It also explains sanitary indicators, national health policy and social security provisions in the health sector.

3.1 Demographic Aspects of the Insurance Scheme's Zone of Operation

The demographic aspect deals with the population growth rate and family size in the area of Insurance Scheme implementation. It also describes the geographical distribution of the target population, and the migratory movements of the people, as well as the average family size.

The majority of the target population covered by the Insurance Scheme are rural area dwellers, with very few of them (less than 15%) having sub-urban resident connections. There has been little change in the covered population size in the recent years. For example, in the year 2000, around 23,434 persons, comprising of 51 percent male and 49 percent female were covered (Table 4).

Table 4: Population Covered by the IS Zone in the Recent Years

Year	Population		Total
	Male	Female	
1998	11,697	11,236	22,933
1999	11,897	11,404	23,301
2000	12,026	11,408	23,434

Source: LMIS, 2000

The population records maintained by the Insurance Scheme are not segregated by age groups. The family size of the population differs by the place of residence, ethnicity and other socio-economic factors.

Very few people permanently migrate from their place of residence to other places. However, seasonal migration, is a common trend among many households. Due to the lack of reporting and registration of the peoples' migratory movements, the actual trend and data on migration could not be presented.

3.2 Economic Aspects

The economic aspects describe the major sectors of people's employment, level of income, their sources and the level of health expenses.

Agriculture is the major occupation for many people in the community. About 90 percent depend on this sector as their major occupation. The remaining 10 percent are employed in the governmental, non-governmental and business sectors. Some people are engaged in manual labour work and earn daily wages, such as in the carpet factories and other informal sectors. For most of the people, agriculture and livestock products and/or the manual labour works are major sources of cash income. The household income of most families falls between Rs.1,000.- to 3,000.- ($ 13.32 to $ 39.95) per month. This low level of income is particularly due to the lack of income generating opportunities at the community level and also limited avenues available to serve the formal sectors (UMN Progress Report, 2000).

3.3 Social Aspects

Most of the children in the Insurance Scheme area are enrolled in school. The concern for educating their children, at least up to the primary level, is quite high among the villagers from all kinds of economic strata. Around one-third of the population in the scheme area are literate. These rates of school attendance and literacy are far above the national average. This is mainly due to the extensive non-formal education, encouragement, and scholarships by CDHP over the past many years. Also, this could be partly ascribed to Lalitpur's proximity to urban areas and their influencing aspects.

Compared to the boys, the girls are in a relatively disadvantaged position. Still there are families who consider sending girl children to the school as a matter of low priority. However, this conception has gradually been changing in recent years with the increased concerns raised from different angles about the need for providing equal treatment to both boys and girls.

3.4 Sanitation Indicators

Nearly one-third of the people have access to safe drinking water with dug well (*Inar*) and piped supply as the two major sources. The Community Development and Health Project has provided gravity flow water systems for the Ashrang, Pyutar and Gimdi VDCs (Asrang HP target area) as well as all the other VDCs in South Lalitpur, except to the Chapagaon catchment area.

The access to health services offered by the scheme has placed many families of the target area in a relatively better position in terms of some health indicators such as Crude Death Rate, Infant Mortality Rate, Child Mortality Rate and Maternal Mortality Rate. The overall mortality rate in the community is lower, of 10 per 1,000 mid-year population; while the national average is 12 per 1,000 mid-year population.

Most of the beneficiaries of the scheme have built toilets for their family's use. This construction work gained momentum after intervention of the Insurance Scheme on raising health awareness.

3.5 National Health Policy

His Majesty's Government of Nepal has been emphasizing the privatization of health care services in the recent years. The Ninth Development Plan (1997-2002) has signalled a possible reduction in the allocation of grants to the government hospitals and health care centres. In the absence of adequate public services, many private health care centres have emerged. Their services are primarily accessible to those who can afford it.

Only few initiatives have been undertaken to cater to the needs of the excluded people in the informal sector, most of whom still lack their legal statute. Despite their legal invisibility, these people are still contributing to the health services at the community level. The need for multiplying such effort has been deemed essential.

The declining focus of the Government on sector health facilities, coupled with the high cost of services offered by the private sector, has excluded many poor people of the informal sector. To fill this gap, the Health Insurance System in the communities has become increasingly important, particularly for the excluded. Such a system has not only delivered the services needed but has also provided people with ownership to the system.

3.6 Supply of Health Care Services

The UMN Community Health Programme (CHP) initiated supply of health care services at the community level by establishing local health posts. The Patan Hospital was designated as the referral unit for the scheme. The health posts provided regular services at the community level, while the Patan Hospital admitted patient's visits only when the referred problem was of a serious nature.

The community clinics are under the leadership of Health Assistants with periodic supervisory visits by community medical officers from CDHP. These doctors also work part-time in the Patan Hospital. The establishment of health service provisions in the communities themselves have reduced people's need to visit Lalitpur or Kathmandu for access to these services. The scheme has particularly benefited the people, who could not otherwise afford the higher treatment cost.

The health posts adopt a practice of forwarding complicated cases to the Patan Hospital, only if the treatment seems beyond their capacity. The patients cannot claim the scheme privilege from the Patan Hospital without the referral sheet from the health posts. However, in emergency cases, exceptions are allowed. Ambulatory service for the access has to be arranged by the patient on his/her own.

3.7 Social Protection in Health

Most villagers covered by the LMIS were at the state of transition in adapting modern medicinal practices from the traditional ones. Before many of them relied on the traditional healers. Their belief was that the sickness that should be treated by the traditional healers cannot be treated by modern medical practices. Additionally, some of them believed that their illness was a result of their previous life's deeds. With the initiation of the Insurance Scheme in their locality, the villagers' superstious beliefs have declined and the number of patients visiting the traditional healers (Dhamis and Jhankris) have gradually decreased[1]. Some of the families who still have faith in the traditional healers have also started to shift towards the modern clinical treatments after their first trial of primary care.

The health care awareness raised among the progressive villagers by the scheme has been useful for wider replication of this demonstration effect. Prior to the establishment of the scheme, the village had no other medical security services. For the first time in 1995, the Government provided social security service to the elderly persons of more than 75 years by introducing a monthly allowance of Rs. 100.- ($ 1.33). This service was further expanded to cover the helpless widows of above 60 years, and physically and mentally handicapped persons (Manandhar, 2001).

IV. IMPLEMENTATION OF THE HEALTH INSURANCE SYSTEM

This part is devoted to the description of the Insurance Scheme creation process. It describes the launching phase and illustrates the operation of the Insurance Scheme.

4.1 Launching Phase of the Insurance Scheme

The Lalitpur Medical Insurance Scheme (LMIS) was established by the United Mission in Nepal in 1976. It is a renewable insurance plan for the households who are excluded from access to medicines. At the initial stage, the scheme was designed with the assumption of covering the

[1] The UMN Community Mental Health Programme, which was developed in CDHP, has for ten years trained and worked cooperatively with these traditional healers, who now refer many patients to the health posts.

cost of medicines, while assuming that the rest of the cost of the personnel and other supplies would be met by the Government. In 1983, the concept of a Microinsurance Scheme was applied at the community health post of Chaughare, and a year later in Chapagaon. In 1986 the scheme was extended to Bhattedanda and in 1988 to Gotikhel (Lee, 1999:194).

Before implementing the scheme, people had very low access to the health services at the community level. Although the Ministry of Health (MoH/HMG) had policies to supply medicine to the health posts, the annual allocations had been insufficient even to meet the need for six months. In addition, the management of the health posts were not so effective because of absenteeism, frustration and rapid turnover of the auxiliary health post staff. This situation was significantly detrimental to the attraction of people towards the health services offered by health posts.

The health post in Bhattedanda was the only effective health post in South Lalitpur in the mid-1970s. For the majority of people in the hills, other health posts were not accessible from their area.

Despite a declining interest of villagers to visit the government health posts, which lacked basic facilities, no substantial measure was taken to improve the management and operation of the services (e.g., to make a regular presence of the health staff and to reduce other health problems) at the health post level. This compelled a considerable portion of the community population to visit traditional healers, as they had no other choice. With an intention of exploring possibilities for overcoming this situation, the UMN Community Health Programme (CHP) staff met with the local Health Post Committees of Ashrang (1976), and Bungmati and Badegaon (1977). Issues were discussed and the existing cost recovery schemes were studied but rejected (Harding, 1997).

As a solution to the emerging problem, the community people proposed an annually renewable pre-payment insurance plan for the households under the administration of Local Health Post Management Committee (HPMC). The people envisioned a system, which would continuously provide accessible quality health care, where essential drugs could always be provided. The scheme was primarily designed as a drug scheme, which did not attempt to address the cost of personnel, transport, maintenance and other supplies (Lee, 1999). The basic assumption of the scheme was that despite their limited access to cash, because of the subsistence economy of the majority, people would be willing to pay for health care when they became ill (Harding, 1997).

The schemes allowed all interested people of the target and non-target areas to take up membership and in order to do this, the members had to make financial contributions to the scheme. In return they received services from the health posts, including essential medicines free of charge. The membership was open to all without any restrictions.

Almost all the members who participated in the scheme were from the rural areas where they had little access to other health care and public facilities like, telephone, electricity, schools, etc. The majority of them relied on agriculture and lived in a subsistence economy with a limited cash income.

In the late 1980s, the Bungmati and Badegaon health posts stopped functioning because of political conflict. Subsequently, their insurance scheme also stopped functioning, but the originally conceived simple system is still in operation with minor changes in other places (Harding, 1997).

4.2 Phases of Implementation

4.2.1 Identifying Needs and Defining Objectives

The staff of the Community Development and Health Project (CDHP) identified the needs for improving the health status of the people. Primary focus was on improving people's access to basic health services and regular supply of medicine. The objectives were clearly defined when the insurance scheme was launched. The target groups of communities, health post staff, local authorities and the District Health Office (DHO) were consulted in this process.

A series of discussions were held with the communities to determine what sort of cost-sharing scheme they preferred to have and the importance of their cooperation in the management of the health post in their communities. Their major role was to support effective management of the scheme and utilize the local resources properly. The District Health Office of the Ministry of Health was expected to provide financial support for the continuity of the scheme. Right from the initial stage sustainability was a major concern,. For this purpose, emphasis was given to increasing the membership and the generation of adequate funds so that surplus could be created for long-term use. Summarily, the following needs were identified for the scheme:

- ensuring regular services from the health post;
- ensuring that essential medicines are available in time;
- making community people more aware of their own health rights and conditions;
- increasing members' ownership of the health care centres;
- increasing motivation of the community people towards the health post and its management;
- making regular presence of the health care personnel in the community level health post.

The stated objectives of the scheme were:

- to ensure the continuous medicine supply at the health post level throughout the year by mobilizing community resources;
- to distinguish costs for the community health services and thereby contribute to equity and equal opportunity for all;
- to increase awareness of the health services available in the community and encourage appropriate utilization of such services, including the ones offered by the base hospital (i.e., Patan Hospital).

4.2.2 Context and Financial Viability Studies

In the implementation phase, no pre-feasibility and feasibility studies were carried out for financing the scheme and determining the benefit-contribution relationships. In the beginning, all health services were provided free of cost, the same as in all HMG/MOH health posts at that time. The United Mission in Nepal (UMN) took this initiative to ensure continuous availability of

medicines. The Insurance Scheme was then conceptualized to become one of the possible alternatives by mobilizing people in the community.

No other Insurance Systems were visited to learn and introduce the support process, and this was partly due to the non-existence of other systems. If they had differing opinions, the people were provided with opportunities to suggest any other alternative programmes,.

4.2.3 Information on the Target Group

Initially, the target group of the Insurance Scheme were all of the people of South Lalitpur including 17 panchayats (now called Village Development Committees, VDCs) in the hills and about 8 more in the valley.

Interactions were maintained through a series of meetings and consultations to attract and reflect the needs of the target groups (who were mostly illiterate). The discussions covered information about the scheme, including its rationale and advantages. After their establishments, the health posts played an important role as information dissemination centres, by providing villagers with details on the role of the Insurance Scheme (through leaflets, notice boards and counselling). The group meetings and general assembly meetings were good venues for information dissemination as well. The booklets contained information about the coverage of the benefits, advantages and eligibility for joining the scheme. The process of acquiring membership was also elaborated upon in these booklets.

In the early years of its implementation, the Insurance Scheme encountered a series of problems in increasing enrolments and convincing them about the benefits of the scheme. The newness of the scheme intervention was even accompanied by the fear of poor cost recovery of the medicines. However, the positive anticipation and confidence of CDHP promoters of UMN did not let the performance of the scheme go down. They believed that the scheme had adequate potential to attract the people in the community, as it could provide access to the health services for people, who were deprived of such facilities before. Finally, this helped the promoters to win over the hearts of the members who started putting forward their promises for the good management of the health posts.

4.2.4 Launching of Major Activities

The establishment date of the Insurance Scheme was not marked by any particular event like a constitutional general assembly or a special meeting of the council of the parent company, etc.

At the onset, the CDHP staff provided leadership in the establishment of the scheme. Also some Health Clinic (HC) members and community representatives participated in initiating the scheme. The Local Health Post Committee (LHPC) was formed to supervise the activities at the health post level. Agreement was signed between the Community Development and Health Programme (CDHP) and the Local Health Committee to set out rules for smoothly running the Insurance Scheme. This agreement covered the rates of premiums to be raised and their administration. Similarly, it also included aspects such as health post management, benefit coverage and charity for the poor.

The household registered as member is given an insurance card with a registration number and with all of the household members listed. A family file is then opened at the health post. Whenever a member of an insured household comes to the health post with his/her insurance card, he/she is entitled to receive free medical service and free consultation for an unlimited number of visits during the year (Lee, 1999).

In its outset the Insurance Scheme had no legal status. Benefits from the health posts were released from the first year of their implementation.

4.2.5 Leadership and Decision Making Process

The UMN-CDHP staff and the Local Health Committee members played a leadership role in making decisions on the scheme activities, and they were active in the creation of the insurance system. They also worked together to make decisions regarding services and benefits coverage; condition of membership and coverage of other beneficiaries (non-target population); rules and regulations for internal management and the collection of the premiums including either lowering or increasing the rates of contribution. The beneficiaries were consulted while making major decisions regarding benefit coverage, contribution allocations and the conditions of membership.

At the start of the scheme, the Patan Hospital, operated by UMN, which was serving as the district hospital, was identified as the only authorized referral hospital for Lalitpur area. In the mid-1990s, the Anandaban Leprosy Hospital opened up a general clinic and some general beds. The scheme then made an agreement with this hospital for the reduction of rates to its members.

4.3 Operation of the Insurance Scheme during the launching phase

4.3.1 Members and Other Beneficiaries

During the launching phase, almost all beneficiary members of the insurance scheme were rural inhabitants. Since the scheme had followed a policy of covering non-target area patients too, some sub-urban area patients also made occasional visits to the health posts.

Each family from the target area was counted as a potential member for the scheme. In this process, individual family members were not identified within the family, but just the families were taken as members at the household level. Other interested community inhabitants could receive the membership of the scheme on a voluntary basis, but there was no system for automatic or compulsory membership. Also, there was no restriction on the pretext of age, sex, health risk, etc. However, the scheme prioritized the poor to be included in the membership.

No registration fee for the LMIS was levied to the members in the beginning of its operations. The first application of a registration fee dates back to 1995 for some health posts, ranging between Rs. 0.50 to Rs. 1.00. At present, all health posts are applying the concept of a registration fee. The prevailing rate is Rs. 5.00 ($ 0.07).

In the beginning, the members of the scheme belonged to the target area only. Later, it was extended to cover the people from the non-target areas as well, who are required to pay full

charge for the health services. The information on the exact number of beneficiaries covered in each category is not available.

4.3.2 Benefits Provided

During the respective launching period of each of the schemes, all health posts focused on increasing the access of people to the health services by regularizing the medicine supply. Accordingly, all insured members were provided with a minimal benefit package of medical services available at the health post, and essential medicines were ready and available, free of charge. The members are entitled to receive subsidized care at the base district hospital when referred from a health post. Also, the high-risk pregnant women, who were referred for admission, received free treatment.

The major services of the benefit package that are covered from the beginning of the functioning LMIS are:

- gynae-obstetrical interventions;
- medical hospitalisation;
- medicines;
- laboratory and radiology services ;
- other tests (e.g. TB and malaria).

These services are offered to both members and others without any delay. However, the non-members are required to pay full charge for the health services obtained.

The benefit package adopted by the scheme was decided on the basis of essential elements of the Primary Health Care as outlined in the Alma Ata declaration. Since this package focuses on the priority needs of the majority, at the onset of the functioning of the LMIS, the members were not invited for their direct involvement in the selection of components of the package.

From the beginning, the health care providers were salaried by the CDHP. So, besides the general medical care services provided through the scheme, the CDHP has an important role in the payment of salary for the health post staff. The CDHP has also provided safe drinking water projects, environmental sanitation, latrine building, agriculture extension, nutrition rehabilitation, community forestry, animal husbandry improvement and animal health care training, non-formal education, school health education, women's development and income generation activities. It has also established outreach clinics for women and children in each VDC.

From the first day of the charges being made, the rates were fixed on the expectation of people's capacity to pay rather than on any detailed cost-benefit analysis. Some benefits were, and are, given in the form of charity to poor family members.

A crude method of monitoring the drug cost per visit over the selected years is taken up by UMN for monitoring the scheme's cost effectiveness. Per patient drug cost is calculated on the basis

of total dispensing of drugs through the health posts divided by the total number of health post visits. (total medical expenses/total visits[2]) (Harding, 2000).

The average drug cost derived through the application of this technique helps to examine the extent of rational use of drugs. According to the status report of CDHP, the figures obtained so far shows that the health post drug costs spent by the Insurance Scheme has remained relatively lower than for the other public and private sector programmes (Harding, 2000). The average drug costs observed for different health posts over the years were as follows:

Table 5: Average Drug Cost per Visit for Health Posts over the years

(Amount in Rs.)

Health Post	1983	1988	1992	1994	1996	1997	1999
Ashrang	5.39	7.10	10.27	14.27	16.06	14.46	16.66
Bhattedanda	-	6.40	9.62	17.41	15.64	14.55	17.26
Chapagaon	3.65	5.60	9.26	10.46	12.73	8.05	7.08
Chaughare	3.35	5.80	11.97	18.15	14.09	-	-
Gotikhel	-	-	8.60	8.98	-	-	-

Source: J. W. Richard Harding, Lalitpur Medical Insurance Scheme: A Status Report After Twenty-FourYears, CDHP/UMN, February 2000.

4.3.3 Financing Arrangements

From the onset, members paid their contribution to the LMIS in lump sum cash on a yearly basis. For greater coverage of the poorest people into the scheme, some charity was provided under recommendation of the Village Health Committee.

Members' contribution was one of the sources for financing the Insurance Scheme. The premiums are collected at different rates by different health posts (For the varying rates charged over the years, review Chapter II, Table 2).

The premium is collected at the beginning of each year. Both the registration fee and periodic contributions are utilized for the management of the health post including the regular supply of medicine. Other resources used to finance the Insurance Scheme during the conception and launching phase are presented in Table 6 below:

[2] This has demonstrated to be a very useful monitoring tool for evaluating the LMIS by the CDHP/UMN. Also, it is shown to be a comparable method conducted by the government institutions and other schemes and private practice to calculate drug cost per patient.

Table 6: Resources Accessed from Various Sources for Setting Up the Insurance Scheme in 1976

Sources	Contributions
CDHP (UMN)	Cash and materials for building construction
Community Members	Cash and labour for building construction and scheme management
Community Health Leaders	Awareness raising programmes

Source: LMIS, 2000

From the beginning, CDHP made yearly contributions toward the scheme.

4.3.4 Health Care Providers

Normal health care services are provided through the health post. Cases requiring interventions above the capacity of the health post are referred to the Patan Hospital or Anandaban Leprosy Hospital, depending upon the nature of the case. Before the establishment of Anandaban Leprosy Hospital in the mid-1990s, Patan Hospital was the only hospital attending service to the referral cases.

4.3.5 Administration and Management

a. Statutes and Regulations

The Insurance Scheme had a very general form of statutes and regulations for its internal management. The rules and regulations mainly focused on annual premium rates for the new households, the rates for those renewing their membership during and after 3 to 6 months' of the registration date, the rates applicable to the members coming from outside the target area, and the rate for those renewing their membership. All these rules and regulations are formed by the Health Post Committees.

b. Management Organization

The Local Health Committee is established to manage the scheme smoothly. In order to ensure this, the CDHP staff also undertake a significant portion of the managerial duties. The responsibilities specified for the HP Committee members are as follows:

- to establish rules and regulations for the scheme;
- to supervise and support health post staff;
- to handle fee collection measures and management of funds;

- to market the programme and establish good public relations;
- to provide charity services to the genuinely poor (i.e., the *Poorest of the Poor*).

Each health post has employed a *Mukhiya*. The Mukhiya is generally a local person selected by the CDHP and employed to work as a regular staff member of the HMG/MOH Health Post. The Health Post In-charge (HPI) and Mukhiya are responsible persons for day-to-day management of the health post.

The Health Committee members are selected from the local inhabitants in consultation with the VDC members. However, in some places, they are selected through an electoral process (for example in Ashrang and Bhattedanda).

c. Information System

An Information System was developed during the launching of the microinsurance system. Table 7 describes the documents introduced to manage information of the scheme during its first year of operation.

Table 7: Documents Used for the Information System During the First Year of Operation

Documents	Yes / No
Members' register	Yes
Membership card	Yes
Contribution register	Yes
Benefits monitor register	No
Accounting documents	Yes

Source: LMIS, 2000

The following tools were utilized to produce information:

Table 8: Information Tools utilized by the Scheme During the First Year of Operation

Documents	Yes / No
Accounting system	Yes
Budget	Yes
Treasury plan	No
Balance sheet	Yes

Source: LMIS, 2000

4.4 Technical Assistance and Training

The scheme is technically supported by the UMN-CDHP. Training and orientation programmes were carried out covering basic implementation norms to be followed, records to be maintained, bookkeeping arrangements to be made, financial records to be maintained, inventory control system to be organized and general management. The training and orientation programmes also covered the norms to be followed for collection and spending of contributions. Some sessions were also organized to inform the villagers about the importance of the health insurance scheme and possible benefits available for their access.

Depending upon the skill improvement needs demonstrated by the staff, CHDP occasionally organized the training programmes. The duration of training ranged from one to five days. Together with the training of its technical staff, CHDP also tried to improve awareness of the community members on preventive health measures. The Local Health Committee members were provided with training on the operation and management of the Insurance Scheme and the proper maintaining of accounting books.

V. INSURANCE SYSTEM CHARACTERISTICS

5.1 Target Group and the Beneficiaries

5.1.1 Target Group

All community people of the Lalitpur District, particularly under-five-children, and women in their reproductive age group (15-45), are target groups of the scheme. The majority of them are living in the rural areas and, comparatively, have low access to health care centres, social services and other infrastructure developments. These people live in a subsistence economy with very limited cash on hand. Currently, the number of member households of the target area covered by the Insurance Scheme, is around 4,240 with an average of 5 persons in each family.

5.1.2 Beneficiary Categories

The beneficiaries of the scheme are mainly categorized into two groups, which are:

- members from the target areas; and
- members from the non-target areas.

The membership to the insurance scheme is by choice and not by force. To obtain membership, people are required to pay a pre-defined contribution to the scheme. In return, they receive health services including essential medicines free of charge. Non-members can also derive services from the scheme by paying required fees.

Household members are classified into two categories: (a) family members with general health condition, and (b) family members having someone with a chronic mental problem. The households falling under the second category are required to pay extra premium as the mentally ill person would be on long-term medicines.

The decision of applying two categories of beneficiaries was taken up by the CDHP only after approximately 10 years of operation. Before this, all types of members were provided with free drugs. However, with their decreased budget, the CDHP programme had to finally discontinue paying for the drugs to all members. In an attempt to continue this highly successful programme, the decision was made to charge families, who included a mentally ill person (who would be on long term medicines), with an extra premium. Despite this, the programme still brings about a great savings benefit to the families enrolled.

The process of registration of a member household has remained more or less the same for the last 25 years. The family membership covers all relatives living under the same roof. A person who is not the relative of the family is not counted as a potential beneficiary. After registration, an insurance card with the registration number is provided to each member, which entitles him/her to access free medical services for any unlimited number of visits to the health post in the year specified.

The insurance card is equally useful for visits to the Patan Hospital for accessing the health services when accompanied by a referral sheet. At the beginning, no restriction was imposed on receiving the membership status. All members were treated equally without the segregation of any individual. However, at present, the membership premium is influenced by several factors, such as place of residence, health risk and by the family size.

5.1.3 Number of Beneficiaries and their Evolution

For the first 4 – 5 years, there was an initial increase in the coverage of household membership. The pattern since then has been fluctuating. During the early years of scheme implementation, there was a rise in the number of membership, which started declining after some years except in Ashrang, where it has increased dramatically (Table 9).

Table 9: Percentage of Household Members Covered by the Insurance Scheme

Year	Ashrang	Bhattedanda	Chapagaon	Chaughare	Gotikhel
1983	20%	-	19%	19%	-
1988	43%	28%	13%	34%	-
1992	52%	44%	21%	29%	47%
1993	43%	45%	28%	28%	60%
1994	48%	48%	31%	27%	65%
1995	41%	41%	36%	27%	48%
1996	47%	48%	33%	32%	NA
1997	41%	55%	30%	NA	NA
1998	39%	50%	21%	NA	NA
1999	48%	44%	19%	NA	NA

Source:
(a) CDHP Hand Notes, 1999.
(b) J. W. Richard Harding, Lalitpur Medical Insurance Scheme: A Status Report After Twenty-Four Years, CDHP/UMN, February 2000.

Note: Data after handover of the Gotikhel and Chaughare Health Posts in 1995 and 1996 is not available.

5.1.4 Reasons for Losing Membership

Some reasons for the decrease in coverage in the recent years were as follows:

- coverage limited to minimal package services only (See Section 4.3.2 for services included into the minimal package);
- insufficient marketing of services;
- availability of growing private sector health services.

The decline of membership is caused by several factors such as the failure of timely payment of contributions by some members, less interest in membership because of the availability of competing services offered by the private sector, and seasonal migration of family members for work outside the village.

5.1.5 Target Group Penetration Status

Continuous efforts have been made to increase the enrolment of members. Activities undertaken in this regard are as follows:

- dissemination of scheme activities and benefits through the printed booklets;
- commitment to charity service for the poorest people.

Information on the penetration rate of membership is not available for all health posts. The new membership and renewal data of the Ashrang Health Post revealed that 182 households continued their membership in 1999/2000, while the number of households joining the scheme was 19. This indicates a penetration rate of 10.4 percent (calculated on the basis of difference between the new and renewed members). Similarly, for the Chapagaon Health Post, the rate of penetration is 96.5 percent as 172 households renewed their membership, while 166 people have taken on a new membership.

5.2 Benefits and Other Services Offered by the Insurance Scheme

5.2.1 Health Services Covered

The health care services provided by the scheme are extended according to the Primary Health Care (PHC) guidelines. The choice of services covered was made on the basis of available services at hand, skilled manpower and major needs of the beneficiaries.

The Health Committee members were given opportunity to make decisions about the possible access to services in consultation with the CDHP staff. The major health services covered at present are described in Table 10 below:

Table 10: Major Health Services Being Covered by the Insurance Scheme

Services	**Persons Covered** (M = members only; B =other beneficiaries)	**Co-payment** (Percent of the service price paid by the beneficiaries)	**Maximum Coverage Limits** (amount or duration of hospitalization)	**Referrals required from the Health Post**
High–risk obstetrical interventions	M+B	Free of charge for Member	100 %	Yes
Medical hospitalization	M	Free of charge for those who are very poor (37%), while others pay (See Table - 12)	Rs.200.- ($ 2.66) subsidized for admission	Yes
Medicines	M+B	Free of charge for M and full payment for B	100 %	Yes
Laboratory test for TB/Malaria	M	Free of charge	100%	Yes
Immunization	M+B	Free of charge	100 %	No
Oral health Clinic	M+B	Registration Fee	100 %	No
Family Planning	M+B	Free of charge	100 %	No
Nutrition Programme	M+B	Free of charge	100 %	No
Maternal and child health clinic	M+B	Registration fee	100 %	No

Source: LMIS Annual Report, 1999

- the members (M) receive different services either free of charge or at a subsidized rates, depending upon the nature of the service accessed;
- the other beneficiaries (B) are required to pay the full amount for accessing the health service;
- the benefit package is fixed and members cannot make a choice for other categories (see Section 4.3.2 for services included into the package). The members are informed about such limited coverage through the health post, group meetings, counselling and printed leaflets.

The number of beneficiaries accessing some services covered by the scheme in the recent past is presented in Table 11, below.

Table 11: Services Accessed by the Beneficiaries in 1998/1999

Services	Number of Beneficiaries	
	1998	1999
Antenatal care	2,359	2,170
Under five child health clinic services	5,055	4,618
Oral health clinic services	NA	662
Mental health clinic services	NA	88
Tuberculosis control programme	NA	210

Source: Health Insurance Report, 1999

Over the years, some changes were introduced in the nature of services provided. For example, oral and mental health clinic services, tuberculosis control services, newer family planning methods are the new interventions included in the benefit categories. The members have had very little awareness of what services exist and what new services are needed. Therefore, the new services were not initiated at the request of the target groups.

5.2.2 Payment of Benefits

The health care provider, Community Development and Health Project (CDHP), is paid the amount of contributions and registration fees in cash directly. Other forms of payment, reimbursement system and billing systems are not applicable because the scheme is carried out by CDHP itself as a health care provider as well as promoter of the scheme.

5.2.3 Other Services Provided for the Members

a. Referral Health Services

In the early years of the scheme, the patients were referred to the Shantabhawan Hospital of UMN, which was a private mission hospital serving the Lalitpur district. From 1982, with the establishment of Patan Hospital, the Shantabhawan Hospital was closed and the services being extended by Shantabhawan Hospital were transferred to Patan. Furthermore, the general clinic and general bed section of the Anandaban Leprosy Hospital started extending referral services after it was establishment.

The "Service Provider" partnership of the Community Development and Health Project with the Patan Hospital and Anandaban Leprosy Hospital has been useful for many patients referred by the health posts. The number referred from the health posts over the past several years is given in Table 12. Of the total patients referred, a high percentage of them have insurance. Around 20 percent of them required admission at the hospital and between 5 – 21 percent of the admitted patients have received charity because of their poor condition (Harding, 2000).

Table 12 Number of Patients Referred from the Health Posts to Patan Hospital

Year	No. of Patients Referred	No. of Patients Attended	No. of Patients Admitted	No. of Patients Receiving Charity
1984-1985	-	- (96%)	- (13%)	-
1988-1989	471 (1.9%)	470 (100%)	97 (21%)	97 (21%)
1989-1990	312 (1.0%)	311 (100%)	31 (10%)	-
1991-1992	643 (2.6%)	563 (88%)	107 (19%)	21 (20%)
1992-1993	507 (2.1%)	440 (87%)	86 (20%)	13 (15%)
1993-1994	519 (1.9%)	481 (93%)	92 (19%)	16 (17%)
1994-1995	462 (1.5%)	462 (98%)	94 (20%)	17 (18%)
1995-1996	499 (2.3%)	482 (97%)	98 (20%)	56 (12%)
1996-19973	409 (1.4%)	400 (98%)	199 (30%)	20 (5%)

Source: J. W. Richard Harding, Lalitpur Medical Insurance Scheme: A Status Report After Twenty Years, CDHP/UMN, April 1997.

b. Health Supply

The Insurance Scheme caters to the beneficiaries from the health post by way of general medical check up, dressing, antenatal care, family planning, maternal and child health clinic, medical consultation, mental health, oral health and supply of essential medicines and immunization. Coverage depends on the availability of health services at hand, availability of personnel and primary needs of the beneficiaries. These services have been continuously made available to both members and non-members in the community on "equal attention basis; i.e. all people in the community are treated on equal priority basis for their access to health services.

c. Prevention and Health Education

The Insurance System has initiated some preventive health education activities at the community level, which includes a sanitary scheme, immunization, nutrition programme, family

[3] In 1999, of the 181 patients who were referred, 42 were admitted, 90 were treated, and 49 received charity (27% of the cases). This implies that in 1999, almost 1/3 of those who were admitted received complete charity (Harding, 2001).

planning and maternal and child health care. The health education and awareness activities have been useful to increase awareness and ownership on the services offered by the health post.

d. Other Services

The environmental sanitation programme involved 55 percent of the total community members in the construction of toilets. About 70 percent of the people have access to safe drinking water. On the outset in 1972, not even 10 percent people had such access. This indicates that the Insurance Scheme interventions have made a good impact on people's health.

5.3 Financial Aspects of the Insurance System's Operation

5.3.1 Sources of Finance

a. Premiums paid by members

The membership fee is one of the major sources for financing the Microinsurance System. The scheme members are required to pay their premiums regularly. The rates vary according to the type of membership and payment schedule. For example, currently, the rates applied by the Chapagaon Medical Insurance Scheme are as follows:

- NRs. 100.- ($ 1.33) per family per year (general condition);
- NRs. 150 ($ 2.-) for the family per year (for members of chronic mental problem);

The premiums set by Ashrang Medical Insurance Scheme are different from the above:

- for a small family (1-7 members) = Rs.125.- ($ 1.66) per year;
- for a large family (7 and more members) = Rs.150.- ($ 2.-) per year;

For an overdue after 6 months of the registration period, extra charges are applied as follows:

- for a small family (1-7 members) = Rs.250.- ($ 3.33);
- for a large family (7 and more members) = Rs.300.- ($ 3.99);
- for the members from the non-target area = Rs.250. ($ 3.33).

At all of the health posts, no differences exist in the charges levied across the age, sex and income levels of the members. However, the rate may vary according to the personal health risk of the individual member. In this context, mental health is the only risk factor considered at present. For the non-members, the scheme charges on the basis of patient's health risk. For all patients, the paying of a registration fee during each visit to the health post is required.

The Health Post Committee members should be responsible for the collection and management of membership contribution. They also make decisions regarding the premium rates to be charged for the members and formalities to be fulfilled for renewal of the registration status and identifying families who should receive free membership.

Most contributions are paid in cash in a lump sum. From the poor families, the payments are accepted on instalments. The HP Committee provides discount to the members, who pay their contribution in advance or at the time of registration. Late payments made after 3 or 6 months of registration date are subject to penalty charges. Some beneficiaries are exempted from contribution against some services. Persons entitled for such services are the mothers in the age group 14-49 and under-5 children. The health post staff are authorized to decide such exemptions. The total number of beneficiary children accessing exemption privilege in the year 1999 is presented in Table 13 below.

Table 13: Under Five Children and Women Accessing Exemption Privilege in 1999

Health Post	Under-5 Children		Women in the Age Group of 14-49 years	
	No. Treated	No. Covered by the Nutrition Programs	Antenatal care	FP program
Chapagaon	2,281	1,269	2,084	1,746
Ashrang	695	641	275	470

Source: Nutrition Report 1999 and Antenatal and Family Planning Report, 1999

Preferred months for the payment of membership contribution are June-July, which coincides with few weeks of the off-agricultural season. However, the members are also allowed to pay their contributions at any due date throughout the year according to their respective membership dates. The contribution rates are reviewed on yearly basis. Such review is justified on the grounds of increased requirement of funds for the medical services, increased management cost of the health post and the need for enhancing sustainability of the scheme as a whole. The Health Post Committee decides the rate of revision.

Members are maintained by renewing their membership card. The card also serves the purpose of acknowledgement of the contributions received.

All members are recorded into a contribution register. For the timely payments of contributions, they are occasionally reminded. Discounts are given for early payments. For the delays, extra amounts to the contribution rate are charged by imposing fines. The process of registering a member household has remained more or less the same for the last 25 years.

b. Service Charge and Social Capital Shares

All beneficiaries (members and non-members) are required to pay registration fee for acquiring health services. The members do not need to pay other charges. However, in the case of non-

member beneficiaries, the service charge should be paid on the basis of their personal health risks. The service charges range from Rs.25.- to Rs.150.-. Table 14 describes the different kinds of services charged, levied to the beneficiaries.

Table 14: Types of Service Charge Levied to the Beneficiaries

Beneficiaries	Types of Charge	Amount	When paid
Members	Registration fee	Rs.5.- ($ 0.07) per visit	At the time of visit
Non-members	Registration fee	Rs.5.- ($ 0.07) per visit	At the time of visit
	Service charge	Rs.25.- ($ 0.33) Rs.150.- ($ 2.-) per visit	At the time of visit

Source: CDHP / LMIS Hand Notes

c. Financial Contribution of the State and Local Collectives

The amounts of drug subsidy allotments made by His Majesty's Government of Nepal and the Community Development and Health Project over the past several years are presented in Table 15.

Table 15: Average Amount of Drug Subsidies Allotted by the HMG/N and CDHP for Each Health Post (In Rs.)

Year	HMG/N	CDHP
1977-1982	6,500.-	8,000.-
1983-1984	8,500.-	8,500.-
1986-1987	12,000.-	12,500.-
1988-1990	-	15,000.-
1990-1991	-	25,000.-
1993-1994	16,206.-	25,000.-
1994-1995	14,443.-	25,000.-
1995-1996	25,000.-	20,000.-
1996-1997	36,000.-	15,000.-
1997-1998	18,500.-	10,000.-
1998-1999	24,000.-	-

Source: J. W. Richard Harding, Lalitpur Medical Insurance Scheme: A Status Report After Twenty-Four Years, CDHP/UMN, February 2000.

Note: 10 percent deducted for handling charge up to 1986-1987.

Each health post is expected to receive an annual drug supply from the Government at the beginning of each year. However, the supply has been irregular for some years. For example, from 1988-1989 to 1990-1991 and also in 1992-1993, no drug subsidy was made available by the Government.

From the beginning of the functioning of the LMIS, the Community Development and Health Project made yearly contributions toward the scheme. In 1994, a new agreement was signed between CDHP/UMN and the Ministry of Health, which assured continued partial funding from His Majesty's Government of Nepal for a gradual reduction of CDHP's annual contribution till it reached the stage of "no subsidy" by 1999.

The Health Post Pharmacy has an inventory list showing maximal and minimal stock levels for each essential drug. An inventory showing the balance of each drug is prepared by the Health Post In-charge along with the assistance of Health Post Management Committee volunteers. Drugs which have reached the minimal level, are put on a refilling request list to the CDHP Office located at Patan Hospital. Upon receipt of the request, the Central Medical Supply Store and Pharmacy supplies the drugs. The total value of the sent drugs is debited to the Microinsurance Scheme Account of the health post. To this, the annual cash drug subsidy provided by the HMG/N and CDHP/UMN is credited.

d. Donation and Subsidies from Other Sources

The scheme has not received any donations.

e. Loans and Credit

The scheme has not taken any loans.

f. Transfer Funds from the IS' Parent Company

(Not Applicable)

5.3.2 Costs

Payment of salaries to the staff, regular management costs of the health post and supply of medicines are the major areas of investment. Salary and the cost of medicines occupy major share in the total investment costs. Annual investment for the operation and the management of the scheme has increased in recent years.

Table 16: Total Operation and Management Cost in the Past Three Years*

Year	Cost (In Rupees / US Dollars)
1997	Rs. 1,675,550.- ($ 22,310.92)
1998	Rs. 1,828,376.- ($ 24,345.89)
1999	Rs. 2,080,199.- ($ 27,699.05)

* The items of expenditure include staff salaries, medicine equipment, training and orientations.

Source: Health Post Finance Report, 2000

The breakdown of cost by items of expenditure was not available. However, the discussion revealed that the management costs of the scheme were higher than the operation costs consumed by the medicines, training and orientations.

5.3.3 Allocation of Surpluses

The Microinsurance Scheme is a non-profit making activity implemented by a non-governmental organization. Over the years, it has accumulated some surpluses in the savings account of the different health posts (Table 17). Part of the surplus amount is transferred to a fixed account to be used as a surplus fund. This account earned 7-9 percent interest per annum.

Table 17: Surplus Generated in Ashrang and Chapagaon Health Posts in 1999 In Nepalese Rupees / US Dollars

Health Post	Registration Fee and Member's Beneficiaries Contribution	Medical Expenses	Total Recovery from MI	Surplus Left
Chapagaon	Rs. 99,051.- ($ 1,318.92)	Rs. 96,931.- ($ 1,290.69)	Rs. 48,825.- ($ 650.27)	Rs. 2,120.- ($ 28.23)
Ashrang	Rs. 154,166.- ($ 2,052.81)	Rs. 127,567.- ($ 1,698.83)	Rs. 90,500.- ($ 1,205.06)	Rs. 26,599.- ($ 354.18)
Total	Rs. 253,217.- ($ 3,371.73)	Rs. 224,498.- ($ 2,989.32)	Rs. 133,325.- ($ 1,775.30)	Rs. 28,719.- ($ 382.41)

Source: Health Post Finance Report.

Note: Salary payment for the staff is made from other sources. 2000

The surplus accumulation of Chapagaon and Ashrang Health Posts in the last five years remained as follows:

Table 18: Total Surplus Gained in the Last Five Years

Health Post	Surplus Amount (In Nepalese Rupees / US Dollars)
Chapagaon	Rs. 300,000.- ($ 3,394.67)
Ashrang	Rs. 250,000.- ($ 3,328.89)
Total	Rs. 550,000.- ($ 7,323.57)

Source: Health Post Finance Report, 2000

5.3.4 Reserve Funds

The Chapagaon and Ashrang Health Posts have some surplus funds, which are sufficient to cover operation and management cost for more than a year. These surpluses are deposited in the Agriculture Development Bank, earning an interest of 6 percent per annum. The Chapagaon Health Post has a surplus fund of around Rs. 600,000.- ($ 7,989.35), while Ashrang has Rs. 300,000.- ($ 3,394.67).

5.4 Health Care Providers

5.4.1 Health Care Providers Linked to the Insurance System

As described in the earlier chapter, Patan Hospital (operated by UMN) and Anandaban Leprosy Hospital are the two cooperating health care providers with CDHP, who are attending to the referral cases.

Information between the health posts and health care providers and also among the members and other beneficiaries is exchanged during the group meetings and also through the scheme leaflets. The health posts have been regularly supplying medicines. Furthermore, they have been effective in raising the people's awareness of their health issues and rights. The health care providers authorized by the United Mission in Nepal at the community level are presented in Table 19. The health care providers were, and are, salaried by CDHP.

Table 19: Authorised Health Care Providers at the Community Level

Name of the Health Care Providers	Location	Type of the Organization	Level of Service	Types of Service Offered
Patan Hospital	Lagankhel, Lalitpur	Non-profit making	Hospital	Curative
Anandaban Leprosy Hospital	Anandaban	Non-profit making	Hospital	Curative
Ashrang Health Post	Ashrang, Lalitpur	Non-profit making	Health Post	Preventive/ Curative
Chapagaon Health Post	Chapagaon, Lalitpur	Non-profit making	Health Post	Preventive/ Curative
Bhattedanda Health Post	Bhattedanda, Lalitpur	Non-profit making	Health Post	Preventive/ Curative
Gotikhel Health Post	Gotikhel, Lalitpur	Non-profit making	Health Post	Preventive/ Curative

Source: CDHP / LMIS Hand Notes, 1999

From their date of establishment, the health care providers have been extending health services and medicines to the beneficiaries. In serving the beneficiaries, these institutions follow the hospital / health post rules and regulations.

The referred members of Patan Hospital receive health services on a subsidized rate or free of charge, depending upon the nature of the problem encountered. For example, Patan Hospital provides free of charge medical facilities to the high-risk pregnant women, if referred from the health post. Similarly, the Patan Hospital also follows a practice of providing subsidy on the hospital admission fee up to Rs.200.-, equivalent to $ 2.70. The outpatients coming with the referral slip of the health post receive a deduction of Rs.30.-, equivalent to $ 0.40.

Since the Insurance Scheme is an undertaking of the health care provider itself, any formal agreement has not been made about the coverage of benefits, subsidies and priorities for the risks to be covered. However, the health care providers and beneficiaries both have a common understanding about their focus to lower the health risk of the scheme members.

Besides the health posts promoted by the Insurance Scheme, the targeted areas are also served by some private medical shops/ pharmacies, allopathic doctors, homeopathic doctors and traditional healers. Depending upon their need and affordability, people in the targeted area access these services, if not from the health post, Patan Hospital and Anandaban Leprosy Hospital.

5.4.2 Relationship between the Health Care Providers and Insurance Scheme

Since the health care providers and the Insurance Scheme are the components of the same organization, no formal contract document was signed between them. However, common understanding is maintained through meetings between the Community Development Health Programme (CDHP) and the Local Health Committees, as and when necessary. The health post has developed a constitution stating its major roles and responsibilities. The rules and regulations are set up for the internal management of the scheme, particularly, with respect to the collection of contributions and allocation of expenditures.

The Patan Hospital has been providing health services to the referred members with a provision of discount of up to Rs.200.- on the hospital admission charge. There was no instance of withdrawal of any agreement from the health care provider. Throughout the scheme years, the rights and mutually agreed upon privilege of the members have been, and are, respected.

The Insurance Scheme occasionally gathers opinion of the beneficiaries through meetings and surveys. These interactions attempt to collect information on the satisfaction of members towards the quality of health services including complaints about the coverage of benefits and premiums, if any. Feedback is obtained on the programme activities in general. Members are also given the opportunity to suggest possibilities of enhancing effectiveness of the medical programme management.

5.4.3 Payment of the Health Care Provider (CDHP)

The health care provider (CDHP) raises the revenue from the premiums paid directly. Up until the past few years, CDHP also annually contributed to the funds of each health post scheme. From 1996, it gradually reduced this input. No other payments are made available.

5.5 The Insurance System's Administration and Management

5.5.1 Statutes and Regulations

The Insurance Scheme is not legally registered with a separate identity. However, it has framed internal rules and regulations to systematize its functions. A written agreement is made between the CDHP and Local Health Committees to make these internal rules consistent during operation and management of the scheme activities. The rules primarily focus on the annual premium rates, their increase or decrease, their collection and management, methods of payment, registration process, charity services, benefit coverage and service charges to be applied for the non-members.

5.5.2 Management of the Organization

Initially, CDHP staff were fully responsible for managing the Insurance Scheme activities. Later on, the management and operation responsibilities were gradually handed over to the Local Health Committees in 1995 and 1996. For example, in Chaughare, Bungmati, Gotikhel and Bhattedanda, the health post management responsibilities were handed over to the community with a gradual reduction of support from CDHP. For the management of insurance systems, the

CDHP has still a major role to play in providing technical assistance. It has been providing training and orientation as needed. Indeed, the CDHP has an important role in the regular supply of medicines to the health posts and in payment of salary for the health post staff.

There is no different management system for the health care provider and the insurance system as it is a creation of the former. Though different agents are involved in the management of the system, they are mutually linked.

The accounts for the insurance system and health care provider are managed separately. The registration fee, service charge and medical expenses are managed under the health post accounts directly. The membership contributions, fine for the late payment of contributions and sale of insurance card are deposited to the Insurance Scheme account.

Three salaried and 27 volunteers are involved in the management and operation of the scheme. Their major roles are described in Table 20 below:

Table 20: Salaried Staff and Volunteers Employed by the Insurance Scheme

Position	Salaried Staff	Volunteer	Major Responsibility
Mukhiya	2	-	Record keeping, account updating
Business officer	5*	-	Bank account management
HC members	-	27	Regular supervision and monitoring

** Out of the 5 officers employed in the central business office, only one person is involved in the LMIS. The cost equivalent to one officer's salary is borne from the CDHP account.*

Source: CDHP / LMIS Hand Notes, 1999

Basic educational background of Mukhiya is fixed at 8 class. The volunteers are rather recruited on the basis of their commitment and spirit of voluntarism than on just their educational background. Volunteers who are working for the scheme are not paid any allowance or compensation except for the refreshments provided during the time of work.

5.5.3 Extent of Democratic and Cooperative Character of the Management System

During the time of their membership, all the new members are informed about their rights and obligations in relation to the scheme activities. They are made aware of the benefit coverage and types of services to be received against contributions.

The new members do not have opportunity to select the services covered and cannot partake in defining the contribution methods. Similarly, they cannot choose the health care provider, as the package is applicable to all members equally. As of yet, they are not involved in evaluating the

operation of the Insurance Scheme.. However, they are occasionally consulted for premium rates to be charged, payment methods (lump sum or instalment), service coverage and strategy to increase enrolments into the scheme. They are also provided with opportunities for sharing views on the management and operation of the scheme and factors leading to sustainability.

5.5.4 Financial Management

CDHP's business office authorizes the current financial expenses. The Health Post Committee has maintained its own bank account for the deposit of registration fees and premiums. When the balance of the Insurance Scheme accounts fall to almost zero, the Health Committee is required to transfer money from its savings account. The proportion of cash transactions is small. Petty cash is handled by the Mukhiya.

5.5.5 Information System and Management Tools

The Central Office of the Insurance Scheme is located in the CDHP Central Office in Patan Hospital. Ashrang and Chapagaon Medical Insurance Schemes are two branch offices under the ownership of CDHP. Ashrang Medical Insurance Scheme covers other two additional VDCs, namely, Gimdi and Pyutar, and it is managed by 10 staff (including volunteers). Similarly, Chapagaon Medical Insurance Scheme covers two other VDCs, namely – Dukuchap and Ghusel. A total of 10 staff members (including volunteers) look after the regular operation of health post activities.

a. Accounting Framework

The accounting system followed is very simple. Accounts are updated in the form of total income and expenditure. In some health posts, the accounting system still needs to be standardized.

The accounts are updated both at the health post and Insurance Scheme levels separately. Mukhiya is responsible for updating work. A person who is educated to at least 8th grade or above is appointed to the post of Mukhiya (accountant). The appointment is made by the Community Development and Health Project.

The CDHP staff provides necessary technical assistance to manage the accounting standard. They occasionally organize training and orientation programmes for the health post staff, to enhance accounts keeping knowledge of the latter.

b. Information about Members, Contributions and Benefits

The Insurance Scheme has the system of updating information about the members, contributions and benefits every year. The documents maintained in this regard are illustrated in Table 21 below:

Table 21: Records Maintained and Their Updating Practices

Records	Updating Frequency
Membership register	Daily
Membership card	Daily
Contribution register	Monthly
Benefit register	Monthly
Other documents used to monitor progress (e.g., Bank account slip)	Monthly

Source: CDHP / LMIS, 2000

c. Management Tools

The Insurance Scheme has introduced some tools for its management system. The tools brought into its regular practice are illustrated in Table 22.

Table 22: Management Tools in Regular Practice

Management Tools	**Yes or No**
Budget	Yes
Income/ expenditure statement	Yes
Balance sheet	Yes
Operation indicators	Yes
Financial management tools (Cost accounting of service provided to each member)	No

Source: CDHP / LMIS, 2000

Budget, income and expenditure statement and balance sheet are the primary tools followed for the management of the scheme. Other management tools such as financial cost accounting are still to be brought into practice. Every year a budget, including tentative plans for the annual expenditure, is prepared.

The day-to-day transactions generate various types of information.

Different lengths of time fixed for their updates were as follows:

Table 23: Length of Time Required to Update Different Types of Information

Information Areas	Time Required (in days)
Treasury condition	30 days
Benefit provided	30 days
Contributions paid	30 days
Financial investment position	30 days
New, renewed and terminated members	365 days
Management cost	Information not available at present

Source: LMIS, 2000

An annual progress report is prepared with highlights of major achievements, reasons for success/failure of specific activities, beneficiary participation rate, total income and expenditures, total contributions received from the members, total medical expenses, benefits paid and total number of cases referred.

d. Formalized Management Procedures

Forms used to formalize the management procedures are as follows:

- Membership request form
- Referral sheet
- Benefit payment form
- Monthly progress report form
- Membership card
- Contract document

5.5.6 Control Functions

Methods followed for internal control of the Insurance Scheme are presented in Table 24:

Table 24: Methods Followed for Internal Control of the Insurance Scheme

Areas of Control	How is it done?	How Often?
Petty cash control	Mukhiya is responsible for handling the petty cash. He/she receives petty cash and records in the accounts register daily. At the end of each month, the remaining amount is deposited to the health post bank account.	Monthly
Accounting system	Mukhiya and the business officer together control the accounting system. The HPC members regularly supervise and monitor the accounting system.	Daily
Beneficiary status	The Health Post Committee representative oversee the beneficiary status. He/she records each member's/beneficiary's visit, his/her health problems and types of services offered.	Daily
Rights to benefit	The HP committee members observe the services accessed by beneficiaries' (including the referral services accessed through Patan Hospital) through occasional interactions.	Daily
Payment of contributions	Mukhiya handles membership contribution payments. He/she records all amounts received in the contribution register and also keeps the record of new members' entry and membership renewals.	Annually
Membership renewals	Mukhiya renews the membership card during June and July every year.	Annually
Medical treatment	The health post staff, who is responsible for the day-to-day operation of the health post, provides the medical treatment facilities. Also, the visits of medical consultant (doctor) help in extending the medical services.	Weekly
Registration fee and service charge	Mukhiya working at the health post records the registration fee and service charges for the non-members. He/she also deals with the HP Committee bank account transactions.	Daily

Source: CDHP / LMIS, 2000.

5.5.7 Role Distribution

Different actors (salaried and volunteers) have different roles in the management and operation of the scheme. Their roles are determined on the basis of their competence in relation to the

nature of work to be accomplished. The Health Committee fixes the role under the guidelines of the CDHP staff. Some roles being adopted by the major actors are illustrated in Table 25 below.

Table 25: Major Actors and Their Respective Roles in the Scheme Operation

Actors	Roles Being Played
a. Insurance Scheme Organs:	
1. General Assembly	Review progress and suggest improvements, as necessary.
2. Council	Health Committee is acting as a council for the Insurance Scheme. Their role is to determine the responsibilities of the different actors, registration fee and service charges, contribution rates, and supervision and monitoring of scheme related activities. It also negotiates with the governmental and non-governmental organizations for cooperation, as necessary.
b. Agent	Not applicable
c. Salaried Staff	Mukhiya and Business office staff are the salaried staff of the Insurance Scheme. They are entrusted with the role for day to day administration, petty cash control, accounts keeping, membership registration, collection of contributions and membership renewal.
d. Health Care Provider (CDHP)	Major role of the health care provider is to extend services to the beneficiaries free of charge and in a subsidized rate, depending upon the nature of the case. It also provides support for regular supply of medicines and technical assistance to the insurance system.
e. External Health Care Staff (e.g., Accountant)	The Accountant from the central UMN/CDHP provides training to Mukhiya and HPC members on methods of proper accounts keeping.
f. Auditor	The Auditor is an external person (health care staff) assigned with the responsibility of carrying out auditing of yearly expenditures.
g. CDHP Staff	The main role of CDHP staff is to provide technical assistance to the scheme and introduce new services to the beneficiaries, whenever opportunity exists.
h. Volunteers	The volunteers provide support for proper operation of the scheme activities. They also make effort to increase enrolment of the community people into the scheme.
i. District Health Office (DHO) and other Governmental Organization	Their major role is to support regular supply of medicines and provide financial assistance to the health posts.

j. Beneficiaries	The responsibilities of the beneficiaries are to provide voluntary support and time for effective management of the health post.

Source: CDHP / LMIS, 2000.

In the early stages, CDHP staff took sole responsibility for the managing of the Insurance Scheme, including the daily operation of the health post. In 1995 and 1996, the management responsibility was handed over to the Health Post Committee by reducing direct support from the CDHP/UMN. In order to sustain the scheme, the staff were provided training and orientation for skills improvement. For example, the Mukhiya was given training by CDHP on internal accounts keeping and management. The purpose of the training was to increase skills on accounts keeping and handling petty cash in the community, to enhance durability of the scheme's management. The total duration of the training was 5 days.

5.5.8 Equipment and Infrastructure

Equipment for basic health facilities are available at each health post. The Insurance Scheme has applied a computerized system with two desktop computers for record keeping. E-mail and Internet facilities have yet to be established.

Communication with the Chapagaon Teaching Health Post is made through telephone; with the Ashrang branch, mail is sent twice a week by the CDHP mail-runner, due to the absence of a telephone connection. In Chapagaon, equipment such as vehicles, motorbikes and photocopy machine facilities are available.

5.6 Actors in Relation to the Insurance System

5.6.1 Reinsurance and Guarantee Fund Systems

The Insurance Scheme has made no provision for any other reinsurance or guarantee fund scheme.

5.6.2 Technical Assistance

The Insurance Scheme has made use of competence of the UMN / CDHP technical staff internally. The discussion revealed that most of the requirements of the Insurance Scheme are manageable within UMN / CDHP's internal capacity. As a result of this, external assistance on technical matters was not necessary.

5.6.3 Social Movements and Social Economy Organizations

The Insurance Scheme has not followed any formal arrangement to link its activities with social movements and social economy organizations. However, in principle, it is open to cooperation

with any organization, provided that the scope falls within the framework of its work and capacity.

5.6.4 Other Actors

Observations mentioned under the section 5.6.3 applies to this case also.

VI. THE INDICATORS OF THE INSURANCE SYSTEM'S OPERATION

6.1 The Membership Dynamics

The population of the members is estimated at 23,434 persons, comprising of 51 percent male and 49 percent female. The number of households covered in the non-targeted area was around 350 in the year 1999. This number remained constant in the year 2000. As discussed under the section 5.1.5, new members penetration rate varied across the health posts. The number of beneficiaries per member household is 5 persons.

6.2 Use of the Services

The Insurance Scheme has covered 845 households, out of the total of 3,393 households in the target area. The drug cost per patient per visit varies across the health posts ranging from Rs. 3.35 as the lowest rate to Rs. 17.26 as the highest rate (Re: Section 4.3.2, Table 5).

6.3 Financing Arrangements and the Financial Situation

As discussed in the section 5.3.3, the Insurance Scheme has been generating some surpluses every year. The accumulated surplus of two health posts at the end of 1999 was Rs. 550,000.- ($ 7,323.57). Information on the total amount of benefits provided to the beneficiaries and non-beneficiaries from different sources (health post and Patan Hospital) is not available, neither have the figures of the contribution recovery rates been worked out. Other information to be maintained by the Insurance Scheme are: budgeted contributions and expenditure ratio, management cost and budget expenditure ratio, ratio of benefits coverage by the surpluses, and the ratio between benefits and budgeted contributions.

6.4 Members' Participation in Management

The opportunity for participation in the management of the scheme is available to around 27 members (25 male and 2 female), who represent the health committees as volunteers. These committee members, along with other ordinary members, participate in the General Assembly meeting every year. The members are also occasionally consulted by the health care providers to present their views on different aspects of the Insurance Scheme operation,,as and when needed.

VII. THE ACTORS' POINT OF VIEW VIS-À-VIS THE INSURANCE SYSTEM

7.1 Evaluation Process

The beneficiaries' opinion about the operation of the insurance system is gathered through group meetings in the health post. Occasional surveys are also conducted for gathering in-depth information. Verbal suggestions are accounted as feedback in the evaluation process. The group meetings seek reactions on the coverage of benefits and premium rates. The meetings make an attempt to assess the quality and adequacy of the services. Field surveys were also conducted to understand the reasons people had for not renewing their membership. Occasional feedbacks are obtained about the ways in which the services extended could better meet the members' satisfaction. They are also pursued to suggest potential measures to be followed to attract new members to join the scheme.

Several studies have been carried out at different occasions; some of the studies were conducted with the purpose of evaluating the contributions of the CDHP Insurance Scheme:

- Donaldson, Dayle S. (1982), An Analysis of Health Insurance Schemes in the Lalitpur District, Nepal, (An UMN Paper).
- Donaldson, Dayle S. (1982), The Potential for Alternative Sources for Financing for Health Services in Nepal, USAID Report, Nepal.
- Harding, J. W. Richard (2000), Lalitpur Medical Insurance Scheme: A Status Report After Twenty Four Years, Community Development and Health Project (CDHP), Patan Hospital, Lalitpur, Nepal.
- Kabarole, Nyanooma (1993), Health Insurance Schemes in Lalitpur District of Nepal, Thesis Study, School of Community Health, Liverpool University, UK.
- Suomi Sakai (1985), Case Study of Health Insurance Schemes in the Lalitpur District, Nepal, Johns Hopkins University, USA.
- MoH (2000), Review of Lalitpur Health Insurance Scheme, A Study Prepared for the National Workshop on "Health Insurance Schemes" in 2000-01, Nepal Health Economics Association (NHEA), Kathmandu, Nepal.

7.2 The Insurance Scheme Managers' Points of View

7.2.1 Implementation of the Insurance Scheme

The officials felt that the acuteness of the health needs of the people, was one of the key reasons for success of the scheme. However, they also recognized the decline of membership in the recent years due to improved transport facilities in the recent years, which has led to the accessibility of people to private services in the urban areas of Patan and Kathmandu (this is particularly true for the people in the Chapagaon catchment area). The Insurance Scheme is

trying to motivate people for membership into the scheme by disseminating information regarding members' benefits and making plans to increase the level of clinical services available at the Chapagaon Teaching Health Post.

7.2.2 Membership Dynamics

Both member and non-member beneficiaries understand the contributions being made by the Insurance Scheme. Most members anticipate access to diverse services, when the need arises. To fulfil this interest, the Insurance Scheme needs to arrange additional resources. Since most members are not willing and able to afford higher premium costs, further expansion of services for the purpose of diversity seems to have limited scope.

7.2.3 Access to Health Services and the Relationship with Health Care Providers

The beneficiaries got local access to the health services, which was non-existent in the area before the establishment of the Insurance Scheme otherwise. Patients who used to tolerate their illness without treatment, some for quite a few days, have now been accessing the services in time. Though the scheme has not been able to cover all kinds of health risks for its members, some primary health care needs of the villagers have been met quite well. There are dropouts in the membership each year. The member, who has not renewed his/her membership by paying contributions must now pay for services.

Besides curative health services, the Insurance Scheme is also involved in preventive services. The health education programmes are occasionally conducted. This has helped most members and non-member beneficiaries to take preventive measures.

In principle, the CDHP / LMIS considers the importance of offering limited but good quality services. Accordingly, both the health posts and Patan Hospital are conscious about this matter. All patients (members and non-members) are treated with equal priority. Therefore, none of the potential beneficiaries have any problem of accessing the services.

7.2.4 Payment of the Contributions

There are no delays in the payment of contribution under normal conditions. Traditionally, the signing up period coincided with the post-harvest season. This time period has been effective for the payment of premiums, as this is the time when all families have access to cash earnings.

The non-payment problems result only: (a) because of a person's reluctance to renew the membership further; or (b) the extremely poor condition of the people, who have other priorities to meet and cannot pay a lump sum premium. For those who cannot pay a lump sum, the Insurance Scheme has allowed payment on instalment basis.

7.2.5 Determining Contributions and the Benefit Relationships

All persons accessing the health services pay an annual premium and visit fees (also called registration fee). The rates are significantly lower than the average out of pocket medical care

cost incurred per-capita at the national level (Harding, 2000). CDHP has made its mandate to extend affordable health care support to a larger number of excluded people, rather than immediate recovery of the costs.

7.2.6 Management of the Insurance Risk

The Insurance Scheme has followed an optimal support approach in the hope of sustaining the provision of health care services. As the services being extended through the scheme are dependent on the subsidized support of UMN / CDHP, the scheme is not free from the risk of cost explosion (against the challenge of recovering full cost from the beneficiaries). The existing level of the surplus fund has the capacity of covering only a few months' cost, if the need arises to do so. The scheme has been attempting to increase in the number of members to be served for wider coverage, which would also help to reduce the administrative costs of its spread over a wider base.

7.2.7 Handling of Fraud Cases

There were not many fraud cases encountered by the scheme. In the past, few occasions have occurred as some non-member patients approached the health post and / or Patan Hospital with a member's card. When the members were told not to lend their card to the non-members, this problem did not appear again.

7.2.8 Administration and Management

The Insurance Scheme is running informally without a legal registration status. All the units of the Insurance Scheme are following the rules and regulations as agreed upon. The members, who have gotten the opportunity to be represented in the health post committees, are satisfied with their involvement in the consultations.

7.2.9 Relationship with the State (federal, national, provincial) and Local Communities

The Insurance Scheme has good relations with the state organizations and people in the local communities. The Village Development Committees have demonstrated cooperative attitude towards the health services being provided. So far, the activities of the Insurance Scheme has not been interfered by any organization or people in the community.

7.2.10 General Operation

Since the Insurance Scheme was initiated by UMN / CDHP, it has no other parent company. The access of health care services provided to the unpriviledged villagers is one of the major contributions of the scheme. Despite this, the scheme has not yet been able to increase the overall number of its members in recent years, partly due to the availability of alternative private health care services for those who can afford them, and also because of the temporary migration for work in the semi-urban and urban market centres of Patan and Kathamandu. This has added challenges of both retaining and multiplying membership of the scheme.

7.3 The Beneficiaries' Points of View

While the present case study was prepared, a survey was being carried out by the Insurance Scheme with a view to understand the position of beneficiaries better. Prior to this survey, the beneficiaries were consulted during the committee meetings and general assembly. The information gathered from these sources, so far, revealed the success of the Insurance Scheme in bringing about positive results in the health status of beneficiaries, as compared to those who were not covered by the scheme.

The Insurance Scheme services are limited to the primary health care services. The beneficiaries are provided with opportunities to visit Nepal's best general hospitals for the referral cases, and this has been quite beneficial to them. However, there are still certain unmet demands of some members who want access to more services. The Insurance Scheme has to respond to these demands carefully, as there may not be a sizeable mass of members who can afford to buy all kinds of new services.

All members are familiar with the rules and regulations of the Insurance Scheme. The rules were purposely made transparent and simple for the members to understand.

The Insurance Scheme has brought the community people together for a common cause of accessing health care services. This has enhanced their interaction on health related issues. Besides the direct health care services accessed by them, the knowledge gained about health related issues has become a valuable asset to them. In general, the quality of care has improved for the community.

7.4 The Health Care Providers' Points of View

Since the Insurance Scheme is implemented by the CDHP as a health care provider itself, the observations made under the Section 7.2 are applicable for this section too.

7.5 Other Stakeholders' Points of View

The local authorities have no grievances against the activities being carried out by the Insurance Scheme. They appreciated the fact the operation of the Insurance Scheme in their locality has helped many people who could not have access to health care services otherwise. The VDC officials have always remained supportive to the requests made by the health posts and vice versa.

VIII. CONCLUSION

The Lalitpur Medical Insurance Scheme, now with twenty five years of in the field experience, has proved to be acceptable, sustainable and manageable. It is an example of a local scheme, which depends on community involvement and on a well run and supervised primary health care provider, the CDHP, that has been willing and able to allow the system to be accepted and grow slowly over the years. It is one method of cost recovery for health posts, with full participation of locally autonomous health committees.

Over the years, the LMIS has demonstrated to spread out the cost of medical care to promote equal opportunity for a wide range of the communities it serves.People who did not have access to health care services before have benefited from the LMIS. The beneficiaries have realized the importance of services offered from the health posts and referral units of the Patan Hospital. It has improved sanitary conditions in the community. Timely interventions for preventive, informative and curative programmes are other contributions of the Insurance Scheme. All these activities have created a good impact on the health status of most beneficiaries.

The referral system built into the scheme has facilitated people to overcome their serious and complex set of health problems. Free treatment facilities for the high-risk pregnant women have helped to reduce the maternal and infant mortality rates in the area. The offer of free medical consultation services and charity services to the poor people has opened avenues for the excluded people to become a part of the mainstream health care services. The Insurance Scheme has not only met the health care demands of the beneficiaries from the target area, but also from the non-target areas.

The management of the IS fully recognises that the IS has to ensure its future financial sustainability. A strong point of the functioning of the IS, is that the cost of drugs and premium rates have risen at the same rate over the years. With increased enrolments, the premiums collected, managed to cover at least 50% of the drug costs for nearly all the schemes at the health posts. This was realized without including subsidies from CDHP and the District Public Health Office. However, a problem that remains, as CDHP has begun to turn the management of the health posts over to MOH/HMG, is that sustainability of the system will depend in the future on a responsible MOH/HMG system.

However, the LMIS was not free from implementation difficulties. Some of the problems encountered included: a decline in membership due to the influx of private service providers into the market; irregularity in the payment of premiums by some members; and the tendency of people to join the scheme only after someone in the family becomes ill (this situation is not unique to the Insurance Scheme, as one can observe similar situation in other places as well). Poor educational status and low-income of people have also made the process of bringing new members into the mainstream more challenging.

References

Harding, J. W. Richard. 2000. Lalitpur Medical Insurance Scheme: A Status Report After Twenty Four Years, Community Development and Health Project (CDHP), Patan Hospital, Lalitpur, Nepal.

Harding, J. W. Richard. 1997. Lalitpur Medical Insurance Scheme: A Status Report After Twenty Years, Community Development and Health Project (CDHP), Patan Hospital, Lalitpur, Nepal.

ILO-STEP ; ILO-SEED. 2001. Mutual health organizations and micro-entrepreneurs' associations. Guide. (ILO, Geneva).

ILO-STEP. 2000. Health microinsurance. A compendium. Working Paper (ILO, Geneva).

ILO-STEP. 2000. Methodological guide for undertaking case studies on health insurance schemes (ILO, Geneva).

Koenig, Thomas ; Beki, Thapa. 2000. Lalitpur Medical Insurance Scheme (LMIS), A paper presented in the CECI Workshop on Health Insurance held at Dhulikhel on 21 June 2000, Dhulikhel, Nepal.

Manandhar, Narayan. 2001. Labor Relations: Problems and Issues in Nepal, Industrial Relations Forum, Kathmandu.

MoH. 2000. Review of Lalitpur Health Insurance Scheme, A Study Prepared for the National Workshop on "Health Insurance Schemes" in 2000-01, Nepal Health Economics Association (NHEA), Kathmandu, Nepal.

PH. 1999. Antenatal and Family Planning Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

PH. 1999. CHDP/LMIS Hand Notes, Patan Hospital (PH), Lalitpur, Nepal.

PH. 1999. Health Insurance Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

PH. 2000. Health Post Finance Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

PH. 1999. Hospital Referral Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

PH. 1999. Lalitpur Medical Insurance Scheme (LMIS) Annual Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

PH. 1999. Nutrition Report 1999, Patan Hospital (PH), Lalitpur, Nepal.

UMN. 2000. Medical Insurance Report 1999/2000, United Mission to Nepal (UMN), Kathmandu, Nepal.

UMN. 2000. Progress Report 1999, United Mission to Nepal (UMN), Kathmandu, Nepal.

Annex – I Chapagaon Medical Insurance Scheme (CMIS)

Information Leaflet

What does Chapagaon Medical Insurance Scheme (CMIS) mean?

1. Who can join and for how much?

Chapagaon Health Post offers to all people living in Chapagaon VDC, Ghusel and Dukuchhap VDC the opportunity to buy health insurance. The price is Rs.100.- (Rs. 150.- for families with mentally sick members) per family and year[4]. Family means all family members living together in one house.

2. What happens if a family member gets sick?

After taking insurance, if any family member gets sick, then he/she has to pay only a registration fee of Rs. 5.-, while attending the health post (HP). All the services provided by the HP, including drugs according to the Essential Drug List, are free of charge, any time, all year.

3. Are there any other benefits?

There is a discount for any insured patient who is referred by the HP to Patan Hospital. Patients admitted to hospital get up to Rs. 200.- cut from their bill (this means, after having bought the insurance for Rs. 100.- you save already Rs. 100.- (Rs. 200.- - Rs. 100.-). Outpatients pay up to Rs. 43.- less (Rs. 13.- for the ticket and Rs. 30.- for medicines).

4. And for pregnant women?

Any pregnant woman classified as high-risk at the HP and referred to Patan Hospital receives any kind of treatment free of charge. This includes delivery by caesarean section (operation).

5. Again, all information at a glance !

- The insurance price per family and year is Rs. 100.- (Rs. 150.- for the mentally-ill).
- A registration fee of Rs. 5.-, on each visit to the HP.
- On admission to hospital up to Rs. 200.- are cut from their bill.
- Outpatients pay up to Rs. 43.- less (Rs. 13.- for the ticket, Rs. 30.- for medicines).
- Any high-risk pregnant woman receives any kind of treatment free of charge.

[4] The price will be reviewed each year and might be increased.

Why is it necessary to have a MIS at Chapagaon HP?

1. **Purchase of medicines;**

Since medicines are not provided by the District Health Office or His Majesty's Government of Nepal and CDHP health insurance has to provide all medicines to meet the HP's needs throughout the year (CDHP finances only mental drugs). The fund, which premiums (insurance fees) and the registration fees go into, is mainly to purchase drugs.

2. **Subsidizes care at Patan Hospital;**

3. **Covers inpatient and outpatient care, with special focus on high-risk pregnancies.**

4. **Helps to increase awareness of health services available in the community.**

5. **Helps to build a large fund, which will ensure the proper running of your HP;**

This means provision of good quality diagnostic services and the continuous supply of essential drugs.

6. **What are Essential Drugs?**

HMG's Ministry of Health made a list of medicines which are considered essential and sufficient to treat all the major diseases occurring in Nepal effectively. Other expensive medicines sold by the private pharmacies, which are usually not necessary, are only a waste of money. Therefore we recommend medicines according the Essential Drug List provided at Chapagaon HP. They are safe, effective and cheap.

Finally, why should I buy medical insurance?

To maintain your Chapagaon HP and improve its services, it is necessary that many families join the CMIS to build a large fund fed by the insurance and registration fees. Only a large fund can secure the proper running of your HP, the provision of good quality diagnostic services and the continuous availability of essential drugs for everybody including the Poorest of the Poor.

Join the Chapagaon Medical Insurance Scheme to stay healthy and to save money !

Annex – II M.C.H. DRUG LIST

INVENTORY ORDER ISSUE ND RECEIPT **SUBCENTER _____**
LIST OF DRUGS **MONTH _____**

STOCK NUMBER	ITEM DESCRIPTION	UNIT OF ISSUE	AUTHORIZED STOCK LEVEL	QUANTITY IN STOCK	QUANTITY ORDERED	QUANTITY ISSUED	UNIT PRICE	TOTAL
ORAL MEDICATIONS								
9.	ERGOMETRINE (0.5 mg)	50						
10.	FERROUS SULFATE (200mg)	1000						
11.	FOLIC ACID (5 mg)	1000						
13.	MEBENDAZOLE SYRUP (100 mg)	100						
14B.	MERTONIDAZOLE SYRUP(60 ml)	1 bot						
15.	MULTIVITAMINS	1000						
16.	PARACETAMOL TABS (500 mg)	100						
18.	PIPERAZINE SYRUP (450ml)	1 bot						
20A.	COTRIM TABLETS (480 mg)	100						
20B.	COTRIM SYRUP (30ml,50ml)	1 bot						
22.	VITAMIN A (200,000)	100						
24.	VITAMIN B COMPLEX	1000						
112.	PARACETAMOL TABS (100 mg)	1000						
INJECTIONS:								
25.	ERGOMETRINE (0.2 mg)	1 amp						
27.	ADRENALINE (1ml 1:1000)	1 amp						
28A.	DEPOPROVERS (150 mg)	1 vial						
28B.	DEPOPROVERA SYRINGS	1 pc						

115.	BENZATHIN PCN (6 L)	1 vial						
ORAL POWERS:								
35.	RD SOLUTION	5 pkt.						
TOPICALS :								
37.	BENZYL BENZOATE (450 ml)	1 liter						
38.	CHLORAMPHENICOL EAR DROPS (5 bottles)	5 bottle						
40.	GENTIAN VIOLET (25 mg)	25 mg						
41.	MENTHYLATED SPIRIT (1L)	1 liter						
42.	SAVLON (1L)	1 liter						
43.	SOAP (10 bars)	10 bars						
45.	TETRACYCLINE EYE OINT (24 tubes)	24 tubes						
48.	WHITEFIELD'S OINTMENT (450 mg)	1jar:450mg						
OTHER SUPPLIES								
54.	HYDROGEN PEROXIDE (500 ml)	500 ml						
152.	SUTKERI SAMAGRI (1 pkts)	1 pkt.						

ORDERED BY: _____SIGNATURE: _____ DATE: _____

ISSUED BY: _____ SIGNATURE: _____ DATE: _____

RECEIVED BY: _____ SIGNATURE: _____ DATE: _____

DATE ENTERED INTO STOCK CARD: _____

INITIAL: _____

Annex – III HEALTH POST DRUG LIST

INVENTORY ORDER ISSUE ND RECEIPT **SUBCENTER _____**
LIST OF DRUGS **MONTH _____**

STOCK NUMBER	ITEM DESCRIPTION	UNIT OF ISSUE	AUTHORIZED STOCK LEVEL	QUANTITY IN STOCK	QUANTITY ORDERED	QUANTITY ISSUED	UNIT PRICE	TOTAL PRICE
ORAL MEDICATIONS								
1.	AMINOPHYLLINE (I 00 mg.)	1000						
2.	ANTACID TABS	1000						
3.	ASPIRIN (300 mg)	1000						
5.	CHLORAMPHENICOL (250 mg)	500						
6.	CHLORPHENRAMINE (4 mg).	500						
8.	SALBUTAMOL TABS (2 MG)	1000						
10.	FERROUS SULFATE (200 mg)	1000						
11.	FOLIC ACID (5 mg)	1000						
12.	FRUSEMIDE (40 mg)	100						
13.	MEBENDAZOLE (100 mg)	100						
14A	METRONIDAZOLE TABS (200 mg)	1000						
15.	MULTIVITAMINS	1000						
16.	PARACETAMOL TABLS (500 mg)	1000						
17.	PENICILLIN V (250 mg)	500						
18.	PIPERZINE SYRUP (450 ml)	1 bottle						
19.	PROMETHAZINE TABS (25 mg)	10						
20A.	COTRIM TABLETS (480 mg)	1000						

20B.	COTRIM SYRUP (30 ml, 50 ml)	1 bottle						
21.	DOXYCYCLINE (100 mg)	100						
22.	VITAMIN A (2OO,OOO IU)	100						
24.	VITAMIN B COMPLEX	1000						
68.	PHENOBARBITOL TABS (30 mg)	100						
111.	POTASSIUM CHLORIDE (500 mg)	500						
112.	PARACETAMOL TABS (100 mg)	1000						
113.	DIGOXIN (25 mcg)	100						
114.	CHLOROQUINE TABS (250 mg)	100						
144.	COUGH SYRUP (450 ml)	1 bottle						
150.	HYDROCHLOROTHIAZIDE (25 mg)	100						
EMERGENCY DRUGS AND INJECTION								
27.	ADRENALINE (I ml 1/1000)	1amp						
29A.	IV SOLUTION NS (500 ml)	500 mls						
29B.	IV SOLUTION 5% DEXTROSE (500 ml)	500 mls						
30.	LIGNOCAINE PLAIN 1% (1 vial)	1 vial						
31.	BENZATHINE PEN (12 laks)	5 vial						
32.	PROCAINE PEN (4 laks)	25 vial						
33.	WATER FOR INJECTION (50 amp)	50 amp						
34.	LIGNOCAINE 2% WITH ADRENALINE	1 vial						
67.	PETHIDINE INJ (50 mg/ml)	1amp						
151.	PROMETHAZINE INJ (50 ml)	10 amp						
ORAL POWDERS								
35.	RD SOLUTION (5 pkts)	5 pkt						
TOPICALS								
37.	BENZYL BENZOATE (450 ml)	450 ml						

38.	CHLORAMPHENICOL EAR DROPS (5 bottles)	5 bottle						
40.	GENTIAN VIOLET (25 mg)	25 mg						
41.	MENTHYLATED SPIRIT (1L)	1 liter						
42.	SAVLON (1L)	1 liter						
43.	SOAP (10 bars)	10 bars						
45.	TETRACYCLINE EYE OINT (24 tubes)	24 tubes						
46.	TINCTURE BENZOIN (450 ml)	450 ml						
47.	TINCTURE IODINE (450ml)	450 ml						
48.	WHITFIELD'S OINTMENT (450gm)	1jar:450gm						
49.	ACRIFLAVIN (25mg)	25 gm						
147.	SILVER SUPLHADIAZE CREAM (250 gm)	1 tube						
149.	NYSTATIN VAGINAL PESSARY (100,000)	100						
CHEMICAL LIQUIDS AND POWERS								
53.	GLYCERINE (450 gm)	450 gm						
54.	HYDROGEN PEROXIDE (500 ml)	500 gm						
55.	MAGNESIUM SULPHATE (450 gm)	450 gm						
56.	SALICYCLIC ACID (450 gm)	450 gm						
58.	TURPENTINE OIL (400 ml)	400 ml						
60.	VASELINE (1 KG)	1 kg						
61.	POTASSIUM PERMANAGANATE(450gm)	450 gm						
MENTAL HEALTH DRUGS								
63.	AMITRIPTYLINE (25 mg)	250						
64.	CHLORPROMAZINE (50 mg)	250						
65.	BENHEXOL (2 mg)	100						
66.	FLUPHENAZINE INJ (25 mg/ml)	1 vial						
TUBERCULOSIS DRUGS (from DHO)								

71.	INH TABS (100mg)	500						
72.	ISONIAZID (INH 300mg)	1000						
73.	STREPTOMYCIN INJ (0.75mg)	10 amp						
139.	RIFAMPICIN (150 mg)	1000						
140.	PYRAZINIMIDE (500 mg)	1000						
141.	ETHAMBUTOL (400 mg)	1000						
	Total							

ORDERED BY: _____ SIGNATURE: _____ DATE: _____

ISSUED BY: _____ SIGNATURE: _____ DATE: _____

RECEIVED BY: _____ SIGNATURE: _____ DATE: _____

DATE ENTERED INTO STOCK CARD: _____

INITIAL: _____

Annex – IV CDHP High Risk Pregnancy Referral Card

HP:

Patient's name:

Age:

Gravida: Para:

Reason for refer:

Address:

Date:

Staff named and signature:

Instruction

- This card will be used for high-risk Pregnancy mothers.
- Patient with this card will be provided by free treatment from Patan Hospital
- Patient must show this card to admitting doctor.

Annex – V GENERAL MONTHLY REPORT FORM

Health Post: ……. Month: …….. Year: …….

MEDICAL INSURANCE ENROLMENT

TARGET VDCs	NEW	RENEW	TOTAL	Rate		Total (Rs.)
				New	Renew	
1.						
2.						
3.						
4.						
5.						
TOTAL						
NON-TARGET VDC's						
TOTAL						

TOTAL number of households insured this year:

TARGET VDCs	
NON-TARGET VDCs	

Cash Record:

Insurance	Registration	Dental	MCH	Lab	Other	Total	Bank Deposit	Cash Balance	Bank Balance

Annex – VI Lalitpur Medical Insurance Scheme (LMIS) Study

Household Questionnaire

Health Post: _ _ _ _ __ _ _ _ _ _ __ _ _ _ _ _ __ _ _ _ _ _ Questionnaire #:

Name of Village / Ward: _ _ _ _ _ _ _ _ _ _ _ _ _ _ __ _ _ _ _ _ __ _ _ _ _ _ __ _ _ _ _ _

Name of Household Head: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _ _ _ _

I. Household Heads

1. Age of the Head (exact age):

(If unwilling to answer or does not know, ask age category):

1 = < 20 years
2 = 20 – 29 years
3 = 30 – 39 years
4 = 40 – 49 years
5 = 50 – 59 years
6 = 60 + years

2. Marital status of the Head:

1 Single
2 Married
3 Widow/widower
4 Divorced/separated

3. Ethnicity/caste:

1 Newar
2 Tamang/Magar
3 Bahun/Chhetri
4 Untouchable/low caste
5 Others specify: _ _ _ _ _ _

4. Education level of the Head

a) Can you read and write?
1 Yes
2 No

b) If "Yes", years of education:
1 Non-formal (adult literacy)

	2	1 – 4 years (primary)
	3	5 – 10 years (secondary)
	4	Higher education (+2 university)
5. Major occupation of the Head:	1	Government job
	2	Business/shopkeeper
	3	Builder/labourer
	4	Farmer
	5	Unemployed
	6	Others specify: _ _ _ _ _ _ _ _

II. Socio-economic status of the family

6. Number of people normally leaving in the household:	1	1 – 5 persons
	2	6 – 10 persons
	3	11 – 15 persons
	4	16 – 20 persons
	5	> 20 persons

7. Monthly family income:	1	< 1000 Rs.
	2	1000 – 2000 Rs.
	3	2000 – 6000 Rs.
	4	> 6000 Rs.

7a. Is it regular (or sporadic)	1	Yes
	2	No

7b. If "No", what is your average annual income, specify: _ _ _ _ _ _ _Rs.

8. How many members contribute to the family income?	1	One person
	2	Two or three people
	3	Four or five people
	4	More than five people

9. Does the family have land?	1	Yes
	2	No

9a. If "Yes", specify

(Chapagaon):	1	< 5 ropani
	2	5 – 10 ropani
	3	10 – 20 ropani
	4	> 20 ropani
(Bhattedanda & Ashrang)	1	< 10 ropani
	2	10 – 20 ropani
	3	20 – 30 ropani

4 >30 ropani

9b. If "9-Yes", the land is predominately khet or bari
1 Khet
2 Bari

9c. If "9-Yes, major cash crops (source of income)
1 Dairy products
2 Cereals (Paddy, Wheat)
3 Vegetables

9d. If "9-Yes", how much/for how long did you produce from the land last year?
1. Surplus
2. Enough for one year
3. Enough for 9 months
4. Enough for 6 months
5. Enough for 3 months
6. Less than 3 months

III Health Care

10. Did the family buy the insurance card this year?
1 Yes
2 No

10a. If "Yes", did you need to borrow money?
1 Yes
2 No

10b. If "No", have you ever bought an insurance card?
1 Yes
2 No

10c. If 10b "Yes", why did you not buy this year? _ _ _ _ _ _ _ _ _ _ _ _

10d. If 10b "No", why did you not want to buy?
1. Limited variety of medicines
2. Services/staff are not good
3. Never ill
4. Cash not available
5. Others _ _ _ _ _ _ _ _ _ _

11. What are the health care alternatives in this area?
1 Ayurveda
2 Dhami/Jhankri
3 Private/pharmacy
4 Clinic/hospital
5 HMG sub-HP

11a. If someone in the family falls sick/ill, which health care alternative does he/she utilize?
1 Ayurveda
2 Dhami/Jhankri
3 Private/pharmacy
4 Clinic/hospital
5 HMG sub-HP

6 (ex-) CDHP HP

11b. Where does he/she go first (only one answer)? 1 Ayurvedic doctor
2 Dhami/Jhankri
3 Private/pharmacy
4 Clinic/hospital
5 HMG sub-HP
6 (ex-) CDHP HP

11c. Why did he/she choose to use that (11b) alternative?
1 Belief
2 Good facilities treatment
3 Cheaper
4 Free treatment
5 Nearby
6 Others _ _ _ _ _ _ _ _ _ _

11d. If 11b <u>not</u> "6 = (ex-) CDHP HP", why not (specify) _ _ _ _ _ _ _ _ _ _ _

12. Do you know the premium for the insurance card in the health post this year?
(If "Yes", check by asking for the actual price)
1 Yes -> how much? Rs. _ _ _
2 No (do not know)

12a. If “Yes", from whom did you get the information?
1 Staff at the health post
2 Health committee members
3 Family members/neighbours
4 VHW/BHDW at home visits
5 Others _ _ _ _ _ _ _ _ _ _ _ _

13. Only for families who bought an insurance card at least once (10 or 10b = "Yes"):
Do you pay for the insurance card only when a family member gets sick?
1 Yes
2 No

13a. If "Yes", why are you waiting before renewing the card?
1 System not understood
2 Cash not available
3 Too expensive
4 No family member got sick
5 Others _ _ _ _ _ _ _ _ _ _ _

13b. If "No", why did you buy the insurance card before a family member gets sick?
1 To support the HP/solidarity to the community
2 The card is cheaper at the beginning of the financial year (does not apply in Chapagaon)
3 To get treatment
4 To save time
5 Others _ _ _ _ _ _ _ _ _ _ _

14. What do you think about the price of the insurance card?

1 O.k.
2 Too high
3 Too low

15. What do you think about the medicines in the health post?

1 Are always available
2 Not available all the time
3 Others _ _ _ _ _ _ _ _ _ _ _

16 What do you perceive as the most important problem in the health post (only one answer)?

1 Staff is not skilled enough
2 Staff is not friendly
3 The medicine is not good
4 Lab service not sufficient
5 Inadequate equipment/building
Only minor illnesses can be treated

17. If 3 “The medicine is not good", please, explain why _

18. Please suggest how the insurance scheme could be improved

1 More MOH aid
2 More VDC contribution
3 Increase premium to improve quality
4 Encourage more families to take insurance
5 Campaign to inform people
6 Others _ _ _ _ _ _ _ _ _ _ _ _

19. Till now, the information you received about the insurance scheme is sufficient?

1 Yes
2 No

19a. If "No", what kinds of information do you need/would you like to get?
(specify) _

20. During the last year, has one (or more) family members been referred to Patan Hospital?

1 Yes
2 No

20a. If "Yes", what was the outcome?

1 Cured
2 Improved (left the hospital alive)
3 Fatal (died in the hospital)
4 Not sure/known

20b. If "3 Fatal", what was the reason for it _

21. How much time does it take to get to the health post?

1	> 1 hour
2	1 – 2 hours
3	2 – 3 hours
4	> 3 hours

Annex-VII COMMUNITY DEVELOPMENT AND HEALTH PROJECT UNITED MISSION IN NEPAL (UMN)

REFERRAL SLIP

Patient referred to: _____ Hospital: _____

Name: _____ Age: _____ Sex: _____

Hospital No.: _____ H.P.Insurance Card No.: _____

Village: _____ V.D.C.: _____ Ward No.: _____

Problem: _____

_____

_____

Treatment already given:

To be seen in: _____ (Clinic or emergency)

Lab test: _____ X-ray: _____

Patient is prepared for admission: ☐ Has own food: ☐

Has relatives: ☐ Social Services: ☐

Please consider time taken to reach hospital: ☐

Referred by: _____

Clinic: _____ Date: _____

FOR INSURED PATIENT

H.P.: _____

Patient's Name: _____

Hospital No: _____ Insurance No.: _____

Patient to Return: ☐ Doctor's Signature: _____

For Cashier: ☐ Date: _____

OUTPATIENT / HOSPITAL REPORT

Date of attendance: _____ Hospital No.: _____

Admitted No. : _____ Yes Date of discharge: _____

DIAGNOSIS OR IMPRESSION:

_____ ☐

TREATMENT AND ADVICE:

It is felt that it is necessary for the patient to attend the hospital again. Time taken for the patient to reach the hospital has been taken into consideration.

Date of next attendance will be _____ at _____ clinic

OUTPATIENT CLINIC / HOSPITAL: _____ Date: _____

SIGNED (PLEASE DO NOT USE INITIALS): _____

Please do not write in this space

Annex – VIII Community Development and Health Project (CDHP)

Membership Card

Card No. _____

Name of the Household Head _____

VDC: _____

Ward No. _____

Valid from Mid-July 200 ……. to Mid-June 200 ……..…

Annex – IX UMN Community Development and Health Project (CDHP) Lagankhel Lalitpur

Member Family Details

Card No.: … … … … … … … … … … … …

Name of the Household Head: … … … … … … … … … … … … …

Municipality / VDC … … … … … … … … … … … … … … … …

S. No.	Name of the Family Members	Age
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Rs.: ……..

Notice

1. This card is valid for treatment up to 200 ……..
2. Bring this card along, while you come for treatment.
3. If the card is lost, inform UMN/CDHP immediately.
4. The medical treatment services can be accessed only by the persons whose names are listed in this card.

Annex – X Community Development and Health Project (CDHP)

Income Details
(For the month of ……)

S. No.	Name	VDC	Ward No.	Insurance		Date	Income (In Rupees)			Dental Service	Stool Test	Total
				Old	New		Insurance	Registration	Additional from Mentally ill			

Annex – XI Community Development and Health Project (CDHP)

Tally Sheet for Monthly Attendance of Patients

S.No.	Age	Female	Total **(a)**	Male	Total **(b)**	Grand Total **(a + b)**	Remarks
1.	Below 5 Years						
2.	Above 5 Years						
		1. New		2. Old			
	Total						

Annex – XII Community Development and Health Project (CDHP)

Insurance Talley Sheet

Month : _____

S.No.	VDC	Insurance Charge (Rs.125.-)	Total **(a)**	Insurance Charge (Rs.125.-)	Total **(b)**	Grand Total **(a+b)**	New	Old
1.	Ashrang							
2.	Gimdi							
3.	Pyutar							
4.	Manthali							
5.	Thuladhurlung							
6.	Others							
Total								

Annex – XIII Community Development and Health Project (CDHP)

Statement of Health Post Medical Expenses
(200 …… / 200 ……)

Date: _____

The Chairperson
Health Management Committee

Payables of 200 …… / 200 ……	**Grant Received from CDHP**	**Medical Expenses**	**Paid to CDHP**
Paid in 200 …… / 2 ..…...			
To be borne by CDHP in 200 ……/ 200 ….			
July 200 …….			
August 200 ……			
September 200 ……			
October 200 ……			
November 200 ……			
December 200 ……			
January 200 ……			
February 200 ……			
March 200 ……			
April 200 ……			
May 200 ……			
June 200 ……			
Total Medical Expenses in 200 … / 200 …			
Balance of 200 …… / 200 ……			
Payable to CDHP			

Note: This form is translated from Nepali.

cc:
Director, Program Unit
Director, Sub-program Unit
Business Manager, CDHP
Coordinator, Lalitpur
Health Post In-charge
Store Keeper