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Health Insurance in Nepal: Premium-claim Imbalance, Equity Gaps, and the Challenge of Achieving Universal Coverage

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Abstract

Purpose: The study examines Nepal's health insurance performance, focusing on enrollment, premium collection, and claims disbursement, identifying operational and policy barriers affecting sustainability and equity.

Design/methodology/approach: A descriptive study analyzed secondary data (2015–2024) from Nepal's Health Insurance Board, using percentage-based trend analysis of insured citizens, premium collected, claim paid, and premium-claim ratio under Universal Health Coverage (UHC).

Findings: Nepal's health cover has grown rapidly since F/Y 2015-16, enhancing universal health cover but at the cost of gender and marginal group equity gaps. COVID-19 caused claim spikes and financial instability, though premiums bounced back in F/Y 2023-24. Despite higher utilization, satisfaction remains moderate due to service gaps. Regional disparities in health security access are evident in Social Health Security Program (SHSP) enrollment trends. The Health Insurance Board needs an urgent reform in premium pricing to ensure longevity of the policy.

Conclusion: Nepal's insurance scheme faces systemic inefficiencies, with an unsustainable premium-claim ratio (331.3 percent in F/Y 2023-24) and irregular enrollments across provinces, undermining UHC. To improve retention and equity, streamlined processes, awareness campaigns, and policy reforms are urgently needed to ensure financial stability and equitable access.

Implications: To attain fair UHC, Nepal must address regional disparities, maintain financial stability, and advance inclusive policies.

Originality/value: The study assesses Nepal's health insurance system, revealing inequalities and financial instability, providing policy recommendations for gender-sensitive reforms and crisis preparedness strategies.

JEL Classification: I13, I18, H51

Introduction

Universal Health Coverage (UHC) is a cornerstone of global health equity, grounded in the World Health Organization's (WHO) mandate for financial risk protection and access to quality care without impoverishment (WHO, 2010; WHO, 2025). Despite this, low- and middle-income countries (LMICs) like Nepal face systemic challenges in translating policy into practice, often due to fragmented financing, weak governance, and socio-structural inequities (Abiiro & De Allegri, 2015; Savedoff et al., 2012).

Achieving UHC, defined by the WHO as ensuring that all individuals receive the health services they need without suffering financial hardship, has become a central policy objective across low-the Low-and-middle-income countries (LMICs) including Nepal. Globally, UHC is deeply rooted in the right to health as articulated in international declarations and the Sustainable

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Development Goals (SDG 3.8), as well as in welfare economics and social contract theory. While many nations have restructured their healthcare financing systems to meet this aim, Nepal's progress has been inconsistent, marked by fragmented policy initiatives and low enrollment rates in state-sponsored insurance programs.

The Constitution of Nepal (2015), under Article 35, guarantees every citizen the right to basic healthcare. To institutionalize this constitutional mandate, the Government of Nepal introduced the National Health Insurance Policy (2014) and established the Social Health Security Development Committee (2015), later followed by the Health Insurance Board (2017). The Social Health Security Programme (SHSP), which falls under SHIP and NHIP, is a social protection programme of the Government of Nepal that aims to enable its citizens to access quality healthcare services without placing a financial burden on them. These include inadequate risk pooling, high dropout rates, low awareness, inequitable service delivery, and systemic inefficiencies.

Theoretically, Nepal's health insurance efforts can be examined through the lens of Social Health Insurance (SHI) frameworks, grounded in welfare state theory (Esping-Andersen, 1990) and the WHO's health system building blocks. These frameworks stress risk pooling, compulsory prepayment, and redistributive financing, especially for marginalized populations. Nepal's reliance on voluntary enrollment, low premium collection, and limited state subsidies for the poor deviates from these principles, undermining sustainability and equity.

Empirically, several countries serve as instructive parallels. Thailand's UHC reform, implemented in 2002, demonstrates how integrated policy, adequate financing, and governance can lead to near-universal enrollment and low out-of-pocket expenditures. Sukmanee et al. (2023) found that Thailand's UHC program successfully reduced out-of-pocket health expenditures (OOPE) as a share of total health spending (THE) from 1994 to 2019. However, the COVID-19 pandemic disrupted this trend, triggering a sharp rise in household out-of-pocket expenditure (OOPE), particularly for medical equipment, which surged from 643 million THB (2019) to 9.4 billion THB (2020). While UHC provided sustained financial protection pre-pandemic, the crisis exposed gaps in equitable access to essential medical supplies. Ghana's National Health Insurance Scheme (NHIS), despite its gains, highlights the fragility of voluntary enrollment, inadequate funding and administrative inefficiencies (Kipo-Sunyehzi et al., 2019). These examples highlight the importance of aligning political will, institutional design, and public accountability, areas where Nepal's system remains fragile.

Despite government efforts, Nepal's journey toward UHC remains constrained by persistent coverage gaps, suboptimal health infrastructure, limited health financing, and low satisfaction among insured citizens. This study, therefore, seeks to evaluate the trends, operational performance, and systemic challenges of Nepal's health insurance system to identify feasible policy recommendations toward achieving sustainable UHC.

Literature Review

Theoretical Foundations of UHC and Social Health Insurance

UHC is conceptualized within intersecting theoretical paradigms of human rights, public goods, welfare economics, and social justice. From a normative standpoint, UHC is embedded in the principle of the right to health and state responsibility (Abiiro & De Allegri, 2015; WHO, 2010). The WHO's UHC cube articulates three key dimensions: breadth (population coverage), depth (service coverage), and height (financial protection). These dimensions are underpinned by decommodification theory, where Esping-Andersen (1990) posits that social policy should protect citizens from market dependency by universalizing essential services like healthcare.

Welfare economics adds further nuance by emphasizing resource allocation efficiency and equity. Arrow (1963) and Musgrove (1999) advocate for prepayment and risk pooling mechanisms to prevent market failure in health systems, which are inherently prone to information asymmetry and externalities. SHI is a strategic response rooted in the Beveridge Model- a government-run national health service and Bismarck Model insurance-based traditions, emphasizing redistributive financing through mandatory contributions and state subsidies (Cichon & Normand, 1994; Toth, 2021).

The applicability of these theories in LMICs is challenged by informal labor markets, fiscal constraints, and governance capacity. Nepal's voluntary SHI scheme contradicts the theoretical ideal of universal, compulsory, and progressively financed coverage. Rather than pooling risk effectively, the model has largely failed to redistribute health financing equitably, particularly among vulnerable populations (Kalita et al., 2023; Savedoff et al., 2012).

Health Financing and Institutional Capacity in Nepal

Nepal's health financing system exhibits structural contradictions that undermine the pursuit of UHC. Although public health expenditure stands at approximately 6.4% of gross domestic product, OOPE comprises nearly 57% of total health spending, indicating a regressive financing model that disproportionately affects low-income populations (WHO, 2025). This fiscal imbalance reveals a state apparatus that delegates health responsibility to households while failing to construct effective public risk pools.

The NHIP, introduced in 2016, was designed to rectify this imbalance through prepayment and risk pooling. However, the scheme's architecture is misaligned with foundational principles of SHI. Its voluntary enrollment for the informal sector, comprising over 81% of the labor force, results in fragmented pools and weak cross-subsidization (ILO, 2025). The flat premium of NPR 3,500 per family lacks income sensitivity, making it unaffordable for rural households and undermining redistributive equity (HIB, 2023).

Nepal's financing model reflects a hybrid structure, combining mandatory payroll contributions for formal workers with voluntary participation from others (Toth, 2021). This arrangement generates systemic inefficiencies: inconsistent revenue streams, inequitable coverage, and policy incoherence. In contrast, countries like Thailand and Rwanda have implemented compulsory participation and income-based contributions, thereby ensuring broad-based risk pooling and sustainability (Tangcharoensathien et al., 2020).

More critically, strategic purchasing, essential for aligning payment with quality, remains largely absent. NHIP continues to rely on fixed-rate reimbursements without linking provider payment to performance or outcomes. This weak purchasing mechanism undermines both efficiency and accountability. Evaluations show persistent drug stockouts, referral inefficiencies, and long wait times in insured facilities, symptoms of provider indifference and inadequate supervision (Ghimire et al., 2024; Paneru et al., 2022). Simultaneously, delayed reimbursements, poor claims management, and the absence of digital infrastructure demotivates providers and deter users (Khanal et al., 2023).

Institutionally, the system suffers from bureaucratic inertia and coordination failures across agencies. The 38% dropout rate reported by the Health Insurance Board (2023) reflects not just individual dissatisfaction but broader governance failures: weak grievance redressal mechanisms, non-transparent benefit design, and procedural inefficiencies (Ranabhat et al., 2019).

Nepal's federal transition, enshrined in the 2015 Constitution, has devolved authority to provincial and local governments. However, this shift has not been accompanied by adequate fiscal, human, or technical capacity at sub-national levels. Field evidence from Ilam district shows local authorities struggling with actuarial analysis, fund management, and program monitoring (Shrestha et al., 2024). Moreover, overlapping mandates between federal, provincial, and local institutions create operational ambiguity and undermine policy execution (USAID, 2022).

Although the Health Sector Strategic Plan 2023–2030 outlines progressive reforms, digital claims, provider empanelment, and performance-based financing, these remain aspirational. Without decisive investment in institutional capacity, regulatory enforcement, and fiscal commitment, these reforms risk remaining on paper.

Empirical Review

Nepal's SHIP exhibits fragmented progress toward universal coverage. Although Ghimire et al. (2023) reported a 77.2% utilization rate among insured households, utilization alone fails to reflect equity in access, as dropout rates remain substantial due to premium affordability and limited benefit packages (Paneru et al., 2022; Poudel et al., 2023). This mirrors global patterns where increased coverage has not translated into adequate financial protection; 13.5 percent of the global population still experiences catastrophic health spending (Chen et al., 2023). In Nepal, income-insensitive flat premiums and voluntary participation further limit redistribution, disproportionately excluding rural and informal populations (ILO, 2022; NHSSP, 2023). Similar trends are observed in Ghana, where Domapielle (2021) noted that shallow pooling and lack of fiscal resilience weaken the equity outcomes of health insurance reforms.

According to Beattie et al. (2016), public funding is essential and closely linked to more egalitarian health systems, and universal health coverage is a political process from the outset. Reforms to universal health coverage should start with closing primary healthcare gaps. Service quality and system responsiveness critically undermine SHIP's legitimacy. Ghimire and Paudel (2019) and Ghimire et al. (2024) document persistent dissatisfaction due to drug shortages, poor referral coordination, and inefficient billing. These are symptomatic of supply-side weaknesses and governance fragmentation. Globally, Yanful et al. (2023) emphasize that UHC must guarantee not just coverage but effective, equitable, and safe care, a standard Nepal consistently fails to meet.

Nambiar et al. (2020) developed and field-tested a monitoring framework for UHC reforms in Kerala's primary healthcare facilities, emphasizing access, quality, and equity indicators. Through a modified Delphi process and field validation using facility data and population surveys, the framework identified gaps and synergies within existing evaluation systems. The findings support refining UHC monitoring to enhance health outcomes and advance equitable service delivery. Studies by Acharya et al. (2023) and Timilsina (2023) revealed that service fragmentation, provider apathy, and low insurance literacy further exacerbate user disengagement. Even in countries like India, Radheshyam et al. (2025) highlight how systemic inefficiencies and weak regulatory oversight obstruct the equitable realization of UHC, despite programmatic expansions. In the context of Kenya, Muinde and Prince (2022) stated that Kenya's UHC reforms, despite their universalist rhetoric, reinforce healthcare inequities and fragmented access, creating tension between promises and realities. While citizens remain skeptical of these reforms, the language of inclusion highlights systemic inequalities but also fosters hope for new possibilities in healthcare access.

Governance deficits and institutional misalignment are critical constraints. Khanal et al. (2023) and Gautam (2024) point to entrenched political economy barriers, including inter-agency fragmentation, weak accountability, and resource mismanagement. Shrestha et al. (2024) reinforce this through sub-national evidence showing limited provider responsiveness and program miscommunication at the local level. Cross-nationally, Thailand's UHC model, initially successful in reducing OOPE, was severely tested by COVID-19 disruptions, emphasizing the vulnerability of even mature systems without adaptive governance (Sukamane et al., 2024). Lubis et al. (2024) emphasized that a dual focus on development (e.g., Human Development Index-HDI) and governance (e.g., government effectiveness) is crucial for advancing UHC, as HDI strongly drives health service coverage, which in turn affects financial protection, with governance also playing a significant role. Endalamaw et al. (2025) conclude that sustainable UHC requires institutional resilience, political commitment, and iterative policy adaptation, not just program expansion.

Methodology

This study employed a quantitative, retrospective longitudinal design to assess the performance of Nepal's SHSP from fiscal year F/Y 2015/16 to F/Y 2023/24. The research focused on three key performance dimensions: enrollment trends, premium collection, and claims disbursement under Nepal's national health insurance framework. Secondary data were sourced from the official annual records, policy documents, and publicly accessible digital dashboards of the HIB The data covered disaggregated indicators across fiscal years, including gender-wise-insured population, provincial enrollment distributions, annual premium collections (in NPR), and total claims paid (in NPR). Provinces were used as stratified units of analysis to identify geographical disparities in insurance coverage. The dataset was systematically cleaned and standardized for consistency and analyzed using descriptive statistical techniques using percentage change, growth rate analysis and premium-claim ratio.

Results and Analysis

This part of the paper covers the analysis of the relevant data that are related to the health insurance coverage in Nepal.

Composition of the Insured Citizens as per Gender

The composition of the insured Nepalese citizens by gender, under the health insurance policy, has been tabulated below:

Table 1: Composition of the Insured Citizens as per Gender

F/Y	Male	Female	Other	Total
2015-16	5,972 (47.31)	6,647 (52.66)	4 (0.03)	12,623 (100.00)
2016-17	107,804 (47.26)	120,277 (52.73)	32 (0.01)	228,113 (100.00)
2017-18	533,829 (47.22)	596,633 (52.77)	113 (0.01)	1,130,575 (100.00)
2018-19	695,987 (53.40)	607,082 (46.58)	157 (0.01)	1,303,226 (100.00)
2019-20	1,671,888 (56.00)	1,313,415 (43.99)	212 (0.01)	2,985,515 (100.00)
2020-21	2,198,410 (48.19)	2,363,362 (51.80)	435 (0.01)	4,562,207 (100.00)
2021-22	3,896,364 (55.76)	3,090,752 (44.23)	648 (0.01)	6,987,764 (100.00)
2022-23	2,259,150 (48.50)	2,398,542 (51.49)	639 (0.01)	4,658,331 (100.00)
2023-24	1,268,860 (48.65)	1,339,014 (51.34)	265 (0.01)	2,608,139 (100.00)

Note. Health Insurance Board; (Value in parentheses is percentage.)

Table 1 illustrates notable shifts in the gender distribution of insured individuals under Nepal's health insurance policy between F/Y 2015-16 and F/Y 2023-24. While females initially comprised the majority (52.66% in F/Y 2015-16), males overtook this share starting in F/Y 2018-19, reaching a peak of 55.76% in F/Y 2021-22. However, females regained a marginal lead in F/Y 2020-21 and again in F/Y 2022-23, accounting for just over half of the insured population. The 'Other' gender category remained consistently negligible, reflecting minimal inclusion. This data highlights significant male enrollment growth, especially from F/Y 2017-18 through F/Y 2021-22, alongside fluctuating yet sustained female participation. Concurrently, the total insured population surged exponentially from a modest 12,623 in F/Y 2015-16 to several million in later years, underscoring substantial expansion in policy uptake and health insurance penetration.

Composition of Premium Collected under Health Insurance Policy

Table 2 illustrates a pronounced exponential increase in Nepal's health insurance premium collection from F/Y 2015-16 to FY 2019-20, escalating from a modest NPR 2.09 million to NPR 2,892.13 million. This surge reflects accelerated enrollment and the impact of initiatives such as the Social Health Security Program. However, the momentum slowed in F/Y 2020-21, with growth tapering to 27.1%, largely attributable to COVID-19 disruptions, followed by a notable 32.8% contraction in F/Y 2021-22, likely driven by economic challenges and diminished policy renewals. A robust recovery emerged in F/Y 2023-24, with premiums rising sharply by 61.3% to NPR 4,177.96 million, indicating the effectiveness of policy adjustments, enhanced enforcement mechanisms, and heightened public awareness.

These trends highlight the program's inherent volatility and its susceptibility to external shocks and policy fluctuations. The trajectory reflects an initial phase of rapid expansion, a pandemic-induced setback, and a subsequent resurgence, signaling a renewed momentum in health insurance uptake across Nepal.

Table 2: Composition of Premium Collected under Health Insurance Policy

F/Y	Premium Collection in million NPR	Change %
2015-16	2.09	-
2016-17	134.50	+6334.5
2017-18	648.84	+382.4
2018-19	1,670.11	+157.4
2019-20	2,892.13	+73.2
2020-21	3,675.85	+27.1
2021-22	2,469.81	-32.8
2022-23	2,589.92	+4.9
2023-24	4,177.96	+61.3

Note. Health Insurance Board

Composition of Claim Paid under Health Insurance Policy

Table 3 reveals a striking escalation in insurance claim payments in Nepal, rising from negligible amounts in F/Y 2015-17 to NPR 13,840.52 million by F/Y 2023-24. The inaugural notable claim of NPR 18.46 million in FY 2017-18 was succeeded by an extraordinary 3,464.7% increase in F/Y 2018-19, reaching NPR 658.04 million, likely driven by significant policy changes, disaster-related claims, or the resolution of claim backlogs. Subsequent years sustained this rapid growth, with a peak surge of 105.7% in F/Y 2022-23 amounting to NPR 9,931.16 million, before growth moderated to 39.4% in FY 2023-24.

This trajectory underscores the rapid expansion and increasing financial burden faced by the insurance sector, influenced by expanded coverage, evolving regulations, and external shocks such as natural disasters and pandemics. Despite the recent deceleration in growth rates, the substantial rise in absolute claim payments continues to exert significant pressure on insurers. If this trend persists, claims may surpass NPR 20,000 million shortly, necessitating enhanced risk management strategies and robust financial safeguards to ensure the system's sustainability.

Table 3: Composition of Claim Paid under Health Insurance Policy

F/Y	Claim Paid in million NPR	Change %
2015-16	Nil	Nil
2016-17	Nil	Nil
2017-18	18.46	-
2018-19	658.04	3464.7
2019-20	2,472.50	275.7
2020-21	4,409.00	78.3
2021-22	4,828.54	9.5
2022-23	9,931.16	105.7
2023-24	13,840.52	39.4

Note. Health Insurance Board

Premium to Claim Ratio for Health Insurance Policy

The premium-to-claim ratio for this health insurance policy shows how much premium income is collected relative to the claims paid out. A ratio above 100 percent means the insurer is paying out more in claims than it earns in premiums, while a ratio below 100 percent suggests profitability from premiums exceeding claims. The insurer is facing severe financial strain from this policy. If the trend continues, drastic measures (like premium hikes or coverage cuts) may be necessary to restore sustainability. Policyholders should watch for changes in terms or costs. Health insurance claims in Nepal have surged drastically since 2020, far exceeding collected premiums, indicating severe underwriting losses likely driven by rising medical costs, COVID-19 impacts, or inadequate pricing.

Composition of Insured under SHSP concerning Provincial Coverage

The SHSP in Nepal exhibits notable provincial disparities in enrollment trends between F/Y 2015-16 and F/Y 2023-24. Koshi Province, which once accounted for over one-third of total enrollments, saw a sharp decline to 19.41% in F/Y 2023–24, suggesting either program saturation or shifting enrollment dynamics. Bagmati Province, by contrast, demonstrated steady growth and emerged as the leading contributor with 35.74% in F/Y 2023–24, reflecting concentrated health infrastructure and administrative outreach. Madhesh Province, which initially recorded minimal participation, expanded modestly before declining to 10.34%, highlighting challenges in sustaining coverage.

Table 4: Premium to Claim Ratio for Health Insurance Policy

F/Y	Ratio in percent
2015-16	0.0
2016-17	0.0
2017-18	2.8
2018-19	39.4
2019-20	85.5
2020-21	119.9
2021-22	195.5
2022-23	383.5
2023-24	331.3

Gandaki and Lumbini provinces showed a consistent downward trend, with Lumbini's share falling from 19.42% to 11.08%, indicating potential program disengagement or limited expansion capacity. Karnali and Sudurpaschim provinces persistently recorded the lowest enrollment shares (4-9%), emphasizing systemic challenges in accessing remote and marginalized populations. These spatial discrepancies reveal an uneven rollout of SHSP, with enrollment momentum consolidating in urbanized or administratively active provinces while lagging in geographically isolated regions. Addressing these imbalances through targeted outreach, infrastructure investment, and localized policy engagement is imperative to achieving equitable universal health coverage.

Table 5: Composition of Insured under SHSP concerning Provincial Coverage

F/Y	Provinces						
	Koshi	Madesh	Bagmati	Gandaki	Lumbini	Karnali	Sudurpacshim
2015-16	There was no maintenance of provincial data, covering only a limited number of districts.						
2016-17	19,362(9.47)	Nil(0.00)	65,911(32.25)	56,059(27.43)	39,699(19.42)	10,232(5.01)	13,111(6.42)
2017-18	249,593(22.08)	12,409(1.10)	265,307(23.47)	167,900(14.85)	224,889(19.89)	101,916(9.01)	108,561(9.60)
2018-19	413,415(24.52)	45,089(2.67)	369,890(21.94)	255,423(15.15)	311,554(18.48)	124,520(7.38)	166,338(9.86)
2019-20	476,422(33.35)	42,768(2.99)	307,585(21.53)	171,963(12.04)	191,950(13.43)	101,998(7.14)	136,065(9.52)
2020-21	438,948(38.82)	31,737(2.81)	231,054(20.43)	117,259(10.37)	141,653(12.53)	65,753(5.82)	104,320(9.23)
2021-22	532,773(33.79)	133,095(8.44)	295,781(18.76)	183,185(11.62)	252,482(16.01)	74,265(4.71)	105,111(6.67)
2022-23	387,384(28.76)	194,895(14.47)	263,258(19.55)	172,689(12.82)	174,873(12.99)	64,229(4.77)	89,402(6.64)
2023-24	209,102(19.41)	111,350(10.34)	384,920(35.74)	163,731(15.20)	119,366(11.08)	43,861(4.07)	44,713(4.15)

Note. Health Insurance Board

Discussions

This study offers a comprehensive examination of Nepal's health insurance system across gender, geography, and financial dimensions, revealing patterns of growth, volatility, and persistent inequities. Consistent with earlier findings by Ghimire (2013) and Paneru et al. (2022), the data confirm that despite major policy efforts, coverage remains unstable. Enrollment peaked in F/Y 2021–22 at nearly NPR 7 million but declined sharply to NPR 2.61 million in F/Y 2023-24, suggesting temporary gains rather than systemic resilience. The gender trajectory, wherein women initially dominated but were later overtaken by men, indicates potential shifts in decision-making authority within households or differing responses to outreach programs. The negligible participation of the 'Other' gender category further exposes gaps in inclusive health policy design.

This trajectory mirrors regional UHC challenges. The rapid increase in claims and disbursements supports prior findings (Khanal et al., 2023; Ghimire & Paudel, 2019) that access and utilization have improved. However, the financial sustainability of the scheme is under strain. The COVID-19 pandemic amplified this vulnerability: a 105.7% rise in claims in F/Y 2022-23 aligns with observations by Sukamane et al. (2024) and Endalamaw et al. (2025) on pandemic-related system overload. The subsequent 32.8% decline in premiums in F/Y 2021-22 reinforces criticisms by Acharya et al. (2023) regarding weak fiscal safeguards and administrative inefficiencies. The paradox of rising claims despite falling enrollments validates Ghimire et al.'s (2024) critique of 'paper coverage', that enrollment does not necessarily translate into sustained access or satisfaction.

Provincial disparities highlight a spatial dimension of inequality. Bagmati Province's ascendancy contrasts with the declining shares in Koshi and Lumbini and persistent underperformance in Karnali and Sudurpaschim, confirming Khanal et al.'s (2023) observations on service delivery imbalances. Theorizing these findings through a systems approach (Domapielle, 2021), Nepal's health insurance architecture appears fragmented, reactive to shocks rather than proactively equitable. While performance in premium mobilization has improved (from NPR 2.09 million to NPR 4,177.96 million), inconsistencies reflect deeper structural and governance issues. Nepal's health insurance system stands at a critical juncture. While the expansion of coverage is commendable, the spiraling premium-to-claim ratio, spatial inequities, and enrollment instability threaten the long-term viability of UHC. As argued by Yanful et al. (2023) as well as Kipo-Sunyehzi et al. (2019), UHC requires not just coverage breadth but also financial resilience and equitable access for the longevity of the UHC. Unless Nepal adopts structural reforms-balancing cost containment, equitable resource allocation, and efficient governance-its UHC aspirations may remain fragile and exclusionary. The time for proactive, evidence-based policymaking is now. These results reaffirm that mere expansion is insufficient; sustainability, equity, and responsiveness are critical pillars of a resilient health insurance framework.

Conclusion and Implications

The study concludes that while Nepal's SHSP has demonstrated quantitative growth in enrollment, premium collection, and claims disbursement, systemic vulnerabilities and disparities persist. Enrollment rose astronomically from 12,623 in F/Y 2015-16 to nearly 7 million in F/Y 2021-22 yet collapsed by F/Y 2023-24. The gender composition shifted significantly, with men eventually overtaking women in participation, and marginalized groups remaining largely excluded. Although fiscal mobilization increased, the program remains susceptible to economic and epidemiological shocks. Provincial data reveal a widening gap between well-resourced and underserved regions, undermining the goal of universal and equitable access to healthcare. The HIB, as an insurer, is facing financial strain due to a surged health insurance claims in Nepal, likely due to rising medical costs, short-term COVID-19 impacts, or inadequate pricing.

To move toward sustainable UHC, Nepal must address structural issues that hinder enrollment, retention, equitable access, and financial viability. Policies should focus on gender-sensitive outreach, decentralized service delivery, and robust financing mechanisms that buffer against shocks. Governance structures need strengthening to ensure transparency and responsiveness.

The findings reinforce the relevance of systems theory and health equity frameworks, which emphasize the interconnectedness of access, utilization, and policy design. Nepal's case illustrates the limitations of linear expansion models and supports a holistic, adaptive approach to UHC. Service providers must improve their infrastructure, streamline claim processing, and enhance the beneficiary experience to reduce dropout rates. Increased digitalization, grievance redress mechanisms, and real-time data monitoring could help. Equitable financing models, such as cross-subsidization and premium waivers for vulnerable groups, are vital. Shock-responsive mechanisms like reserve funds or reinsurance should be institutionalized. Gender and region-specific policies can help address disparities.

Awareness campaigns and participatory policymaking can bridge gaps in public trust and enhance inclusivity. Strengthening the representation of marginalized identities in policy design is essential. The Government of Nepal must reassess premium structures, introduce risk-pooling mechanisms, and explore cross-subsidization to stabilize the health insurance system. Without corrective measures, the scheme risks insolvency, forcing beneficiaries to bear higher costs or lose coverage entirely.

Limitations and Future Research

This study is based on secondary data and may not capture qualitative dimensions such as patient satisfaction or service quality. Future research should explore the socio-cultural and behavioral determinants of insurance participation, cost-efficiency analyses of claims, and comparative studies with other LMICs to extract contextually relevant lessons.

Conflict of Interest

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