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Social Health Security Program and Poor: A Case Study of Dhangadhi Sub-Metropolitan City

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Abstract

It is a well-known fact that Alma Ata Conference on Primary Health Care held in Kazakhstan in 1978 called for all the countries to implement primary health care for increasing health care access to all the people at affordable cost and achieving the targets of "Health for All" by the year 2000.The conference had also emphasized the provision of preventive, promotive, curative, and rehabilitative services up to the community level for addressing main health problems (Gilllam, 2008). The World Health Organization also affirms that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" To ensure these rights to its citizens, every state has to invest organizational, human and financial resources to its optimum level.

Keywords : Implement, affordable, emphasized, rehabilitative & fundamental rights.

Introduction :

During the last few years, social security systems have been under pressure in most countries. Suggestions as to how to change the system to make it perform better. Social Security being the backbone of the welfare state, there is no understanding of the welfare state without some understanding of the functions of the social security system(Oyen, 1986). In the past, low-income populations were not considered for insurance. They were assumed to be too poor to save and pay a premium. Hence,the government assumed the responsibility of meeting the health care need of the poor. One could argue that if the government pays for the poor anyway, why think of insurance at all? Instead, why does the government not continue providing free health services to the poor, as in the past? Well, the strategy of free public health provision has not worked well. Shrinking budgetary support to the public health services, inefficiency in the provision, and unacceptably low-quality of these services are reflective of this problem (Ahuja, 2004).The socialposition of poor, women, socially excluded, marginalized community and othersreflect the unequal distribution of materials and other resources in every society, which can be portrayed as a system of social stratification or a social hierarchy, including educational achievement, income level, and gender, often captured by markers of discrimination (e.g., race/ethnicity). These social positions are characterized by health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability likewise determines differential consequences of ill health for the more and less advantaged group

(WHO, 2007). Health inequalities are health disparities, reflecting differences in access to a range of promotional, preventive, curative, or palliative health services or differences in outcomes including disability, morbidity, and mortality spanning physical, mental, and social health. The causes of inequalities in health are dynamic and reflect multiple determinants. Health inequities, however, are differences in health that are judged to be avoidable, unfair, and unjust (Whitehead,1992). Two important documents set out rights for attaining the best average level of health and the smallest feasible differences among individuals and groups within countries and around the world: the Constitution of the World Health Organization (WHO, 1948) and the Universal Declaration of Human Rights (UN,1948). Both documents share the principle of nondiscrimination and equal opportunity, outline the right to health, link health outcomes with social determinants of health (SDH) and other social goals the enhance population well-being, and address responsibilities of duty-bearers, primarily member state (e.g., government) and those who act on their behalf, such as intergovernmental organization. The Sustainable Development Goals (SDGs) and the Global Health Security Agenda (GHSA) areas leading frameworks for guiding policy and program development to improve health globally. In 2015 AD, 193 countries adopted the SDGs as global development goals for 2030 to achieve a more equitable, healthy, and prosperous world (UNGA, 2015). Global evidence and experience show that explicit political commitment to implementing policies that reduce health inequality, combined with current knowledge, can yield improvement. Synthesizing research, observational evidence, and evaluated innovations by researchers are helping to reduce health inequality. Numerous reviews across the low, middle, and high-income countries continue to document that health inequalities are related not only to biological or genetic factors but also to social factors that are amenable to policy.

Nepal had also adopted the SDGs as global development goals for 2030 to achieve an equitable, healthy, and prosperous world and this scholarly research article is also aimed to support better health facilities for all under Social Health Security Program (SHSP).

According to the National Planning Commission's 2014 Survey of the Multidimensional Poverty Index,the incidence of poverty had fallen from nearly 60% in 2006 to 28.6% in 2014, largely because household incomes rose due to remittance. The survey conducted by Sharecast Initiative for UNICEF in October 2020 involved a representative sample of 6,558 households with children all over the country shows that with the Covid crisis, Nepal's poverty rate may have climbed back to the level 15 years ago at the end of the conflict. The most striking finding was that 42% of households in Nepal have no earnings at all, and a further 19% have a combined monthly family income of less than Rs10,000. This means the official figure for Nepal's population living below the poverty line will need to be drastically revised (Nepali Times, 2020). In such a critical situation, the Social Health Security Program initiated by the government of Nepal is a great help for the poor, women, socially excluded, marginalized communities, and others.

Research Problem

Traditionally, sociologists have had a tendency to avoid economics, and social security has mainly, and wrongly, been defined as an economic issue. At present days, sociologists have shown little interest in the social security system because it directly or indirectly influences the lives and life chances of the majority of the people. The ISA Research Committee on Poverty, Social Welfare and Social Policy and the Department of Health and Social Policy Studies, University of Bergen, in collaboration with the International Social Security Association (ISSA), called for an international conference on The Sociology of Social Security. The conference was held in Bergan, Norway, in June 1984. Forty-eight people from 15 countries and 4 continents participated. The specific topic was "Innovation and Change".The Social Health Security Program (SHSP) is new in the context of Nepal and still, it is not becoming a part of sociological inquiry. To fulfil the academic gap, the topic "Social Health Security Program and the Poor: A case study of Dhangadhi Sub-Metropolitan City" has been chosen. The Social Security system is the foundation of the welfare state. If it is not understood correctly and implemented properly, it won't be efficient and accessible to all citizens, particularly the poor.

Research Question

I intend to investigate the following research question to know thequality of health service to the poor, and effectiveness.

(a) How poor people are benefited from social health security programs?

1. Social Health Security Program (SHSP) in Nepali Context

Health has universally been considered a fundamental human right. In consideration of all these, National Health Policy, 1991 was formulated to extending basic primary health care services up to the village level. As a result, sub-health posts wereestablished in each VDC, and health posts, public health centers (PHCs), and hospitals were established in each area, constituency, and district level respectively. The Constitution of Nepal 2015 addresses health as a fundamental right, stating that every citizen has the right to basic health services free of cost. But the reality is a far cry. Only 61.8% of the Nepalese households have access to health facilities within 30 min, with significant urban (85.9%) and rural (59%) discrepancy. The decreasing health budget over the last 5 years shows that Nepal needs to find new ways to increase health care financing. Addressing barriers to health services needs urgent interventions at the population level. In February 2015, the Government of Nepal formed a Social Health Security Development Committee as a legal framework to start implementing a social health security scheme (SHS) (technically considered as social health insurance). The insurance scheme aimed to ensure universal health coverage by increasing access to, and utilization of, quality health services. The first phase of the SHSP has been planned to start in three districts (Kailali, Baglung, and Ilam) in 2015 (Global Health Action, 2015) and now mostly all provinces and districts of Nepal. The government meant of Nepal Social Health Security Program (health insurance) is based on a comprehensive social contributory scheme with a subsidy to the poor and universal health coverage. It

provides a subsidy to ultra-poor, poor and marginalized groups up to 100%, 75%, and 50% respectively by government base posed poverty card. The yearly premium cost of health insurance is Rs. 3500 for 5 members of the family, additional Rs. 425 is added for additional each member of the family in a year. The objective of the program is to ensure access to quality health services (equity and equality) and to protect from financial hardship and out-of-pocket payments. The health care services provide (1) Free Drugs (2) Free Care Services (3) Targeted Free Care Services. Until now, it is implemented in 15 districts, covering 5% of the population. It aims to achieve its target 20 % in 2017, 50% in 2020 and 100 % in 2030" (Insurance Board, 2020). The government of Nepal has an important tax-based component in its health financing system. However, various forms of SHSP were lunch, for those who can afford the premium cost for the SHSP scheme were not charge. Identified poor are receiving free SHSP scheme and elderly citizen above 70 years old are also getting free scheme under SHSP. As tax-based funding normally benefits the entire population. The government of Nepal is making SHSP scheme compulsory for all citizens all over Nepal (Pandey, 2019).

Methodology

The Government of Nepal identified the different levels of poor households through the "Local Level Poor Households Identification Survey in 2070 BS (2013 AD)." Based on the Local Level Poor Households Identification Survey's Final List, I purposefully scheduled interviews with the 30 ultra-poor households in Ward Numbers 2 and 3 of Dhandathi Sub-Metropolitan City. Three color groups, yellow, green, and red, were used to categorize the various poverty levelsby Local Level Poor Households Identification Survey-2013 AD.Among the three different level of color, Red is regarded as ultra-poor and family income served as one such indicator of that survey. I will therefore interchangeably use the terms "poor," "low income," and their equivalents words and sentences in the context of economic poverty.

I used both quantitative and qualitative research method.I used quantitative research methods because it would be difficult to understand and analyze the respondent's current economic statusof income, spending, and saving. After all, poverty is not a constant state; it fluctuates. Yesterday's poor may be wealthy today, and vice versa. The purpose of the qualitative data is for wider understand ofthe respondent's additional status, which cannot be spelled out in quantitative terms. Multiple questionnaires were applied to testing the impact of SHSP on health service utilization, expenditures, and poverty impact. The analysis aims at highlighting the poverty implications related to ill health on the poor and their households. The analysis focuses on linkages between the use of free health services and households' financial savings.

2. Social Health Security Program Assessmentin Dhangadi Sub-Metropolitan City

According to the Census Report 2021, the population of Nepal has reached 29,192,480, which is an increase of 2,697,976 compared to a population of 26,494,504 ten years

ago.Dhangadhi Sub-Metropolitan City has a total of 39249 houses, 46670 families, and 204788 inhabitants overall, with 102334 men and 102454 women.

According to the 2018 Economic Census, Dhangadhi Sub-Metropolitan City has a total of 6,089 enterprises engaged in a variety of economic activities. Total 22,909 people are employed in those establishments for economic purposes, either as employees or as independent contractors. Men make up 15,353 of these employees, while women make up 7,556. The average number of employees per business was 3.76, with male employees making up 2.52 and female employees 1.24 on average. The ratio of men to women working in businesses is 2.03, which indicates there are 2.03 more men working in the economy for every woman. The main sources of income, in order of relevance, are business, foreign employment, government services, labor work, and farming. The most common economic activities include sales at small shops and work in construction sites and factories.

For this research, data were collected from Ward Number 2 and 3 of Dhangadi Sub-Metropolitan City. The ultra-poor households and populationshown in following Table 1:

Table-1: Ultra Poor Population and Household Size

Municipality	Ward No	HHs	Population			Percent
			Male	**Female**	**Total**	
Dhangadi Sub-Metropolitan City	2	16	46	49	95	52.8
	3	14	42	43	85	47.2
	Total	30	88	92	180	100.00

Source: Field Survey, May 2021

The study revealed that the average household size is 6, which is higher than the national average (4.8 CBS census, 2011). The detail data revealsthat the female population is slightly higher than the male population, i.e., males were 88 (48.9%) and females were 91 (51.1%). The bigger size of the family could be another factor for falling in the category of ultra-poor.

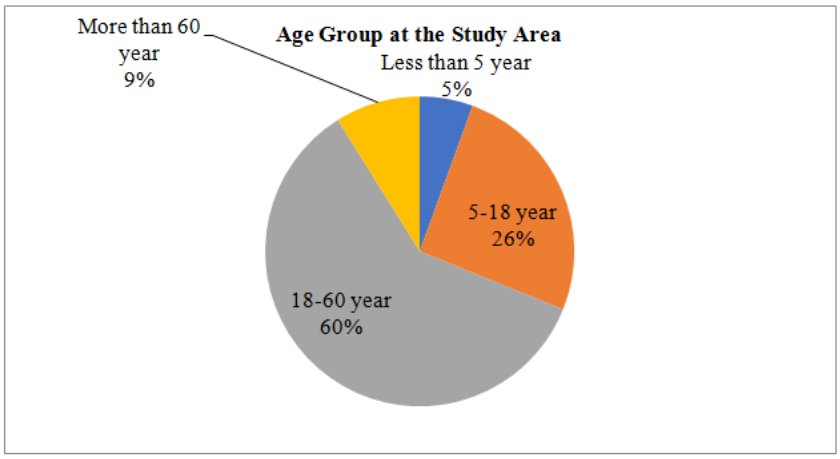
Table-2: Family Type

S.N.	Family Type	Dhangadi Sub-Metropolitan City /Ward No.		Total	Percent
		2	**3**		
1	Joint	2	3	16	53.3
2	Nuclear	9	7	14	46.7
	Total	15	8	30	100.00

Source: Field Survey, May 2021

Table-2 shows 53.3% percent of them are living ina joint family, whereas 46.7% percent are living in a nuclear family. The family size also determined the level of poverty.Among the respondent, most of them were found having free SHSP scheme.

Chart-1: Age Groups

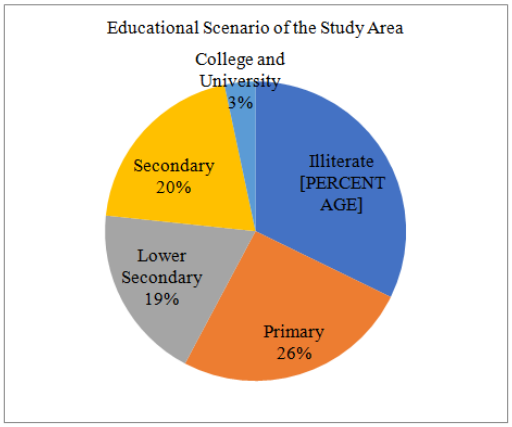


Source: Field Survey, May 2021

The population composition is considered an important indicator for demographic analysis. The Chart:1. as the data shows a high 60% percent population falls under the age group 18-60 years, followed by 26% percent population of 5-18 years and 9% percent of 60 years above group. Likewise, the population of fewer than 5 years is 5% percent respectively.

The age group between 18 and 60, which made up 60% of the population, was the most productive and re-productive age group. This age group is unable to get employment and ultimately trapped in ultra-poverty. The dependency ratio of age between 5-18 and 60 above age groups wasalso found high.Without revenue production and market opportunities, people would not be able to significantly improve their own lives, that of their families, their communities and organizations, and society at large.

Chart-2: Educational Scenario Free SHSP holders



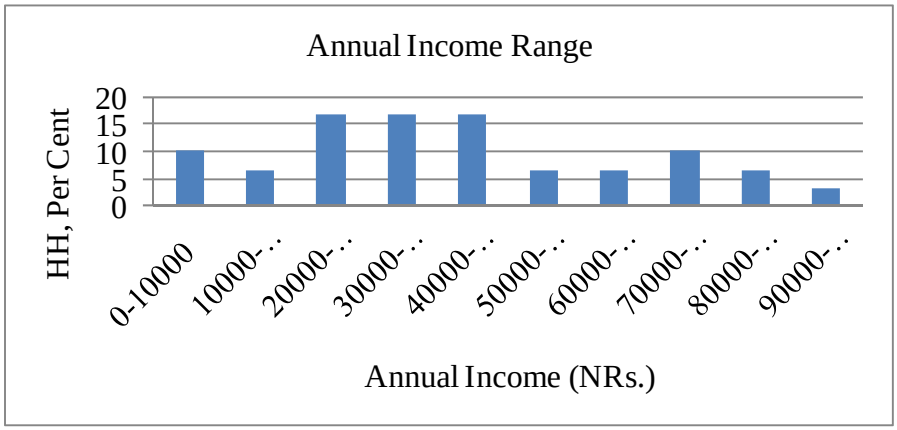
Source: Field Survey, May 2021

Educational information was also taken from respondents which shown in the Chart-2, because it is expecting that the more educated a person is, the more likely to be aware of the

relationship between health and diet or physical exercise, health-related information, and many more. Regarding the educational status of the population aged 5 years above, the survey data reveals that about 32% percent are illiterate. The literate by level of education, 68% percent of total populations are literate. Almost 26 percent of the population has attained primary level education, followed by 19 % percent lower secondary level, about 20% secondary level, and 3% percent university level. The level of awareness and education must have helped them to enrolment in the process ofSHSP scheme on time.Most of the respondents informed that they visited the hospital for the treatment of diarrhea, seasonal fever, typhoid, pneumonia, stomach pain, headache, chest pain, body pain, eye, ear, and throat related problem, external injuries due to unexpected accident, asthma, etc. are the common diseases of the study area. Among the respondent, some had minor surgical facilities along with medical facilities from the authorized pharmacy.

The level of education is a key factor associated with processes of socio-economic development. Future educational achievements of a given population will be vital in determining that population's chances of developing and prospering. Educated women's opinion becomes respected in society, especially in their family circles. They influence household decisions concerning expenses, family planning, and the education of children.

Chart-3: Annual Income Range



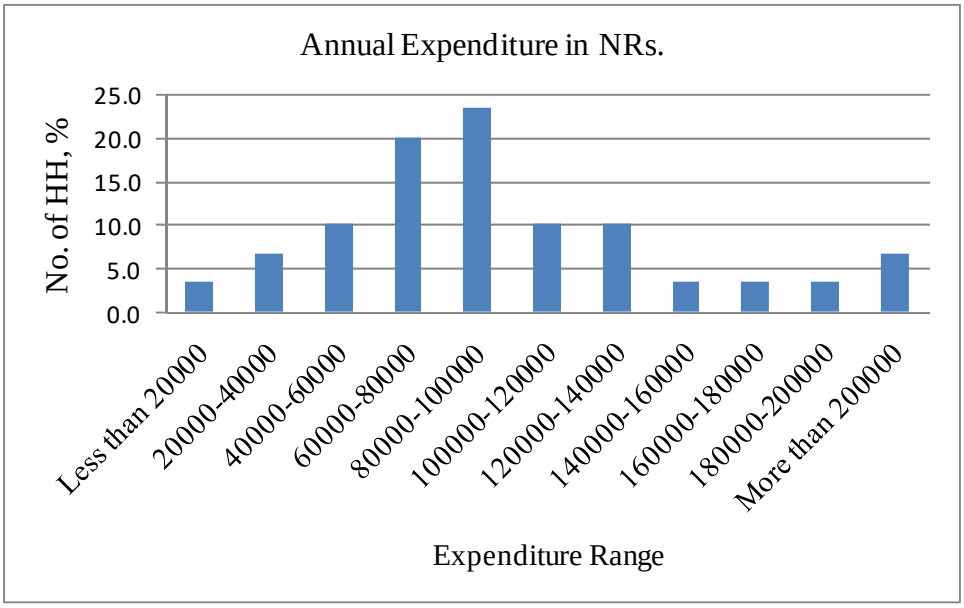
Source: Field Survey, May 2021

The third Nepal Living Standard Survey (NLSS-2010/2011) has defined the poverty line for Nepal in terms of per capita annual income level, which has been estimated at NRs. 19,261; the food poverty line is NRs. 11,929 (per capita consumption 2,220 Kcal per day) and the non-food poverty line. 7,332 based on average 2010-11 prices. The poverty line for a household in terms of income level has been derived assuming an average household size of 4.8, which is adopted from the census survey of CBS -2011.Accordingly; the household level poverty line comes to be NRs. 7704 per household per month. Based on this figure, the household monthly income of NRs. 8,000 is assumed here as the poverty threshold for the identification of poor households, which implies that a household with a monthly income less than NRs. 8,000 falls under low income or poor group.

Despite already identified poor household by Local Level Poor Households Identification Survey in 2013 A.D. I did take some information related to the family's income, expenditure, and saving because lower-income tends to reduce one's opportunity to purchase what is needed for good health, such as sufficient quantities of high-quality food and health care. In addition, other social risk factors mediate the association between income and health. For instance, low-income individuals tend to have lower educational attainment and less social capital and reside in less affluent neighborhoods. All these factors are likely to negatively impact health.

The study found that about 16% of SHSP Scheme holder's households have NRS. 20,000 to 50,000annual income which is very low in comparison to the average poverty threshold. Similarly, about 10 % have NRS. 10,000 to 80,000 and about 6% have NRS. 10,000 to 90,000 and 3% have NRS. 90,000 to 1,00,000. On average, all 30 SHSP scheme holders are ultra-poor as shown in Chart-3.

Chart-4: Annual Expenditure



Source: Field Survey, May 2021

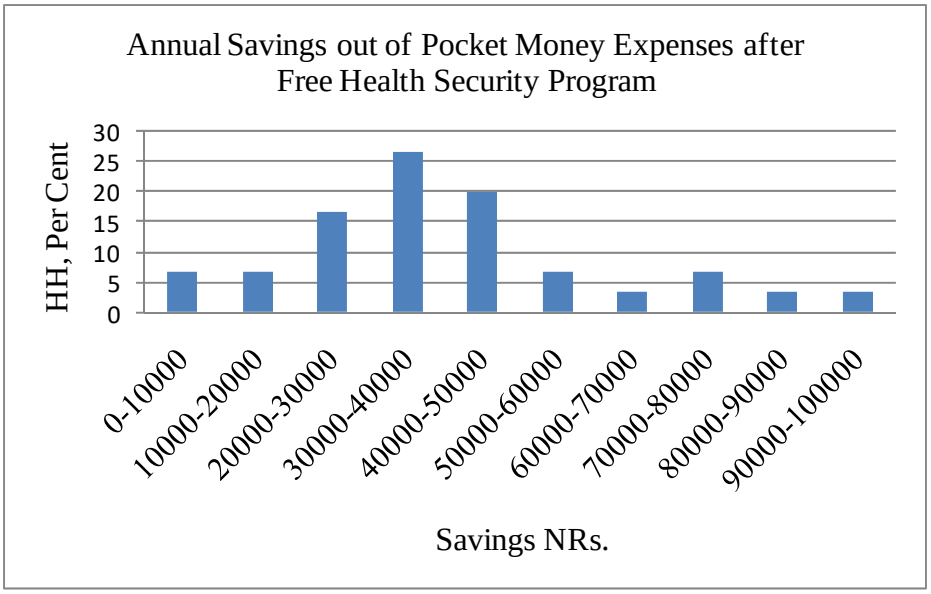
As the survey data shows Chart-4, the majority of the SHSP scheme holders' households 24% fall in the annual average expenditure range of NRS.80,000 to 1,00,000, followed by 20% percent of households with NRs. 60,000-80,000 annual expenditure range categories. Likewise, 10% of households have their yearly expenditure within the range of NRS 40,000 to 1, 40,000 and 5% and below 5% households have highest expenditure level NRS. 2,00,000 annually.

The annually average income and expenditure of SHSP scheme holders' houses indicate that their expenditure is high in comparisonto their income. Most of the respondents said that

they are managing extra expenditureby taking loans from relative and local loan providers. More or less, most of them are under pressure of paying back the loan.It was also found that some families are doing extra-expenditure on drinking, tobacco chewing, smoking, etc. It was also found that they are spending a little bit amount in travel to arrive in hospital and to back home. Some have had a bicycle but it was not ideally useful to get to the hospital in serious problems.

Permanent or higher-paying jobs are more likely to have sick leave benefits, formal or informal, and therefore, are less likely to lose any income as a result of illness but daily wage workers have no such facilities. Despite protective measures, some of the family members of the household suffered from Covid-19. Most of the households lost their daily wage income during the Covid-19. Poor households suffered the most, the Covid-19 had push people toward more vulnerability.Some information was also collected to know the reason for visiting hospitals.

Chart-5: Tentative Amount of Benefit Received from SHSP Scheme

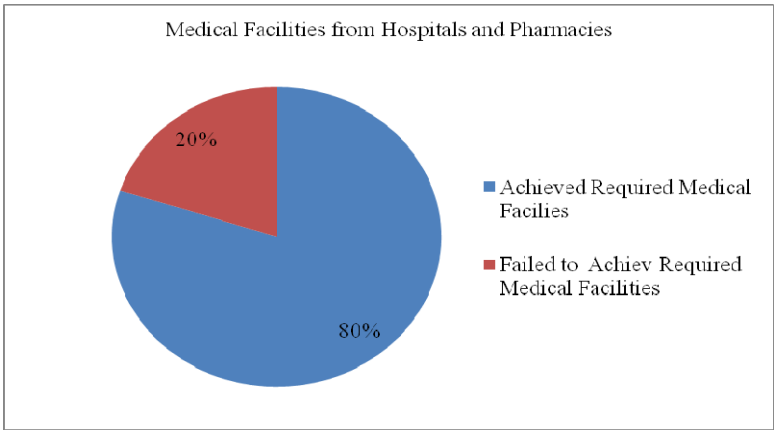


Source: Field Survey, May 2021

Chart- 5 shows, about 26 %of SHSP scheme holders manage to save NRS. 30,000 to 40,000 annually, similarly 20% were able to save NRS. 40,000 to 50,000, about 15% were able to save NRS.10,000 to 20,000 and below 5% were able to save NRS. 10,000 to 1,00,000 yearly.

It seems positive though saving high in-comparison to their annual income, free SHSP scheme helped them to save their out-of-pocket expenses which they can use in the required area like in education, better food, house renting and repairing, clothing, communication, and entertainment. The saving can help them to come out of the poverty thresholds. On average, the respondents received SHSP services equivalent to NRs. 17,467 per annum.

Chart- 6: Medical Facilities from Hospital and Pharmacies



Source: Field Survey, May 2021

Chart-6 shows, about 80% of the respondent from SHSP were able to achieve hospital and pharmacy facilities and 20% of respondent were not able to have that facilities under the scheme. Those who did not get pharmacy facilities, took some sort of loan to purchase the medicine from their relative. This is a negligence of auth authorized pharmacies. If free medicine were not provided as prescribed by the doctors,then definitely ultra-poor suffer the most in the future. This kind of negligence will push groups toward more and more vulnerability. Some respondents reported that hospitals are not able to meet SHSP's scheme holders' expectation and the environment of the hospital does not seem patient-friendly, most of the respondents felt difficulties to peruse SHS scheme because of improper infrastructure and negligence of hospital authority and pharmacy. The respondents found that process for treatment is very lengthy, complicated and discriminatory. some respondents were found very busy to peruse their own business so they did not get enough time to utilize the SHSP scheme. Some respondents had reported that SHS-related pharmacies are cheating the patient.

The secondary data shows that there are a total of 8 urban health centers, including one zonal hospital and two health posts, for a total capacity of 150 bedsin Dhangadi Sub-Metropolitan City. There are 36, with 13 doctors, 9 nurses, 6 auxiliary nursing midwives, and 8 auxiliary registered health workers (IOM, 2020). The limitation numbers of registered health workers, doctors, nurses and bed facilities could another reason for poor health service and facilities for SHSP seekers.

Analysis

It is well-known that socioeconomic status is closely associated with health. Thegovernment of Nepal had provided a subsidy to the people who were below the poverty level. It was a good advantage for poor but it was found that SHSP is not providing all types of health promotion and disease prevention services.While analyzing the collected primary and secondary qualitative data,about 80% of the respondent from SHSP were able to achieve

hospital and pharmacy facilities and 20% of respondent were not able to have that hospital and pharmacyfacilities under the scheme.

Conclusion

Poverty is a major cause of ill health and a barrier to accessing health care when needed. The costs seeking health care system include not only out-of-pocket spending on care such as consultations, tests, and medicine, but also transportation costs and other informal payments like meal etc. Because of the ill health of a breadwinner, both breadwinner and family members may be obliged to stop working or attending school or work to take care of an ill relative. In addition, poor families coping with illness might be forced to sell assets to cover medical expenses, borrow at high-interest rates or become indebted to the community. The study had found, some families had taken loans to manage their day-to-day expenditures in education, food, clothing, communication, travel, and even in medicine. It is good that those whohave been recognized as the below poverty line no need to pay at the point of service which they used to do previously, after SHSP, they get required checkup facilities and medicine for free.

In conclusion, trust needs to build by assuring quality health service delivery and capacity building of health institutions. The management of the resource, capability of the state, level of awareness, and service providers' commitment to providing quality service seem a major problem in the health sector. The hospital authority like doctors, nurses, and supporting staff including pharmacy people need to be genuine toward their assigned job.Still, most of the poor and even reach families are not participating in SHSP, participation towards SHS program is not encouraging because of the scheme providers negligence. Better protection of the poor against health risks is crucial in this endeavor. Poor health drastically impedes the social and economic development of a country: beyond directly affecting people's well-being, life expectancy, high infant mortality,the spread of infectious diseases, etc.)poor, health also lowers the productivity of labor and menaces the entire economy.

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