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Services Provided by Health Facilities and Health Insurance Impact on Nepal's Community Human Health Care

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Abstract

The purpose of this study is to evaluate health services provided by health facilities and health insurance impact on Nepal's human health care. The researcher employed mixed, cross-sectional, and descriptive methods. Google search and relevant literature review. A total of 210 samples (11%) were chosen using the random sampling technique. A structured questionnaire was used to gather primary data, and SPSS software was used for data analysis. All Nepalese residents now have access to health facilities thanks to the government's implementation of health insurance nationwide. There are 155250 medical personnel in Nepal, including doctors and nurses. Nepal's total population is 29164,578 (census report 2021). One health person's coverage ratio is 187.86. Therefore, the government hospital was unable to offer prompt, 100% service. Long wait times for blood tests, operations, medication, and name registration (minimum 3 months). In a government hospital, patients are treated rudely. Increased costs for a city scanner and pricey medications from a private pharmacy. In the event that the government is unable to handle financial difficulties, it will boost the insurance amount or percentage claim amount two or three times and offer 100% free medical examinations, medications, lab tests, and patient surgeries within a week. Every month, make a home visit and offer health care to mothers, children, the elderly, and those with disabilities. It shortens the unwelcome long line at the government hospital.

Keywords: Health Facility, Health Insurance, Health Personals, Medicine

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Introduction

In order to attain universal health coverage, the Nepali government launched the Social Health Insurance Program (SHIP) in 2016 (Ghimire, Singh, & Acharya, 2023). The Nepal Hygiene Improvement Project (NHIP) has experienced low enrolment and renewal rates despite its fundamental goals. Only 13% of people in Nepal actively use the program, according to the most recent statistics. High out-of-pocket costs, which make up 51.3% of healthcare spending, continue to be a significant barrier, indicating weaknesses in the system's safeguards against financial risk (National Policy Forum, 2024).

By 2030, the Nepalese government is dedicated to attaining universal health coverage. This accomplishment is nonetheless hampered by the Health Insurance Board's high dropout and low enrolment rates. Using cross-sectional secondary data from the 2022 Nepal Demographic and Health Survey, this study attempts to evaluate the degree of enrolment status and related characteristics with enrolment in the government health insurance program. Just 10% of men and women between the ages of 15 and 49 received government-implemented health insurance. Madhesh residents had the lowest health insurance coverage (3.1% of men and 2.7% of women), while Koshi Province residents had the highest (21.8% of men and 20.4% of women). Although no group had coverage exceeding 30%, coverage was higher in metropolitan regions, among the wealthiest households, and among those who were employed. Those who have health insurance are more likely to visit a medical facility and to report fewer problems getting care. According to the data, Nepal's government health insurance program is not on track to reach its target of covering 60% of the population by 2023–2024 (Devaraj, Sharma, & Bietsch, 2024).

The foundation for providing effective preventive, promotional, curative, and rehabilitative services is the health system. Six fundamental components of any health system have been identified by WHO. These include information management, workforce, infrastructure, funding, governance and leadership, and access to necessary medications. Despite a number of obstacles in every WHO building block, Nepal has been working to improve its health system. Nepal's health system has long been beset by a lack of funding, geographic disparities, a shortage of medical personnel, poor logistics, a subpar health information system, and inadequate infrastructure (S & R, 2024).

Citizens are shielded from unforeseen high medical expenses by public health insurance. In many nations, it guarantees the quality and equity of healthcare. In contrast to developing nations, all people of industrialized nations are covered by health insurance. Health expenditures at the household and national levels are rising as a result of inadequate health insurance coverage in developing nations. High out-of-pocket medical costs are a problem for many households, and access to high-quality healthcare is still a major obstacle. Due to excessive expenditures that they are unable to pay for out of pocket, many people have even lost their lives as a result of not being able to receive healthcare treatments. The ideal healthcare coverage age for African citizens has been reached by nations with operational public health insurance programs (Masereka, Alanyo, Ikiriza, Andinda, & Kimera, 2023).

The National Health Insurance Program (NHIP) was launched in Nepal in 2016, yet enrolment is still low and the dropout rate is rising. This study looked at how NHIP affected insurance enrollment and health service utilization, as well as the experiences of service providers and

beneficiaries. They had to deal with issues like low motivation, trouble with claims and reimbursement, time-consuming medication procurement, and a lack of knowledge about the insurance program (Bharati, et al., 2025).

Literature Review

Nepal's health system is distinguished by a vast network of medical facilities, volunteers, and community workers. Every person of Nepal has the right to free basic medical care, according to the country's 2007 Interim Constitution. However, the actual situation is very different. Just 61.8% of Nepalese families have access to medical facilities within 30 minutes, with a notable difference between urban and rural areas (85.9% and 59%, respectively).

Urgent population-level measures are required to remove obstacles to health services. Following the release of the National Health Insurance Policy in 2013, the Government of Nepal established a Social Health Security Development Committee in February 2015 as a legislative framework to begin implementing a social health security system (SHS). Although there are still financial obstacles, the program's goal has been to improve health service access for the underprivileged, disenfranchised, and those living in remote parts of the nation (Mishra, Khanal, Karki, Kallestrup, & Enemark, 2015).

Table 1: Health Facilities by Provence's of Nepal

Types of Health Facilities by Provinces wise	Koshi	Madhesh	Bagmati	Gandaki	Lumbini	Karnali	Sudur Paschim
Public hospitals	46	18	54	23	28	28	18
PHCCs	33	2	40	25	29	13	15
HPs	632	740	643	487	568	332	376
Non-public Facilities	217	250	1536	157	234	75	82
Basic health services centres	1302	1217	1303	1942	1080	817	921
Basic hospitals (5-15 beds)	81	27	63	16	25	17	17
General hospitals (25-50 beds)	41	55	79	66	75	16	19
General hospitals (100-300 beds)	11	16	26	9	12	3	2
Specialized hospital (100+Beds)	6	2	12	0	4	0	4
Super Speciality hospitals (50+ beds)	2	0	15	1	3	1	0

Academic/Teaching hospitals (300+beds)	3	3	13	3	6	1	0
Other types of health facilities	136	180	1430	93	175	83	67
Total	2510	2540	5214	1822	2239	1386	1521
Grand total	17232						
Register Health Professionals							
Health Professionals	2018/19	2019/20	2020/21	2021/22	2022/23	Remarks	
Doctors*	26346	28477	30133	32218	34910		
Nurse	55534	56405	68316	73889	82471		
ANM	33660	35168	36446	37236	37420		
Foreign Nurse	843	844	845	848	449		
Total	116383	120894	135740	144191	1534910345250		
Note: Nepal Nursing Council (Based on the registration) *Nepal Medical Council (Based on the registration) (National Statistic Office, Nepal, 2024).							

(Government of Nepal, National Statistics Office, 2024).

According to the data, there were 155250 medical personnel in Nepal in FY 2022–2023, including 34910 doctors, 82471 nurses, 449 foreign nurses, and 37420 ANM. According to the National Population and Housing Census 2021, the total population of Nepal is 29,164,578. The population to medical manpower ratio is 835:1 for doctors, 352:1 for nurses, and 779:1 for ANM.

In a similar vein, there are 17232 total hospital beds available (public hospitals, PHCCs, hospitals, super specialty hospitals, teaching hospitals, and other types of health institutions). According to the National Population and Housing Census 2021, there are 29,164,578 people living in Nepal. The ratio of one bed in a medical facility is 1692.47. The government of Nepal develops long-term vision medical personnel (physicians and nurses) and health facilities (health care centres, primary hospitals, teaching hospitals, and hospitals) as quickly as feasible in the future.

Adults between the ages of 15 and 49 who are socially and economically active have not been adequately engaged by the Hygiene Improvement Project (HIP). It calls for high-quality medical care and HI literacy in homes, hospitals, and schools. Furthermore, the program's sustainability depends on the provision of progressive taxes on goods and services that compromise health, providing multiple coverage and a one-door system (Acharya, et al., 2026). The foundation for providing effective preventive, promotional, curative, and rehabilitative services is the health system. Six fundamental components of any health system have been identified by WHO. These include information management, workforce, infrastructure, funding, governance and leadership, and access to necessary medications. Despite a number of obstacles in every WHO building block, Nepal has been working to improve its health system. Nepal's health system has long been beset by a lack of funding, geographic disparities, a

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shortage of medical personnel, poor logistics, a subpar health information system, and inadequate infrastructure (S & R, 2024).

The primary sources of income for health insurance in Nepal are (a) contributions (premiums) from members who are able to pay and (b) tax funds provided by the Ministry of Finance (MOF) as an annual block grant to the health insurance fund, which is used to pay for administrative costs and subsidize premiums for the elderly and impoverished. The national HI program is currently being implemented gradually, and the MOF set aside US$5.3 million for the 2018–19 fiscal year to help the underprivileged pay their premiums.

There is currently no implementation of the Social Security Fund (SSF) health insurance preview. However, both HI and SSF will depend on tax-based subsidies and premiums paid by enterprises and enrolees when stipulated by specific legislation. Nevertheless, there is no effective method for identifying the poor, which can delay the complete implementation of the national new national Health Insurance established the Health Insurance Act in October 2017 (HI) (Government of Nepal, Ministry of Health and Population, 2019).

Globally, health insurance has been acknowledged as a critical policy instrument to improve residents' well-being by lowering the financial burden. In order to help achieve universal health care, Nepal has likewise embraced this program. The program's overall performance in Nepal is influenced by a number of factors. Evidence regarding the various elements that have impacted the insurance program in the Nepalese setting is lacking, nevertheless. Individual, societal, and policy-related factors all have a role in promoting the usage of health insurance services. These characteristics include shifts in treatment seeking, enrolment assistant support during enrolment and renewal, proximity to the original point of care, and policy elements such as individual cards, contribution amounts, and cashless treatment systems.

Similarly, organizational constraints included a lack of physical infrastructure, ineffective staff management, lengthy wait times, inadequate medication availability, and delays in budget reimbursement. Obstacles at the interpersonal level include issues with employee conduct, interpersonal connections, and the information supplied by service providers. The necessity of raising the standard of healthcare and service delivery methods was highlighted by the identification of barriers to the delivery of health services at various levels (Ghimire S, 2024).

Health insurance literacy measures an individual's ability to compare health insurance policies and determine which one best meets their needs and preferences. Families can strengthen their stability by enrolling in a comprehensive plan and taking proactive measures to address financial and health issues. The strategy must be implemented successfully by adjusting to changing conditions and putting the household's prosperity and well-being first. A person's use of medical services can be greatly impacted by having public health insurance.

Having health insurance encourages people to seek medical care as soon as possible, without delay or treatment avoidance because of financial concerns. Access to specialized care and costly therapies that might otherwise be out of reach for those without insurance can also be enhanced by public health insurance. Having health insurance can help people and families feel less financially burdened by medical costs, which improves access to and affordability of medical care (V & V, 2024).

In India, health insurance enrolments and service accessibility have significantly improved, but they also highlight persistent issues such limited outpatient coverage, unequal access in rural areas, and insufficient financial risk protection. The study concludes by recommending policy

changes that enhance scheme design, beneficiary knowledge, and system accountability to guarantee more effective and fair healthcare delivery (Raghuwanshi, 2025).

The idea that poverty is sustained by illness is becoming more widely recognized. Developing nations have been rapidly adopting different health insurance schemes in recent years to improve access to healthcare for low-income households and stop the downward spiral of poverty and illness. The argument over the best health insurance plan for the impoverished persists despite the overwhelming evidence that health insurance programs have increased access to healthcare in general (Domapielle, 2014).

Health promotion and disease prevention, patient safety, ethics, interoperability, intellectual property, data security (confidentiality, integrity, and availability), privacy, cost-effectiveness, patient engagement, and affordability are all factors that should be taken into account when using digital health. People-cantered, trust-based, evidence-based, effective, efficient, sustainable, inclusive, equitable, and contextualized are all important. Additionally, the increasing worldwide problem of digital waste's negative effects on the environment and human health must be properly addressed (WHO, 2021).

Improving access to healthcare, especially for underprivileged communities, is greatly aided by health insurance. Better health equity and sustainability are typically attained in nations with hybrid public-private financing arrangements. Digital innovations and community-based health insurance have also demonstrated potential for boosting service efficiency and participation. However, obstacles including dispersed policies, inadequate infrastructure, and low public awareness impede the advancement of universal health coverage (Firmansyah, 2024).

The Government of Nepal's social protection program, known as health insurance (also known as social health security), aims to provide its citizens with access to high-quality medical care without burdening them financially. Despite this, people in Nepal are still not as interested in the health insurance program as they should be. The local government should offer efficient healthcare services from the nearby medical facility in order to alleviate citizens' health issues. It should also regularly review the program, solicit feedback, and make recommendations to improve its efficacy and dependability (Aryal, Gharti, & Adhikari, 2019).

The insured individuals have expressed dissatisfaction with the care they have received due to complaints about the low quality of services provided by healthcare providers. Just 42.7% of respondents who used private healthcare facilities and the majority of respondents (82.7%) who used public health facilities expressed satisfaction with the quality of the medications they received at their individual pharmacy. Enrolees utilizing public and private health institutions reported overall satisfaction with care quality at 60% and 40%, respectively (Akande, et al., 2022).

By increasing access, raising the standard of care, and easing the financial burden on individuals and families, health insurance has a revolutionary impact on healthcare systems. The full realization of its benefits is limited by the persistence of administrative inefficiencies, coverage discrepancies, and cost-containment issues worldwide, despite its substantial contributions. Health insurance lowers out-of-pocket costs and greatly increases healthcare consumption, particularly among vulnerable groups (H., A., S., M., & Alanazi F. T. H., 2022).

Bananas are grown commercially and in greater quantities in the Terai area of Nepal. the more reliable and significant benefit between September and February. Nepal imports more than 60–

70% cheaper Indian goods throughout the winter. The banana farming area of Nijgadh uses pesticides and insecticides seven to twenty-four times a day. Compared to sugarcane and cereal crops, banana planting offers twice as many advantages. Soil degradation due to poisoning and decreased output following decomposition. It should be demonstrated after a prolonged period of use and harm to human life as well. Farmers in the Nijgadh area must be informed in a timely manner to avoid severe problems. It will soon be necessary to begin producing and supplying organic goods to Nepal's central, regional, and local markets (Ghimire, et al., 2024).

Parents and children in the Chepang community should be aware of their health condition in relation to other communities. One of Nepal's remote tribal communities, the Chepang are an indigenous ethnic group that reside in Central and Southern Nepal, particularly in the districts of Chitawan, Gorkha, and Dhading. Although they speak a language called Chepang, the locals refer to it as Chyo-bang. The Chepang village is frequently inaccessible, unfertile, and situated on extremely steep terrain. Compared to other communities, Chepang are more likely to seek medical attention. 100% of mothers said they had given birth to their first child before turning 20. However, Chepang children's health was determined to be better than that of children from other communities (Ghimire, Health status of children of Chepang and other communities of Nepal, 2014).

The characteristics of foreign employment as returnee workers, such as leadership abilities, employment prospects, accountability and responsibility, and teamwork in entrepreneurship development, may have an impact on the degree of entrepreneurship among returnee participants (K, M, & S, 2023).

Due to the high summer precipitation rates, Nepal is particularly vulnerable to floods, landslides, drought, forest fires, and hot and cold waves of virus diseases each year. Due to the intense monsoonal rain that falls during the summer (June to September), landslides are more common in Nepal's river hills and Terai area. Flooding is more common in the up-stem area of rivers, while dipping is a problem in the down-stem area. Homes, crops, and human life are all negatively impacted by sedimentation. The study uses weight, height, and mid-upper arm circumference (MUAC) to identify nutritional differences between children under five who have experienced flooding and those who have not.

Compared to youngsters in sane social neighbourhoods that were not harmed by the flood, the children are more malnourished. Unimaginable floods in the Karnali River end human life. Nearly all dwellings are evacuated for one to four weeks during the flood and remain as rubbish in community structures (community housing, schools, and Godam buildings). This situation happens one to three times a year, according to the Karnali River floods. It costs a lot of money to maintain their house, toilet, and hand pump after each flood before they can resume their regular lives (Ghimire, Mishra, & Aithal, 2023).

The effects of chicken farming on employment and income in Nepal's mid-Terai area. In the mid-Terai region, raising chickens is a very lucrative business. In remote locations, broiler farming in particular has been found to be a profitable short-term farming practice. According to the study, raising 100 broiler chickens can bring in between NPR 800,000 and NPR 900,000 a year, with a net profit of NPR 320,000. Furthermore, two people can find work in poultry farming (Timilsina, Ghimire, Mishra, Shrestha, & Adhikari, 2014).

With frequent earthquakes, floods, landslides, droughts, hot and cold waves, and vector-borne illnesses, Nepal is an extremely disaster-prone nation. Every year, the most vulnerable

populations in the lowlands and hills are impacted by monsoonal floods and landslides. The purpose of the paper is to review how children's nutrition is affected during floods. In Nepal, the floods had an impact on women, children, and senior citizens. In Nepal, the primary monsoon months are June through September. Houses, food, crops, cattle, poultry, and clothing are all harmed by floods. The Terai region of Nepal is affected by flooding. Floods have been reported to have impacted children aged three to five in Bangladesh, Bhutan, India, and Nepal (Ghimire M. , 2, 2023).

Based on perspective, the study compares and evaluates child nutrition in flood-affected and non-affected households. Malnutrition was discovered in both areas, however it was more prevalent in the flood-affected area than the non-flood area. Karnali, Nepal's deepest river, is impacted one to three times a year. It affects society by forcing people to spend one to four weeks (7 days to 30 days) a year in secure locations such community centers, school buildings, and Godam (Ghimire M. , 2, 2023).

The way neighbourhood schoolchildren currently snack, as well as the long-term, economical, and significant effects of snacks on eating patterns and health. Children's attachment to school, enrolments, and consistent attendance are all aided by the School Day Snacks. A lot of parents wish to send their kids to school without snacks during the day. It views hunger as a chance for worthy kids to get an education. In Central Hills and possibly other places, midday lunches are a challenge for schoolchildren's nutrition. In a similar vein, to increase children's access to nutrient-rich foods and nutrition awareness. Additional fruits and vegetables for children's growth, health development, and illness detection

Adolescent pupils in both public and private schools consume extremely large amounts of junk food. The Day Snacks Management Guidelines 2020 state that each child should have 150–200 grams of fruits, green vegetables, cereals, and gedagudi (peas, grains, pulses, etc.). 50–60 grams of foods high in animal protein were also required. In Nepal, it is believed that "Harek bar Khana char" (every four distinct meal categories, such as rice, vegetables, animal-related dishes, and pulses) must (Ghimire M. , Mishra, Aithal, & Bolar, 2024).

The dietary habits and health status of community school students' snacking behaviors. Mangal Secondary School, Kirtipur-10, Kirtipur, Kathmandu, had severe wasting total (1) 4.5%, moderate wasting (1) 4.5%, and normal (20) 90.9%, while Mahendra Adarsha Secondary School had moderate wasting (3) 11.1% and normal (24) 88.9%. Based on height-for-age Z-score, the frequency of stunting by age at Mangal Secondary School, Kirtipur-10, Kirtipur, Kathmandu, was 9.1% for children aged 42-53 months, 13.6% for mild stunting, and 77.3% for normal height. In a similar vein, the overall prevalence at Mahendra Adarsha Secondary School, Mahalaxmi-4, Imadol, Lalitpur, revealed normal height at 66.7% and mild stunting in children aged 42–53 months at 33.3%. Mid Upper Arm Circumference (MUAC) is used for screening and emergency situations to evaluate children's nutritional status (Ghimire M. , Mishra, Aithal, & Bolar, 2024).

Due to the vital health status of both the mother and the unborn child, health examinations are essential both during and after pregnancy. The study determines how mothers from Chepang and non-Chepang groups in Makawanpur and Chitwan district, Nepal, seek health care with reference to ANC and PNC examinations. The study used a cross-sectional descriptive design. According to the findings, non-Chepang communities in both districts had better health check-up practices and were more aware of them than Chepang groups. Chepang and other

marginalized and underdeveloped groups should be given priority by the Nepali government in order to improve their access to healthcare services. Concerned authorities should also take responsibility for resolving any issues that may be preventing them from changing their health-seeking habits (Ghimire & Maharjan, 2014).

This empirical review closes a major gap in the literature by exploring the complex relationship between employee engagement and HRD practices in the particular setting of Nepalese firms. Employee commitment is the dependent variable in the conceptual framework that directs this investigation, and it is influenced by demographic factors that function as moderating variables. Career development, organizational development, and training and development are among the independent variables. This framework provides an organized perspective for analysing and understanding the intricate relationship between HRD practices and employee engagement in Nepal's unique organizational environment (Thakur, Chhetri, T. Jha, & Ghimire, 2023).

Statement of Problem

Following the creation of health insurance policies in 2014, Nepali citizens use a health insurance agent to obtain insurance cards. Each family up to five members will receive a total of NRs. 3500 (35 USD) annually. Nepal's government-recommended medical services are offered by various government hospitals. The issues or problems are following:

• A ticket, a doctor's examination, a lab test, and standing in a long line at the drugstore.
• The hospital's chief and short-term medication availability. Costly medication purchased from a different
drugstore.
• The hospital does not have a municipal scanner service since it is constantly spoiled.
• The minimum wait time in the operation line is three to six months.

The six health building blocks—governance, financing, service delivery, health workforce, health information, and medical and pharmaceutical supply—have gaps and difficulties in the new federal health system (Government of Nepal, Ministry of Health and Population, 2019).

Objective

To evaluate services provided by health facilities and health insurance impact on Nepal's human health care.

Methodology

The researcher looked up comparable topics on Google. Descriptive, cross-sectional, and mixed methods (qualitative and quantitative) were used in the research. A structured questionnaire was created, and in-person interviews were used to gather primary data. The research area was Ratnanagar Municipality ward 12 in the Chitwan district. A total of 210 (11%) home representatives were chosen using a random selection technique. SPSS programs were used to analyse the data. Ethical consideration (preserving privacy, making a contribution, and not hurting anyone).

Results and Discussion

Table 2: **Gender and Education Cross tabulation**

			Education				Total
			illiterate	literate	Secondary 9-12 class	Bachelor/Master	
Gender	male	Count	2	34	64	24	124

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		% within Education	20.0%	50.0%	72.7%	54.5%	59.0%
	female	Count	8	34	24	20	86
		% within Education	80.0%	50.0%	27.3%	45.5%	41.0%
Total		Count	10	68	88	44	210
		% within Education	100.0%	100.0%	100.0%	100.0%	100.0%

The table shows that gender and education, total participant were 210, among them male 124 (59%). Male respondents were illiterate 2 (20%), literate 34 (50%), Secondary education (9-12 class) 64 (72.7%) and Batchelor/Master or above Master 24 (54.5%) were. Similarly, female illiterate were 8 (80%), literate 34 (50%), Secondary education (9-12 class) 24 (27.3%) and Batchelor/Master or above Master 04 (45.5%) were.

Table 3: **Gender and occupation Cross tabulation**

			occupation				Total
			Agriculture labour	government & private job	Business	other	
Gender	male	Count	44	57	21	2	124
		% within occupation	42.3%	68.7%	100.0%	100.0%	59.0%
	female	Count	60	26	0	0	86
		% within occupation	57.7%	31.3%	0.0%	0.0%	41.0%
Total		Count	104	83	21	2	210
		% within occupation	100.0%	100.0%	100.0%	100.0%	100.0%

The table shows that gender and occupation total participants were 210, among them male 124 (59%). Among them agriculture labour 44 (42.4%), government & private job 57 (68.7%), business 21 and others were 2. Similarly, female respondents were 86 (41%), among them agriculture labour 60 (57.7%) and government & private job 26 (31.3%) were.

Table 4: H**ealth post, hospital is in your village Cross tabulation**

			Health post, hospitals yes in your village	Total
			yes	
Gender	male	Count	124	124
		% within health post and hospital in village	59.0%	59.0%
	female	Count	86	86
		% within health post and hospital in village	41.0%	41.0%

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Total	Count	210	210
	% within health post and hospital in village	100.0%	100.0%

The table shows that hospital and health post is in your village, total participants were 210, among them both male and female 100% replied yes health post is in the village.
Government of Nepal focus on citizens' health and access basic health treatment facility available in village.

Table 5: **Type of heath facility access in village Cross tabulation**

			Types of heath facility access in village		Total
			Health post	Hospital	
Gender	male	Count	2	122	124
		% within heath facility access in the village	50.0%	59.2%	59.0%
	female	Count	2	84	86
		% within heath facility access in the village	50.0%	40.8%	41.0%
Total		Count	4	206	210
		% within heath facility access in the village	100.0%	100.0%	100.0%

The table shows that types of health facility access in the village, total participants were 210, among them 124 (59) male. Male replied health post 2 (50%) and hospital 122 (59.2%). Similarly, female were 86 (41%), among them health post 2 (50%) and 84 (40.8%) were.
The data show that almost have access hospital due to chitwan is hub of medicine hospital. In less than 20 kilometre distance and in a 30 minute driving can reach in hospital access. Next thing there is Palika level Municipality hospital in Tandi Bazzar. All the respondents go and health check-up in this hospital.

Table 6:**Service available (blood, urine & stool test, ECG, ECO, Vaccine, Operation facility & doctor check-up) in the hospital Cross tabulation**

			Facility available in the hospital		Total
			yes	No	
Gender	male	Count	122	2	124
		% within service available (blood, urine & stool test, ECG, ECO, Vaccine, Operation & doctors facility) in the hospital	58.7%	100.0%	59.0%
	female	Count	86	0	86

		% within service available (blood, urine & stool test, ECG, ECO, Vaccine, Operation & doctors facility) in the hospital	41.3%	0.0%	41.0%
Total		Count	208	2	210
		% within service available (blood, urine & stool test, ECG, ECO, Vaccine, Operation & doctors facility) in the hospital	100.0%	100.0%	100.0%

The table shows that service available (blood, urine & stool test, ECG, ECO, Vaccine, Operation facility & doctor check-up) in the hospital, total respondents were 210, among them 124 (59%) were male. Male 122 (58.7%) replied yes and 2 say no. similarly, 86 (41%) female replied yes.

Normally, hospitals provided facilities are blood, urine & stool test, ECG, ECO, Vaccine, Operation facility & doctor check-up. After check-up medicine could not get 100%. Expensive medicine could not available in hospitals but chief rate medicine available from hospital.

Table 7: **After dr. check-up get medicine free or not Cross tabulation**

			After dr. check-up get medicine free or not	Total
			yes	
Gender	male	Count	124	124
		% within Dr. check-up get medicine free or not	59.0%	59.0%
	female	Count	86	86
		% within Dr. check-up get medicine free or not	41.0%	41.0%
Total		Count	210	210
		% within Dr. check-up get medicine free or not	100.0%	100.0%

The table shows that after checked get medicine free or not, total participants were 210, all the respondents replied normal tests blood, urine & stool test, ECG, ECO, Vaccine, Operation facility & doctor check-up easily access. But expensive medicine purchase from private clinic.

Table 8: D**istance from village to local health facilities Cross tabulation**

			distance from village to health facilities		Total
			6-15 minute	15-30 minute	
Gender	male	Count	124	0	124

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		% within distance from village to health facilities	59.6%	0.0%	59.0%
	female	Count	84	2	86
		% within distance from village to health facilities	40.4%	100.0%	41.0%
Total		Count	208	2	210
		% within distance from village to health facilities	100.0%	100.0%	100.0%

The table shows that distance from village to local health facilities, almost total respondents replied 6-15 minute driving reach in local level health facility available. 2 female respondents replied reach 15-30 minute driving distance.

Table 9: **Any service charge paid in hospital Cross tabulation**

			Any service charge paid in hospital	Total
			yes	
Gender	male	Count	124	124
		% within any service charge paid in hospital	59.0%	59.0%
	female	Count	86	86
		% within any service charge paid in hospital	41.0%	41.0%
Total		Count	210	210
		% within any service charge paid in hospital	100.0%	100.0%

The table shows that any service charge paid in hospital, total 210 all respondents replied yes 20% charge paid in hospital according to hospital claimed.

Table 10: **Made insurance card Cross tabulation**

		made insurance card	Total
		yes	
Gender	male	124	124
	female	86	86
Total		210	210

The table shows that made insurance card, total 210 respondents replied yes.

The health insurance is very effective for mid and poor households of community. It helps free doctor check-up, laboratory test (blood, urine, X-ray and small operation) and medicine available. But there is management problem in hospital like long line in doctor check-up, medicine receive next long line and long-time (above 3 moths) wait for small operation. Some patient will die to wait queue for operation.

Table 11: **Hospital provide medicine free of cost Cross tabulation**

			Hospital provide medicine free of cost	Total
			yes	
Gender	male	Count	124	124
		% within hospital provide medicine free of cost	59.0%	59.0%
	female	Count	86	86
		% within hospital provide medicine free of cost	41.0%	41.0%
Total		Count	210	210
		% within hospital provide medicine free of cost	100.0%	100.0%

The table show that hospital provide medicine free of cost, all the 210 (100%) respondents replied yes.

Summary of findings

- The Nepali government prioritizes the health care of its population and makes basic medical facilities accessible in villages through insurance. Because of the medical centre, nearly every inhabitant in the Chitwan district has access to a hospital.
- A large hospital may be reached in less than 20 kilometres and up to 30 minutes by vehicles.
  Tandi Bazzar has a Palika level Municipality hospital. Every individual with a middle-class or lower-class income visits this hospital for a health examination.
- Typically, hospitals offer blood, urine, and stool tests, ECG, ECO, vaccinations, surgeries, and insurance card-based doctor visits.
- The hospital pharmacy was unable to provide 100% of the medication after the examination. The hospital pharmacy only has chief rate and short-date medications left. Purchasing pricey medications from a private pharmacy.
  In accordance with hospital invoices, a total of 20% cash was paid to the hospital.
- The community's middle-class and lower-class households benefit greatly from the health insurance. Free medical examinations, laboratory tests (blood, urine, X-rays, and minor surgeries), and medication are provided.
- There is a management issue at the hospital because of the lengthy wait times for regular operations (at least three to six months), large lines for doctor examinations, and pharmacies. A serious patient will pass away prior to the scheduled surgery.

Suggestions

- The health insurance amount is NRs. 3500.00 (three thousand five hundred) for a five-person household. If people have greater financial difficulties receiving medical care,

the government may increase the amount by two to three times or by a percentage, but it will still offer 100% free services like city scans and medications.

- Increase and oversee medical staff in accordance with the volume of services the hospital provides on a daily basis.
- The operation case is completed in a week.
- Every month, three levels of government—central, provincial, and local—develop guidelines and policies for one-day home visits to assess the health of mothers, children, the elderly, and people with disabilities.
- A follow-up call for people who require a hospital procedure and city scan. It shortens the hospital's long line and crowds.
- Create a system or policy that allows Nepali citizens with insurance cards to visit any government hospital in the country without a referral letter from a nearby medical facility.
- Make use of student physicians and nurses for both hospital and home visits.

Conclusion

Although the health insurance program is particularly beneficial for community members with middle-class and lower-class financial statuses, it has not been successfully administered. Name registration, pharmacy, and lab testing time are the primary issues. Government hospitals have enormous lines and lengthy wait times for services. Health services include the purchase of pricey medications from a private pharmacy and city scanning.

People in the community ask the government to increase insurance premiums by two or three times, increase the percentage of hospital fees, and offer 100% free and comprehensive services. Every month, teaching hospital health personnel mobilize house visits and offer door-to-door services to women, children, the elderly, and people with disabilities. For follow-up calls to hospital patients in need. It shortens the lengthy and unwanted line at the public hospital for treatment.

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Conflict of Interest Statement

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