Health Care Financing in Nepal

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This paper examines health care financing in Nepal with its functions, creating fiscal space, risk pooling, and purchasing. The paper was produced by Mr. Shiva Raj Adhikari, RTI International provided technical assistance. The opinions expressed herein are those of the author and do not necessarily reflect the views of DFID.

HSRSP provide policy and strategy support to the Ministry of Health and Population (MoHP) in implementing its sector reform agenda. Additional information on HSRSP is available by contacting: Dr. Rob Timmons, Team Leader, or Damodar Adhikari, Deputy Team Leader, at: HSRSP, Ministry of Health and Population, P.O. Box 8975, EPC 535, Kathmandu, Nepal. (telephone: 977-1-426-6180; fax: 977-1-426-6184; e-mail: hsrsp@np-hsr.rti.org).

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List of Acronyms

CHI	Community Health Insurance
CHIS	Community Health Insurance Scheme
DfID	Department for International Development (UK)
EDP	External Development Partner
EHCS	Essential Health Care Services
FMIS	Financial Management Information System
FY	Fiscal Year
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MTEF	Mid-Term Expenditure Review
NGO	Non-Governmental Organization
NHSP-IP	Nepal Health Sector – Implementation Plan
NNHA	Nepal National Health Accounts
OOP	Out-of-Pocket
PPP	Public-Private Partnership
RTI	Research Triangle Institute
SDIP	Safe Delivery Incentive Plan
SWAp	Sector Wide Approach
WHO	World Health Organization

I. Introduction

The health system in Nepal has had to change due to a number of factors including drastic changes in political system, changes to the development process, increase urbanization, changes in lifestyle, expanded opportunities, the influx of revenue through remittances, reduced poverty levels, enhanced access to information and information technology, and a dramatic growth of paramedic and medical schools. The government, besides strengthening the current public health system has also the challenge of utilizing the private health system to address public health goals and making it accessible to the poor at affordable prices. The financing method chosen is of critical importance because it determines the collection of revenue, the risk-pooling arrangement and the distribution of the cost burden, and the purchasing of services.

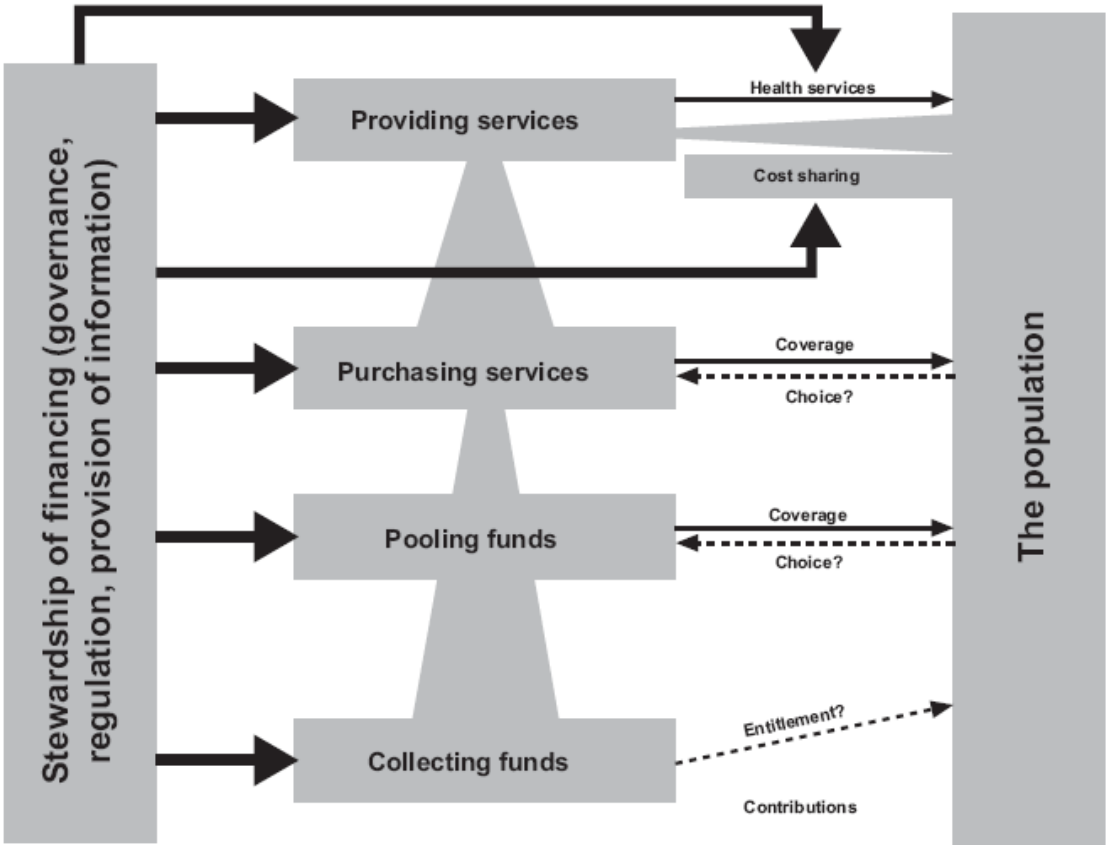
Health care financing has an important role to play in transforming the health care system into one which provides efficient and effective health care to poor and vulnerable people in Nepal. The functions of health care financing - the collection of revenue, risk pooling and purchasing - are all critical to policy design. The function of revenue collection deals with how financial contributions to the health system are collected from different sources. There are domestic sources and external (or international) sources of financing for health. Domestic resources, including the collection of contributions and taxes, finance the majority to health care services. Private spending on health from households and companies complements these public domestic resources. External resources, including official development aid as well as foreign loans and grants, contribute a significant share of total funding for health care in Nepal.

Risk pooling is a mechanism in which revenue/contributions are pooled so that the risk of having to pay for health care is spread among users. A number of organizational entities exist that can provide risk pooling options. These include tax-based financing, social health insurance, and private health insurance, among others. Purchasing is how funds are used to purchase effective health services from public and private providers.

The objectives of health care financing are: a) equitably and efficiently raising sustainable revenues to support health care; b) pooling risks in an efficient and equitable manner to ensure financial protection to the Nepalese population; and c) purchasing services in an allocatively and technically efficient manner. The following framework depicts the full range of health financing functions and policies. The health financing system involves the three functions of collection, pooling, and purchasing; these functions, however, are integrated rather than carried out separately. The framework facilitates analysis of health financing reforms, since reforms may affect specific functions rather than health financing as a whole. For example, an increase in the health budget by incorporating external development partner (EDP) contributions into the Red Book is a type of reform related to the collection function, but this reform will not directly change the function of purchasing services; we would need additional reform strategies for purchasing.

We introduce universal free health services at below the district level that are primarily purchasing functions, but additional funds are needed for this policy to address collection functions, requiring another strategy for collecting funds. These functions are integrated under the term 'health care financing,' but each function requires separate reform strategies to change the health care financing policy.

Figure 1.1: Framework for descriptive analysis of health financing functions



Sources: Adapted from Kutzin 2001 and WHO Regional Office for Europe 2006.

A systematic review and analysis of health care financing is required to improve the health system. Unfortunately, such review is limited by data availability. Data on technical and allocative efficiency are limited, making how this data translates into policy and practice a challenge. Hence, this paper has two objectives: to review the existing health care financing policy, and to explore options for designing better health care financing strategies with the goal of producing efficient, equitable, and effective health care services. This paper utilizes data from various published and unpublished government documents, including the Nepal National Health Account, public expenditure reviews, economic surveys, the Mid-term Expenditure Framework (MTEF), annual reports, published articles, and research reports, among others.

II. Health Financing Policy Goals

There are two important health care mechanisms in health care financing: allocative efficiency, meaning 'doing the right thing,' and technical efficiency, meaning 'doing it the right way,' regarding the use of resources. Allocative efficiency refers to the allocation of resources at different levels of care, and among services dealing with different areas of care. 'Doing the right thing' specifically through allocative efficiency means allocating resources to those services dealing with the heaviest burden of health problems in the community for which effective interventions exist and, within those services, giving priority to the most cost-effective interventions, i.e. interventions offering the lowest cost per unit of health outcome. 'Doing it the right way' specifically through technical efficiency means providing resources to the maximum number of fundable services and minimizing the cost of each service without compromising quality of care (Donaldson and Gerard, 1993).

In addition to equitable and efficient mechanisms, feasibility and sustainability are frequently included in the evaluation of how health care financing mechanisms use resources. Feasibility examines administrative capacity, including actuarial expertise and information systems, to ensure successful implementation. The sustainability of a financing mechanism refers mainly to its long-term stability and potential for generating revenue. If the revenue generated by a financing mechanism is subject to considerable and frequent fluctuations, the mechanism cannot be regarded as reliable and is likely to be replaced by financing mechanisms that are more predictable in the medium to long term. Sustainability also relates to the ability of a financing mechanism both to maintain its level of funding in the long term and to expand its level of funding over time as the need for health care grows (McPake and Kutzin, 1997).

Health care financing in resource-poor country like Nepal relies mostly on household out-of-pocket payments which often results in financial catastrophe or poverty if services are paid for, or welfare loss if the client is refused access to healthcare due to financial barriers. It is with this in mind that it becomes clear that the government must provide health protection to the poor.

We need also to mobilize more resources for health. In light of limited fiscal space, donor resources are important. However, the government's political and financial commitment to health and harmonization in order to maximize the impact of donor funding remains a major challenge. The growth rate of health expenditure and ratio of health expenditure to total government expenditure suggests that there is limited fiscal space to further increase the health budget, in particular in consideration of competing government priorities in other sectors. The contribution of the health sector to improving socioeconomic development and poverty reduction must be redefined and emphasised to increase the budget for health sector.

Policy goals are summarized as the following:

- Ensuring financial protection associated with ill health to prevent impoverishment and financial shock as a result of using health care;

- Promoting a more equitable distribution of the burden of financing, meaning that the rich proportional to their income pay more for health care than the poor;
- Promoting equitable use and provision of services, meaning that access to health care is based on need rather than ability to pay;
- Improving the transparency and accountability of the system;
- Rewarding good quality care and providing incentives for efficiency in service organization and delivery;
- Promoting administrative efficiency by minimizing duplication of responsibility for administering the health financing system, and minimizing costs that do not contribute to achieving the aforementioned goals.

III. Fiscal Space for the Government Budget

Fiscal space is the financing that is available to the government as a result of concrete policy actions for enhancing resource mobilization. In its broadest sense, fiscal space can be defined as the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position (Heller, 2005).

The concept of fiscal space is linked to the concept of fiscal sustainability, which addresses how we can create the fiscal space for health care financing, and is similar to the collection of resources. We use fiscal space in this paper to mean the collection of resources for health care financing.

The macroeconomic performance of the country has a significant bearing on expenditure applied to the health sector and on health sector outcomes. Thus, the level of economic growth determines the fiscal space. A higher growth rate expands the revenue space of the government which leads to scaled-up health interventions, expenditures, and outcomes. Unfortunately, in recent years, the real GDP growth rate has remained quite low, limited to less than five percent (MoF, 2009). An analysis of government sources of financing along with trends in health expenditure compared to total government expenditure reveal the fiscal space for health financing available. The pie chart in Figure 3.1 shows all the sources of government financing for fiscal year 2007/08. Revenue mobilization has contributed almost two third of total government expenditure, followed by foreign grants. However, foreign grants and domestic borrowing are equal.

Figure 3.1: Sources of government financing 2007/08

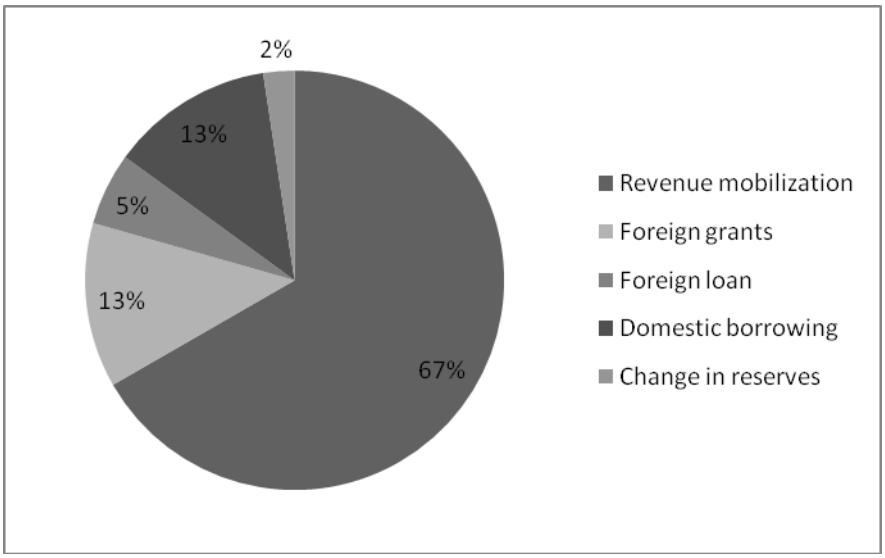


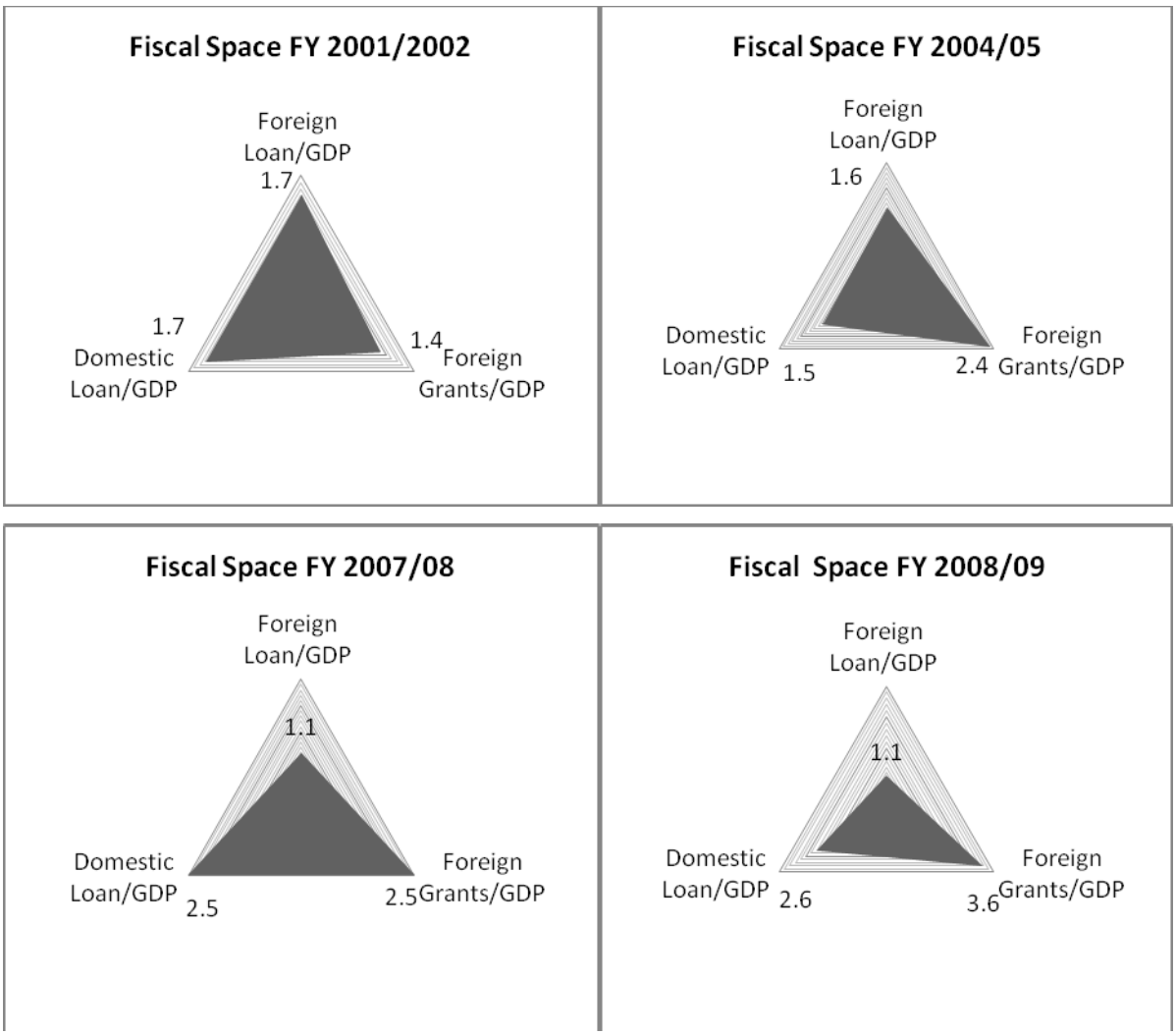
Table 3.1: Fiscal Space indicators

Description	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Revenue (growth rate)	3.2	11.5	10.9	12.5	3.1	21.3	22.7
Total government expenditure (growth rate)	0.3	4.9	6.5	14.7	8.1	20.5	20.8
Recurrent expenditure (growth rate)	6.6	6.6	6.6	11	8.6	15.1	18.6
Capital expenditure (growth rate)	-12.5	-9.8	3.3	18.4	8.3	34.2	34.7
Revenue /GDP	11	11.4	11.6	11.9	11.1	12.1	13.2
Tax revenue/GDP	8.6	8.7	9	9.2	8.8	9.8	10.4
Non-tax revenue/GDP	2.4	2.8	2.6	2.7	2.3	2.3	2.8
Total government expenditure /GDP	17.4	17.1	16.7	17.4	17	18.4	19.7
Recurrent expenditure/GDP	10.6	10.6	10.3	10.5	10.2	10.6	11.2
Capital expenditure/GDP	5.4	4.5	4.3	4.6	4.5	5.5	6.5

Sources: Economic survey, 2009 (MoF, 2009)

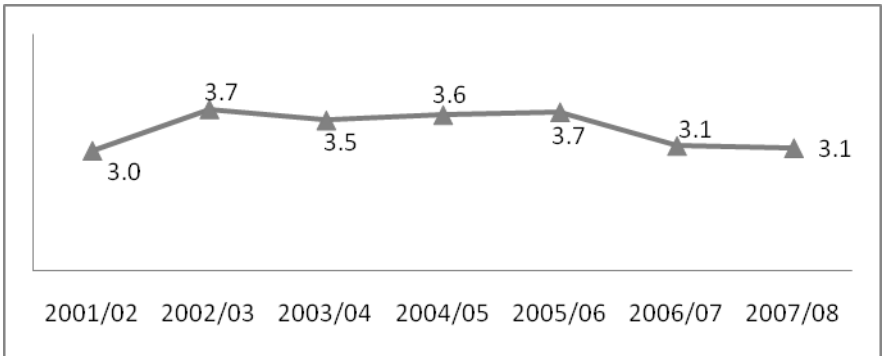
In principle, the fiscal space in Nepal could increase through changes to the tax system (tax increases or better tax administration), domestic borrowing, or external financing (loans and grants from donors). Domestic borrowing to finance health spending is a less desirable route because of the impact it would have on economic activities in the domestic market. The following four diagrams compare the available fiscal space excluding revenue for selected fiscal years.

Figure 3.2: Fiscal space in 2001/02, 2004/05, 2007/08, and 2008/09



Sources: MoF (2009).

General tax revenue is the primary domestic source of financing. Indirect taxes contribute at least three times as much revenue as direct taxes. Revenue collection has been increasing over the last three fiscal years through changes in the tax base (MoF, 2009). The ratio of direct to indirect taxes shows a constant structure of revenue collection. Figure 3.3 Ratio of indirect to direct taxes



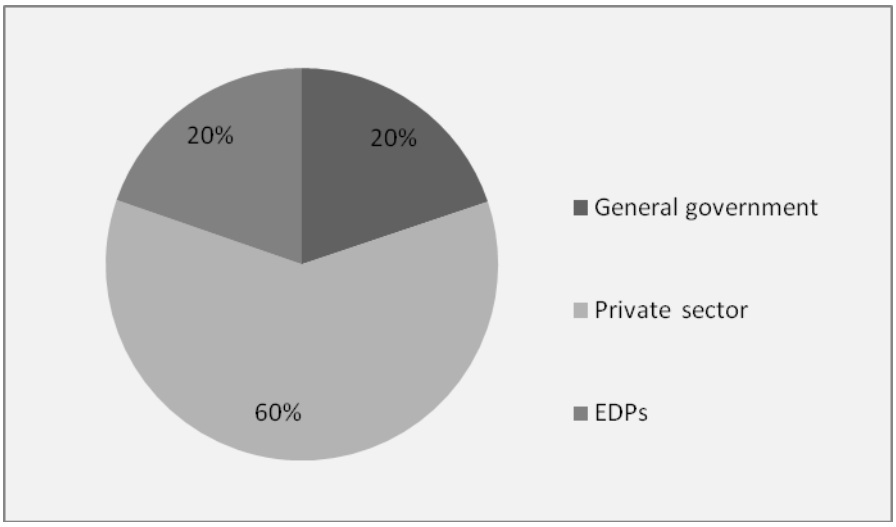
Sources: MoF, (2009) and estimated.

Both direct and indirect taxes are progressive, with closely similar magnitudes (concentration indices: 0.4828 and 0.4538 respectively) (O'Donnell, et al 2008). This suggests that there are still possibilities of increasing the tax base, particularly from the consumption and production of goods and services.

3.1 Existing health care financing

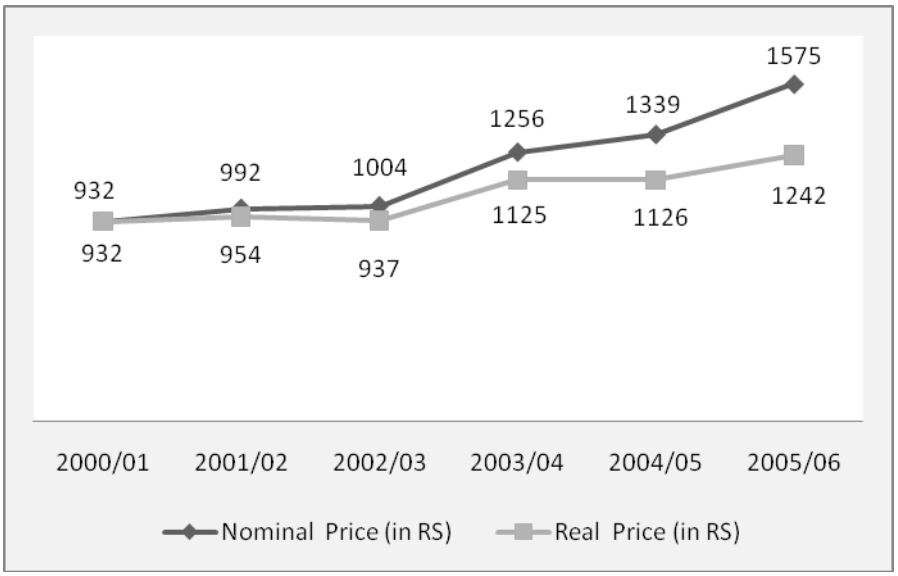
The most recent data from the Nepal National Health Accounts suggests that the government contributes less a quarter of total health spending, while out-of-pocket payments (OOP) contribute almost 60 percent of total health spending. Total per capita spending has continued to increase over the years in both nominal and real terms (at 2001 constant prices).

Figure 3.4: Sources of financing 2004/05



Sources: MoHP (2009a).

Figure 3.5: Per capita health spending



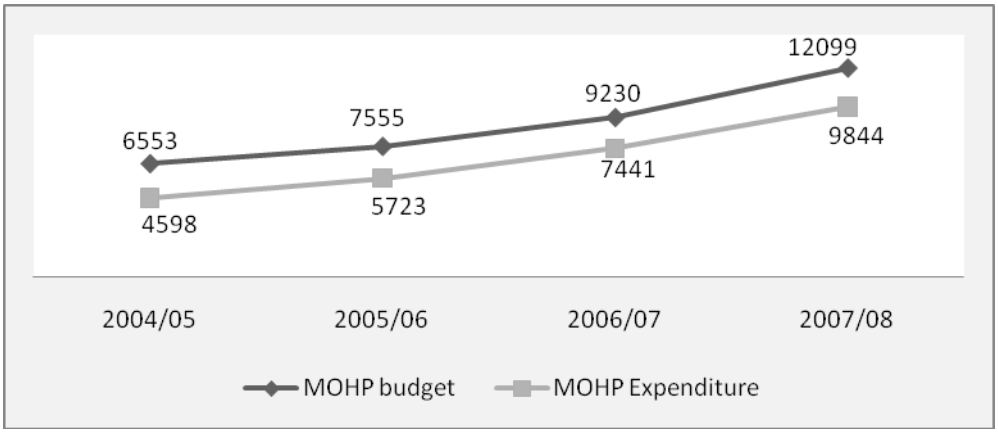
Sources: MoHP (2009a).

Public spending on health has been increasing in recent years due to the growing realization of the importance of health to socioeconomic development and the direct welfare to citizens. The Ministry of Health and Population (MoHP) alone has contributed almost 75 percent of total public spending (MoHP, 2009), and the absorptive capacity of the MoHP has been increased dramatically over the last four years (RTI, 2009). The biggest sources of funding for public expenditure on health are tax revenue, foreign grants and loans, allocations by local bodies, state owned enterprises, and autonomous universities which receive annual budgets from the Ministry of Education.

Foreign grants and loans, the second-greatest source of public funding, comes through bilateral and multilateral commitments. Bilateral and multilateral agencies, called external development partners (EDPs), provide funding for health through two channels: direct funding and indirect funding. Direct funding is the fixed amount of money EDPs commit to, as recorded in the Red Book, while money that is expensed by the EDPs themselves to improve health is referred to as indirect funding. Public expenditure on the health sector from direct sources is available from various published government documents such as FMIS; the Red Books, and auditors' reports. Indirect sources of funding from EDPs are not included in government budget documents as those funds are channelled through non-governmental organizations (NGOs).

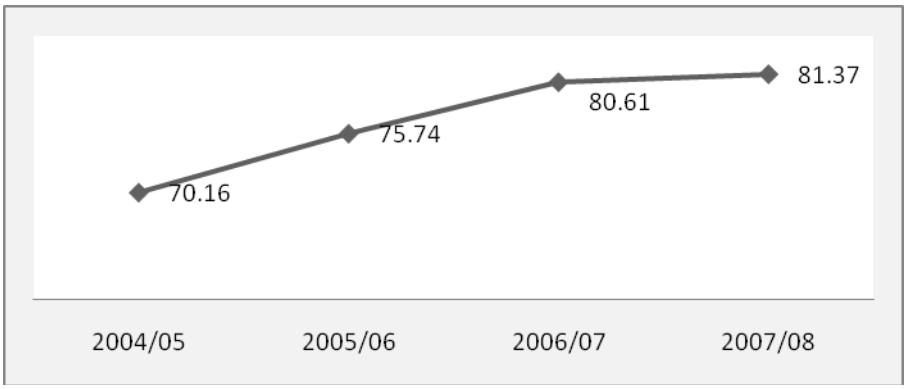
The Sector wide approach (SWAp) has been implemented in the health sector since FY 2004/05. The NHSP-IP was implemented through SWAp under the ownership/leadership of the MoHP. The agreed aid flow model in the NHSP-IP is pooled funding and parallel funding. The World Bank and DfID are pooled partners while the rest of the EDPs are non-pooled partners whose funds flow parallel way to the NHSP-IP. After implementing the SWAp the health sector budget increased from 5.9 percent of the total government budget in 2004/05 to 7.16 percent in 2007/08. During the same period the EDPs' share of the health sector budget also increased, from 41 percent to 50 percent, and the absorptive capacity of the MoHP has increased from 70 percent to 81 percent. Similarly, the absorptive capacity of the pooled donors increased from 72 percent to 86 percent, while the capacity of non-pooled donors increased less dramatically, from 44 percent to 59 percent during the same period.

Figure 3.6: MoHP budget and expenditure (in millions of NRs.)



Source: RTI International (2009).

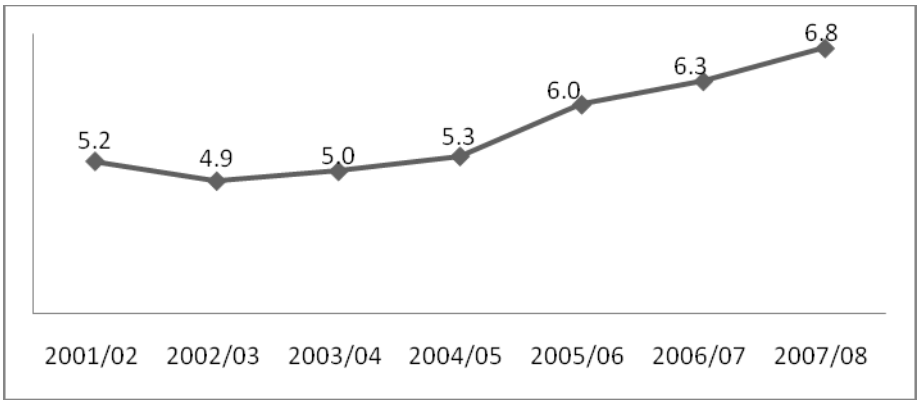
Figure 3.7: Absorptive capacity of the MoHP, in percent



Source: RTI International (2009).

The government has allocated a budget or spent funds on a number of social services which include education, health, drinking water, local development, as well as other services. There are eleven headings, including social services, for government expenditures. In the first stage, these eleven categories compete with one another for government resources, followed by the second stage in which the health sector competes with education, drinking water, local development and other social services for funding.

Figure 3.8: Health expenditure as a percentage of total government expenditure

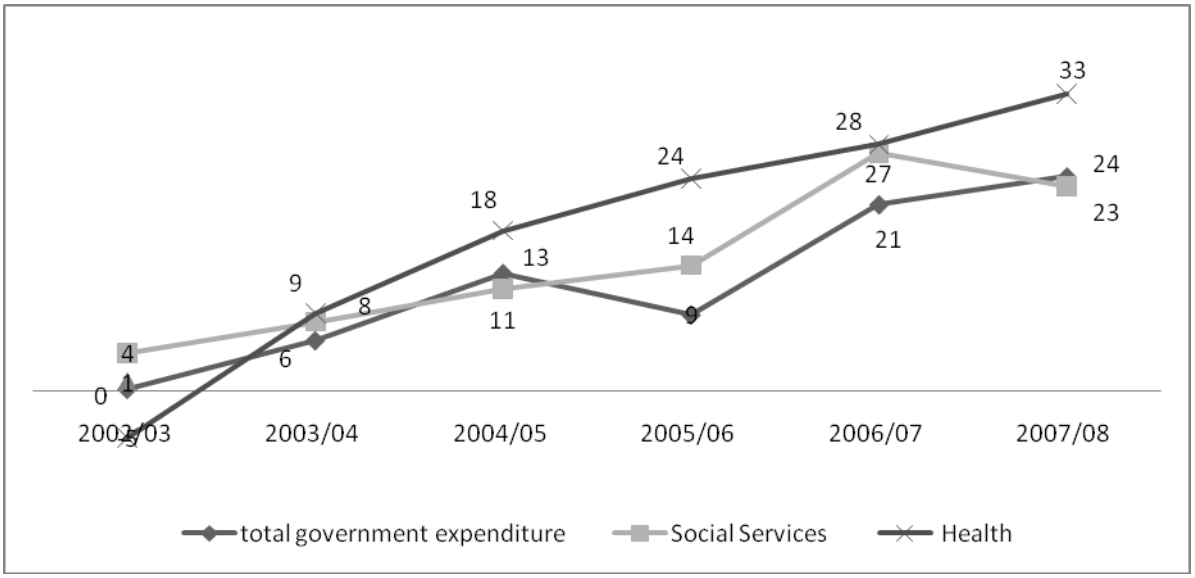


Sources: Economic Survey (MoF, 2009).

The share of total government expenditure devoted to the health sector has been increasing over time, and has grown at a faster rate than total government expenditures or other social services.

It seems that maintaining this growth rate for health is difficult without further justification of additional expenditures.

Figure 3.9: Growth rates of total, social services, and health expenditures

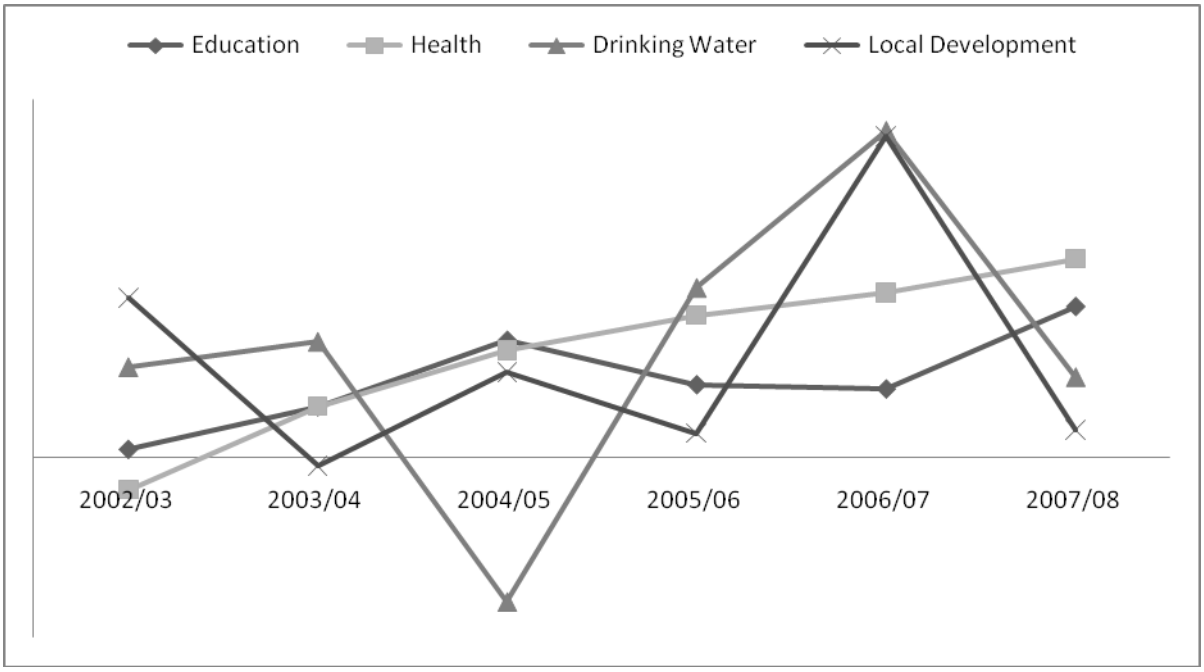


Sources: Economic survey, 2009 (MoF, 2009)

3.2 Health budget competing with other social services budget

A comparison of growth rates for social services funding demonstrates that health and education have relatively smooth trend lines; however, expenditures on drinking water and local development services have fluctuated dramatically. The health sector has benefited in terms of receiving more resources than most services.

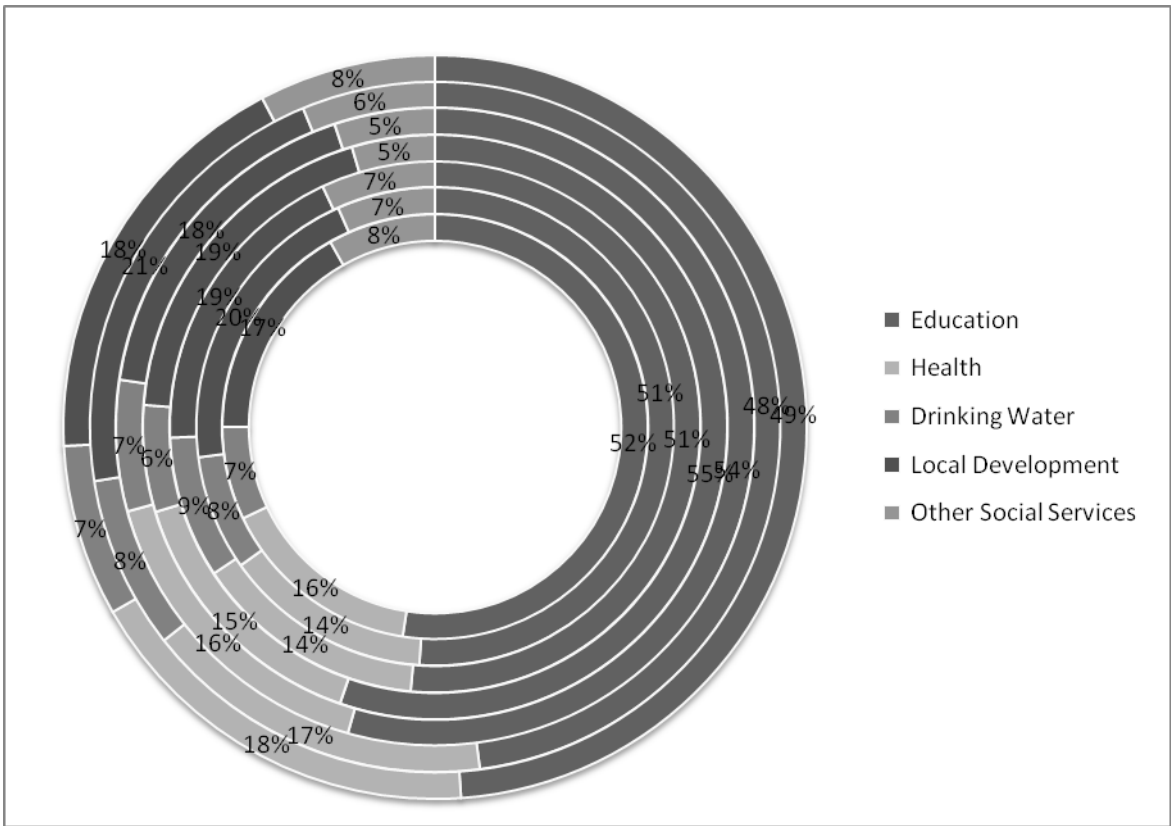
Figure 3.10: Comparison of growth rates of social services



Sources: MoF (2009).

The following graph shows the distribution of government expenditure on social services (a complete circle shows one fiscal year). Educational services have captured almost 50 percent of total social service expenditures. This is followed by local development services which have consumed almost one fifth of total social services expenditure. The health sector gets the third-greatest amount, accounting for almost 16 percent of total social services expenditure. It would appear that there is a negative correlation between education expenditures and health expenditures (correlation coefficient = -37 percent). Health expenditure has negative correlations with drinking water and local development, as well (correlation coefficients, -19 and -29 percent respectively), meaning that the health sector competes with these components, but it has complementary correlations with social development. Education, drinking water and local development services can contribute to health sector development since, in principle, greater efficiency in the education, health, drinking water, and local development services sectors will attract more resources for social development.

Figure 3.11: Distribution of resources to all components of social services, 2001-2008 (chronological from inner ring to outer ring)



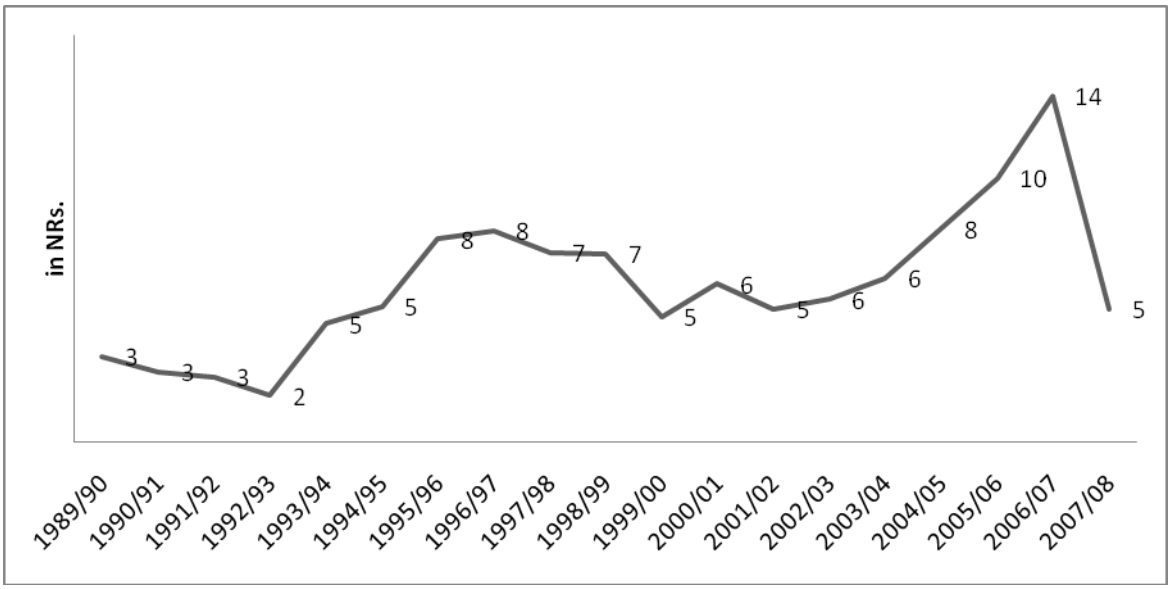
Sources: Economic survey, 2009 (MoF, 2009).

3.3 Revealed policy preferences in health-service financing

Recent data shows a trend of growth in government health expenditures. There might be other factors, however, such as high fluctuation in expenditures for other social sectors that have affected the health sector budget. Real per capita government expenditure on health can be used to reveal a policy preference in health service financing. The results suggest that real

per capita government expenditure on health at constant 1990 prices is increasing, but with fluctuations. This demonstrates that government policy is not necessarily dedicated to increasing the health sector budget, but rather that government health expenditure is determined by changes to the budgets of other social sectors.

Figure 3.12: Real per capita government health expenditure



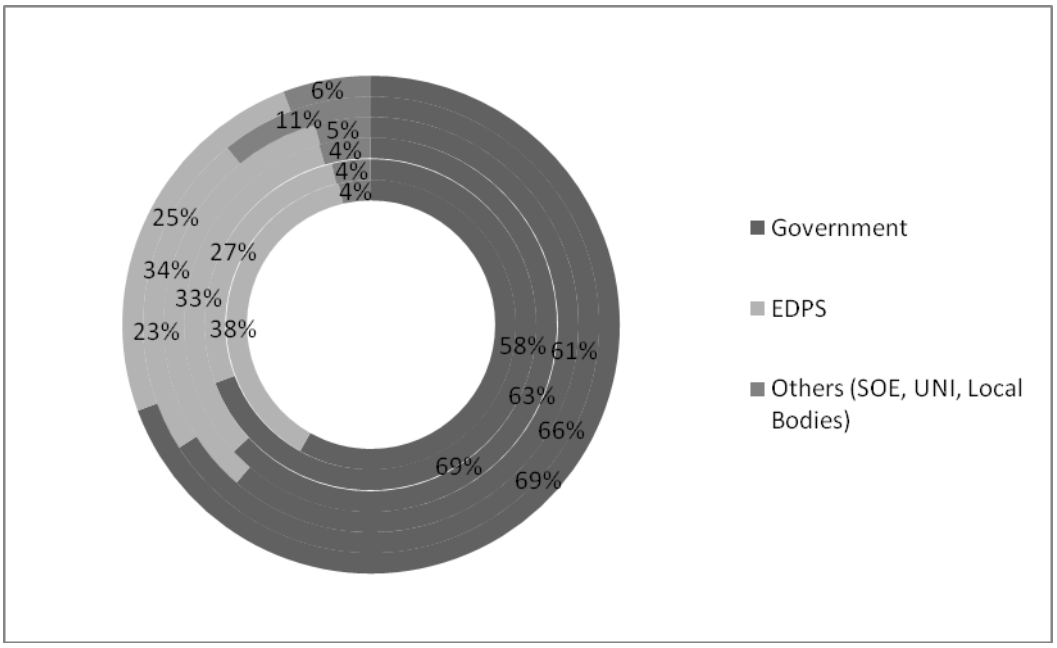
Sources: estimated by using data of health system performance working paper, 2009

3.4 Sources of public expenditure on health

The government is the primary source of financing for health expenditure, contributing almost 65 percent of the total health budget. This percentage, however, is subject to change depending on other sources of financing. The government is a relatively stable source of financing, while the EDPs – the second largest source of financing – are not as consistent, as their contribution falls from 38 percent to 23 percent. The contributions of EDPs are unpredictable due to a number of reasons, including political and budgetary decisions by the donors, administrative delays on the donor's side, or very low absorptive capacity in donor funding activities.

Other sources of financing for public expenditure on health include state-owed enterprises, local bodies, and universities, who together contribute almost five percent of total financing.

Figure 3.13: Sources of public expenditure on health 2000/01 to 2005/06 (chronological from the inner ring to the outer ring)



Source: MoHP, 2009 (public expenditure review on health)

IV. Creating Fiscal Space for Health Care Financing

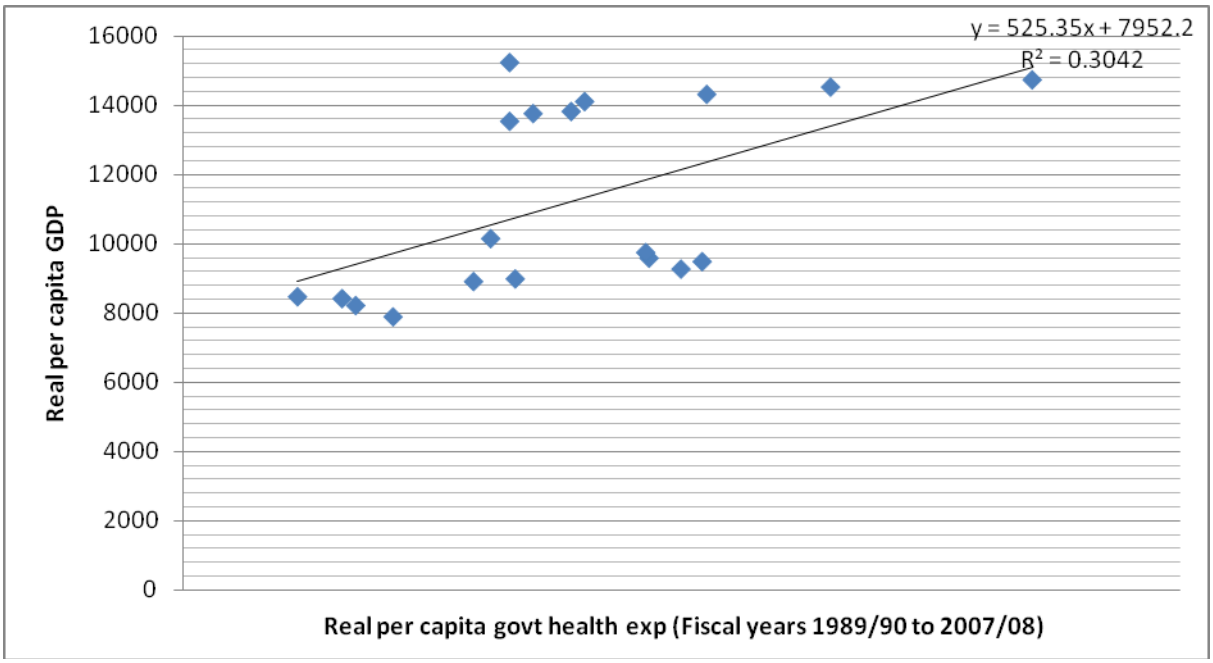
An analysis of the different dimensions of fiscal space for health care financing reveals that there is very little fiscal space to increase government expenditure due to competition for resources from other sectors. Education, for example, has greater power than health in terms of number of institutions, the labour-intensive nature of work in education, and a better defined highly-productive area than health has. The local development sector, the other main competitor for resources, is directly related to local political leaders, who can influence budget allocations. Furthermore, local development includes empowerment and decentralization, two especially hot topics in both political and social development. The major political parties in the country have almost identical policies for local development, but it is difficult to identify their health policies, and sometimes they have conflicting visions about the role of government in the health sector. Health issues are beginning to be framed in terms of fundamental human right, the public good, and human capital, among others, but the health sector has very limited evidence to justify the required resources. Therefore, it is essential to find ways of creating fiscal space for health care financing.

4.1 Generating additional revenue through changes in tax policy

Mobilization of revenue for earmarked purposes can be an important vehicle for expanding fiscal space. Increasing the tax revenue as a share of GDP is an obvious option for countries with low tax shares. Nepal's revenue share of GDP has been nearly 19 percent in recent

years, which is not particularly low compared to other developing countries. For low-income countries, raising the tax share to at least 15 percent of GDP should be seen as a minimum objective (Heller, 2005). Reforms aimed at improving the tax system in developing countries must necessarily take into consideration the level and composition of total tax revenue and the factors influencing them. The following diagram compares real per capita government health expenditure to real per capita income. As indicated by the trend line, an increase in government health investment contributes to growth in real per capita income.

Figure 4.1: Contribution of real per capita health expenditure



Source: estimated

Although taxes on tobacco and alcohol were introduced some time ago, due to administrative difficulties, they were incorporated into the excise duty by 2003/04. From then on, a portion of the revenue collected from taxing tobacco and alcohol was earmarked for programmes for preventing tobacco-related diseases. The annual report 2060/61 published by Department of Customs shows that tobacco and alcohol taxes generated at least 75 percent of total revenue from excise duty.

Figure 4.2: Revenue from sales of alcohol and tobacco received by the health fund (in millions of NRs.)

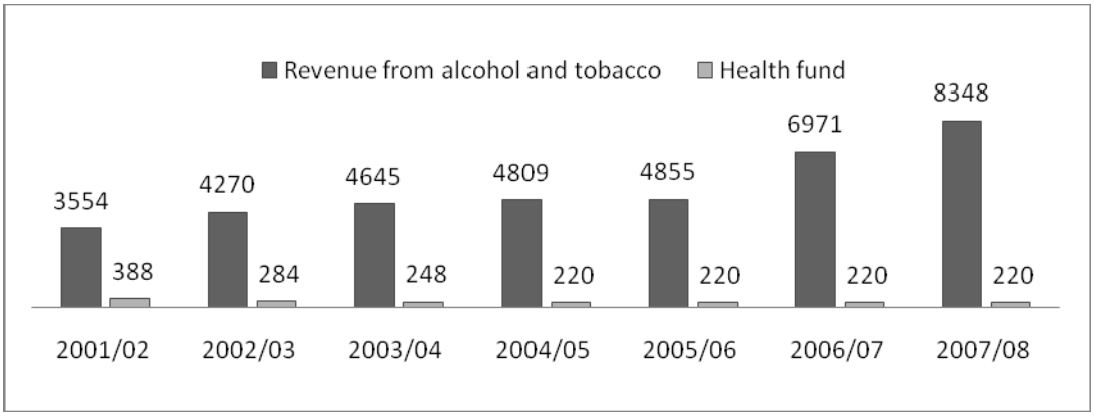
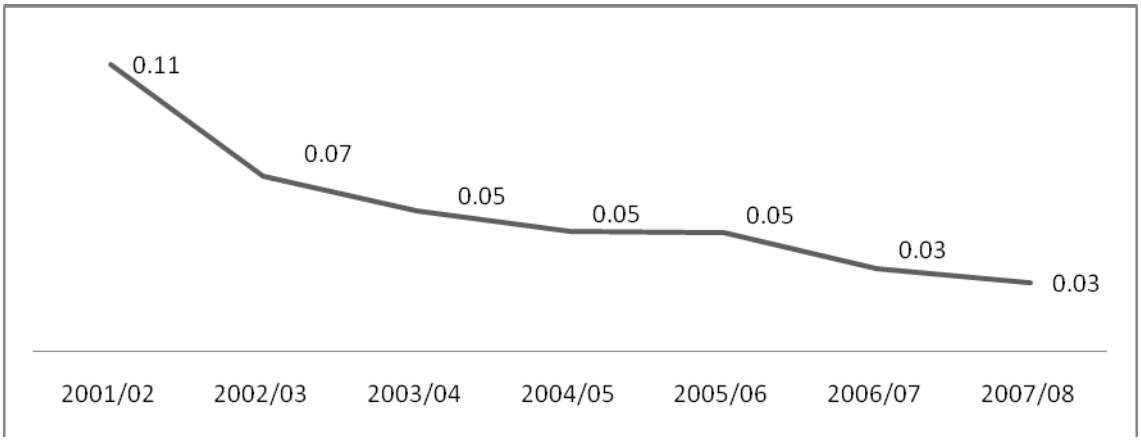
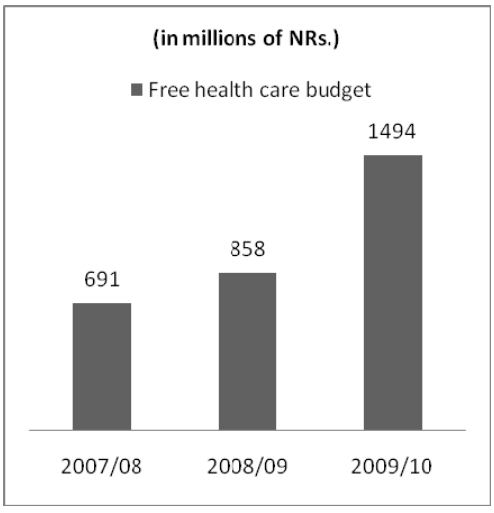


Figure 4.3: Percentage of outgoing funds from revenue of alcohol and tobacco



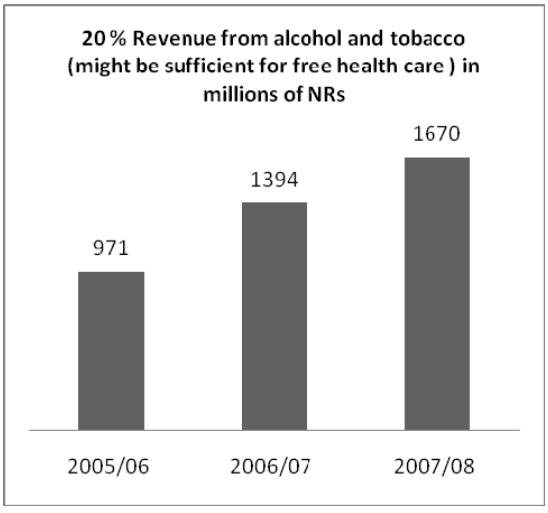
Since the consumption of tobacco and alcohol has a spillover effect on health, it is logical that a greater proportion of revenue collected from tobacco and alcohol sales be earmarked for health care. If we allocate at least 20 percent of the revenue from tobacco and alcohol sales, it could be enough to cover the entire budget for free health care based on existing allocations, freeing up a great deal of fiscal space.

Figure 4.4: Budget for free health care



Sources: RTI, (2009)

Figure 4.5: Possible sources for health



Sources: estimated

4.2 Reallocation from lower to higher priorities

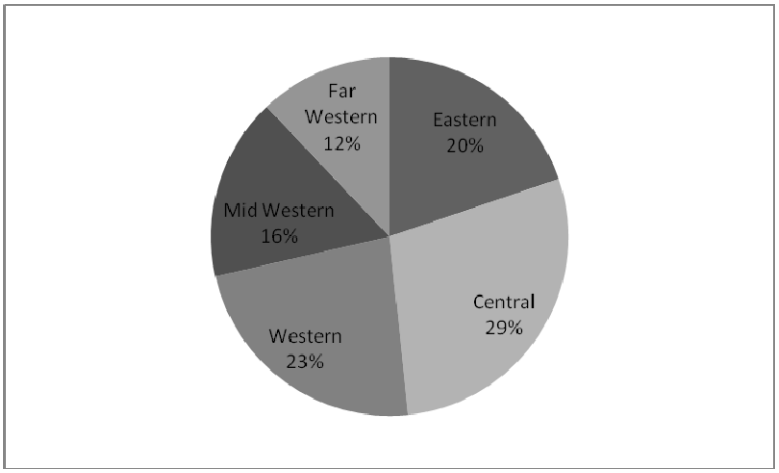
We can create fiscal space through shifting priorities within the budget. For example, there is growing evidence that subsidising simple curative treatments brings limited welfare gains (Filmer, at al 2002), hence priority can be given to preventive services or health services that effect a high degree of public good. Primary health services should be given greater priority than secondary and tertiary services. If secondary and tertiary services depend on fees for services, then there will be more fiscal space for primary health services.

Changing priorities is difficult in all health-related services, including those that invest in programme evaluation. But spending units often adjust expenditure without going through the whole budgeting process, so changes are not impossible. Further research is needed to evaluate possible areas of reallocation within the budget to create fiscal space.

4.3 Public-Private Partnerships

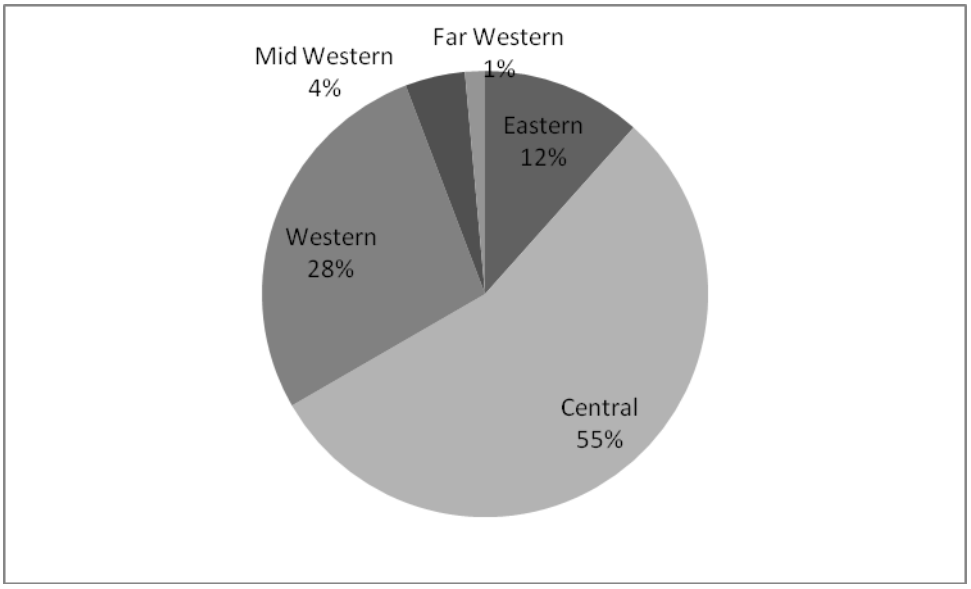
The private health sector is growing very quickly in Nepal. In Nepal's 'mixed health system,' centrally planned systems operated by the government exist side by side with private entities that provide similar or complementary products and services. After the 1990s, there was remarkable growth in private sector health services that is today a major source of health care. Health policy has thus far emphasized the development of government-owned health services, largely financed by government tax revenues. Furthermore, the government is promoting universal access to subsidized public services, focusing on implementing government norms, paying salaries, and ensuring that minimum facilities are available. This focus results in a supply-driven approach. Private health providers, however, are based on a demand-driven approach because they charge fees for services. Together, the public and private sectors can complete the health system. The following pie charts present the regional distribution of public and private health care providers. Private providers are based primarily in the Dentral region (55 percent of private facilities), while public providers are more evenly distributed across the regions.

Figure 4.6: Distribution of public hospitals by region



Sources: MoHP (2008).

Figure 4.7: Distribution of private hospitals by region

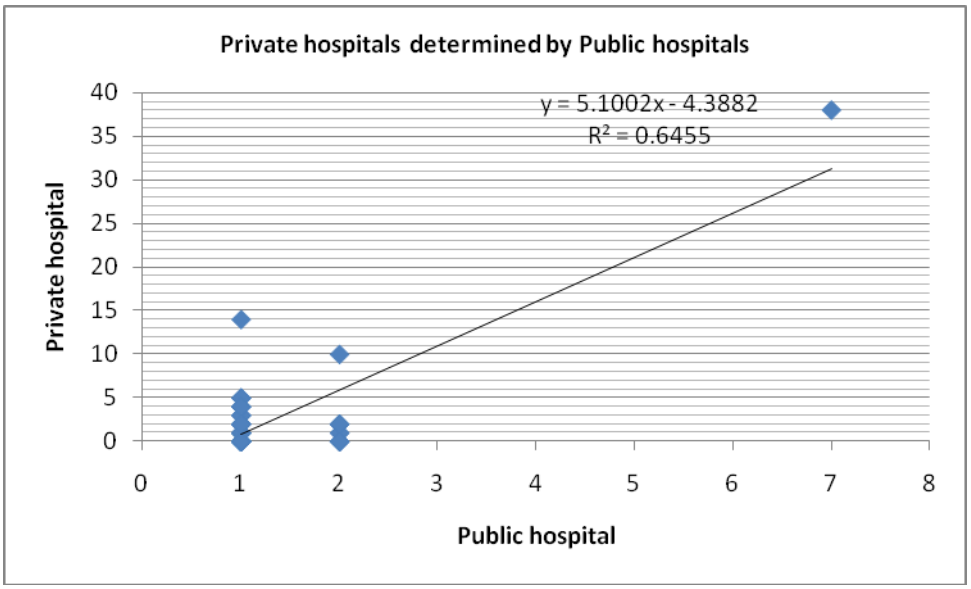


Sources: MoHP (2008).

4.3.1 Complements or substitutes

Public and private providers are sources of health care services. To achieve the right mix of sources, we need to know whether public providers and private providers are complements or substitutes. In other words, the question that must be answered is: if the level of public investment is relatively high, is the private sector share of supply consequently higher or lower? If it is lower, we can conclude that the public and private sectors are substitutes. If it is higher, the two sectors are complements (Hanson and Berman, 1998). As mentioned earlier, in recent years public spending has increased to provide services, but total private investment in the health sector is more difficult to ascertain. The number of private providers is increasing, which shows private investment is increasing, but we do not know the volume of investment. The above hypothesis can be evaluated by the degree of correlation between public and private providers across regions, as a rule of thumb. The correlation coefficient is 80 percent and it is statistically significant at one percent level.

Figure 4.8: Relationship between public and private sector



Sources: MoHP (2008), and estimated.

Figure 4.8 describes the relationship between the public and private sectors in the health care system. This relationship suggests that the public sector acts as a first-mover and chooses its level of investment in the health sector. The private sector then observes the level of public investment and invests to meet residual demand, which may be a function of both quantity of services supplied by public providers and the quality of those services (Hanson and Berman, 1998). The role of the public sector is to explore the health market for private providers; however, they are complements rather than substitutes. Thus, if the government invests more in the health sector, a similar investment in the health care market should be expected on the part of private providers.

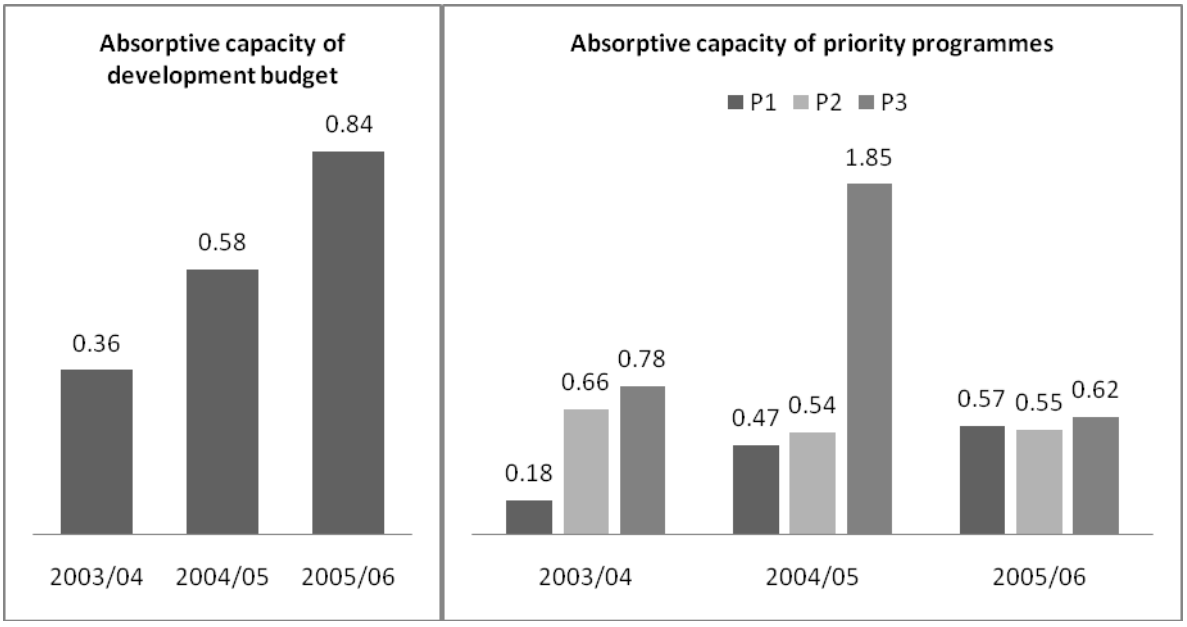
Without expansion of the private sector, it is difficult to increase the role of public-private partnerships (PPPs). PPPs can be described as public sector programmes with private sector participation. PPPs can help to develop innovative financing and delivery programmes selected on the basis of their relevance to broader health systems and potential to achieve a positive impact for the poor. An innovative delivery model of emergency response services under a public-private partnership structure would provide health services to people through a mix of private and government funding. Such a model can save health system resources through greater efficiency because private providers are sometimes more efficient than public providers. This means they can produce health services at lower cost at given levels of output and quality. Hence, PPPs also help create fiscal space for health.

4.4 Absorptive capacity

The absorptive capacity of a programme is the percentage of the allocated budget that is spent each year. Results suggest that absorptive capacity is increasing, although it is still quite low, particularly for development (capital) budgets. The absorptive capacity index presented in the following graph suggests that capacity was very low in 2004; P1 programmes, in particular

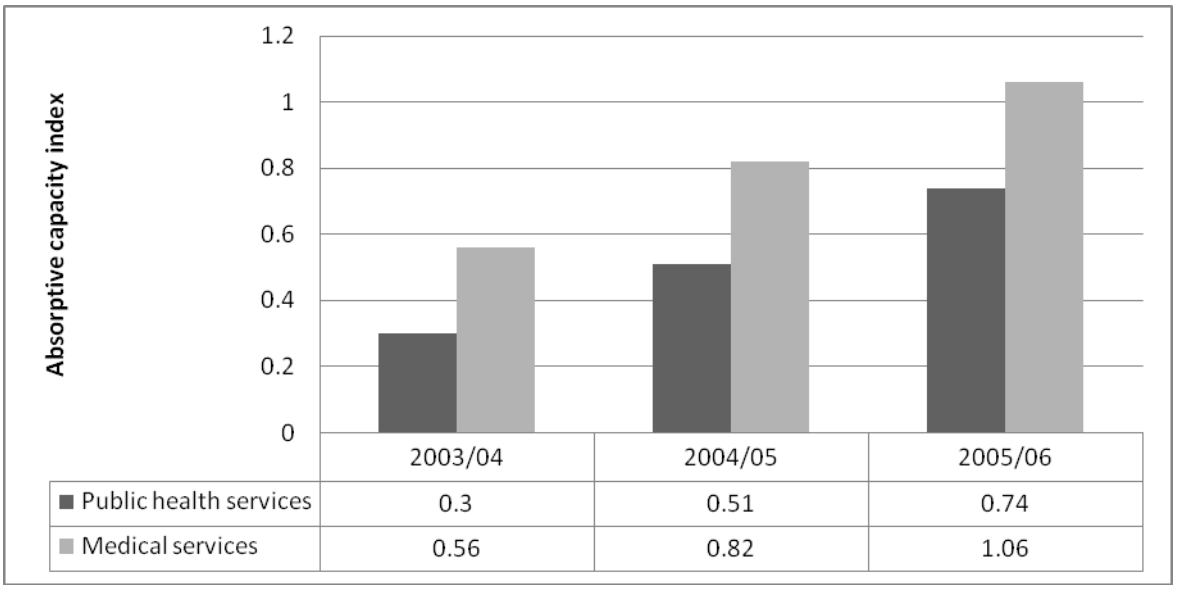
had a surprisingly low absorptive capacity for that year. Although absorptive capacity has increased over the years it remains very low. P2 programmes consumed more resources as allocated in the budget in 2006. However, it had almost 50 percent absorptive capacity in 2003/04 and 2004/05. Briefly, all priority programmes had low absorptive capacity, meaning that absorptive capacity is one of the hurdles to producing the desired health outcomes. The results show that medical services had a higher absorptive capacity than public health services, indicating that public health services have greater barriers to utilization of resources than medical services.

Figure 4.9: Absorptive capacity



Sources: MoHP (2009b).

Figure 4.10: Absorptive capacity of public medical services



	2003/04	2004/05	2005/06
Public health services	0.3	0.51	0.74
Medical services	0.56	0.82	1.06

Sources: MoHP (2009).

The ability to track expenditure within the government seems weak. This is mainly due to the fact that budget systems at the district level and below are very complex and have a variety of fund flow mechanisms. Furthermore, the monitoring of finances is not given a high priority in the planning process. As a result, there has been consistent under-spending in the health department. One reason is the excessive control exercised by the finance department leading to delays in the release of funds. To reduce under-spending, the MoHP needs rigorous monitoring and reporting of expenditures at all levels. The ministry needs help in developing an integrated financial information system for better budget management including that of funds flowing from the Ministry of Finance. Additionally, support is needed to analyze the effectiveness of initiatives. The obstacle does not seem to be a lack of resources, but rather an issue of motivation to shift the allocation of the resources. This is further complicated by the perceived lack of accountability and transparency in the financial management of new initiatives. The evidence clearly shows that a better financial management system would increase absorptive capacity, yet another way of increasing fiscal space for health care.

V. Risk Pooling

Risk pooling refers to the spreading of financial risk across a population or a subgroup of the population through the accumulation of prepaid health care revenue. It facilitates the pooling of financial risk across the population (or a subgroup), allowing the contributions of healthy individuals to be used to cover the costs of those who need health care. Pooling can also, depending on the method of funding, be used as a mechanism to divide risk between the rich and the poor. Thus, it is an essential means of ensuring equity of access to health care. The pooling mechanisms employed in Nepal are government health organizations, community health insurance, and private insurance companies.

5.1 Insurance systems

Community health insurance (CHI) is a mechanism that allows pooled resources to cover the costs of future, unpredictable health-related events. The government has committed to contributing at least five percent of health expenditures borne by local communities at health facilities through CHI. With the introduction of the free health care policy, however, the poor are no longer a viable segment for this mechanism since services are now provided free of charge. Instead of primary, CHI could be shifted to secondary care.

CHI has been implemented in the informal sector and targets low-income populations. It offers individuals and households protection against the uncertain risk of catastrophic medical expenses in exchange for regular payment of premiums. The scheme offers the hope of reducing the financial burden caused by sickness to a large segment of the low-income population. As opposed to social health insurance, membership is usually voluntary rather than mandatory. The result of this has been that CHI has been faced with the problem of *adverse selection* (where only the sick want to join) and *moral hazards* [meaning excessive consumption of health care resources (the rich, in particular, over utilize services)]. CHI follows two modalities: low cost and high frequency of illness; and high cost low frequency

of illness, however, it is only offered in a very limited number of areas (ar primary health care centres from six districts: Morang, Nawal Parashi, Kailali, Dang, Rautahat, and Udayapur).

Because of the introduction of the free health care policy, the role of CHI must be redefined. Some service providing institutions have tried introducing CHI in their catchment areas (examples include BP Koirala Health Insurance Scheme, the Lalitpur Medical Insurance scheme [LMIS], and the Public Health Concern Trust [phect-Nepal]).

The number of health insurance companies in Nepal is growing, but their contribution to the health sector are negligible, so organizations other than the government health offices have a very limited role in risk pooling.

5.2 Unitary risk pooling mechanism

Nepal also uses a unitary risk pooling mechanism. Under a unitary risk pool, revenue (general taxation) is placed in a single central pool that seeks to cover a chosen package of health care services. Payments are then made to providers in line with patient demands. Under the unitary model, risk pooling must be mandatory, in the sense that rich or healthy citizens cannot opt out of contributing. In particular, an important administrative function is then to ensure that all providers are offering uniform levels of care, in line with the chosen package.

The government, using general tax revenue, heavily subsidizes all public health facilities. The public health facilities aim to provide health services, particularly to the poor. Broadly speaking, this is also considered a resource transfer mechanism since it collects taxes from the rich and provides health services to the poor; the rich tend to utilize private health services rather than public facilities. All publicly collected funds for health care are pooled nationally, which means there is a single pooling system in Nepal. The government has implemented targeted free care interventions for the poor, destitute, underserved, elderly, people living with physical and psychological disability, and female volunteers, which is in turn funded via the pooling mechanism. The following figures show how the pooling mechanism transfers resources from those of productive age to those of unproductive age (elderly people), male to female, rich to poor, and non-Dalits to Dalits.

Figure 5.1: Cross-subsidizing by age and gender

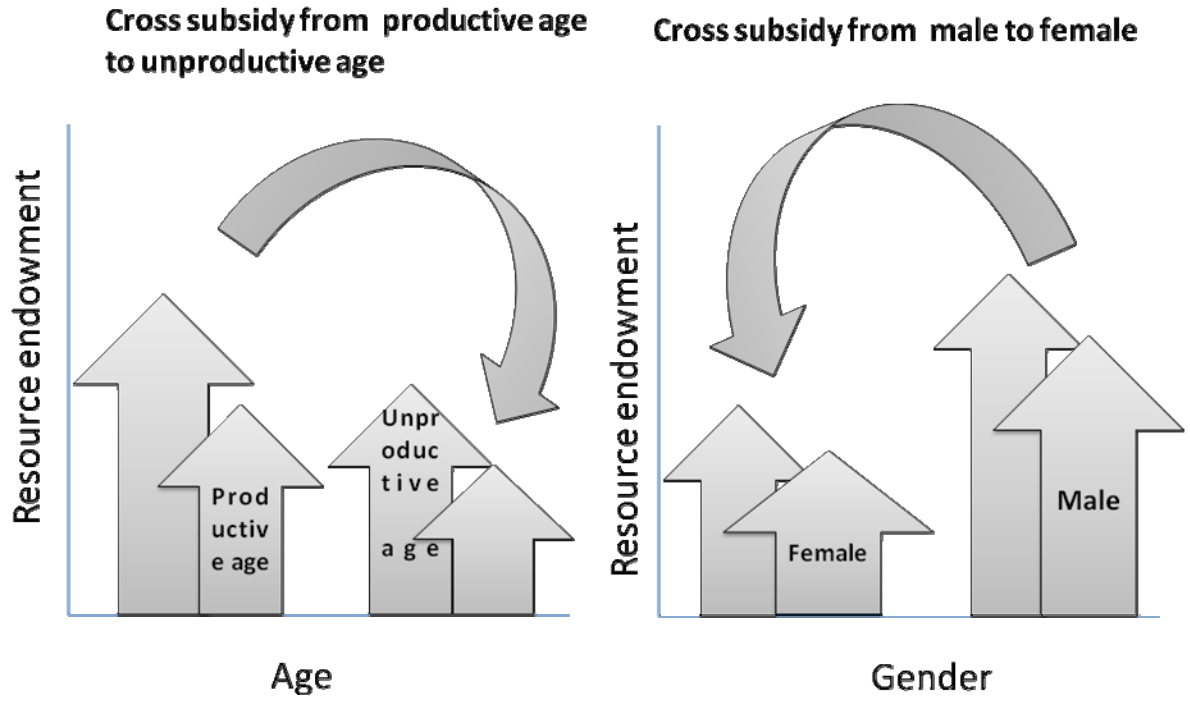
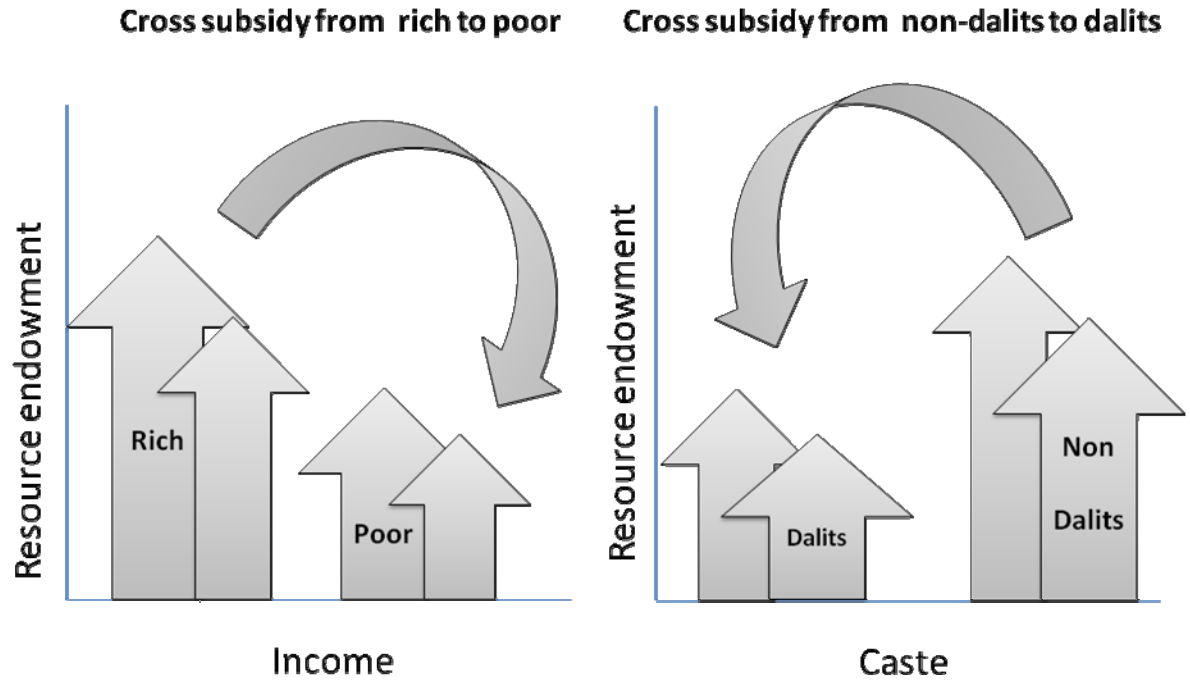


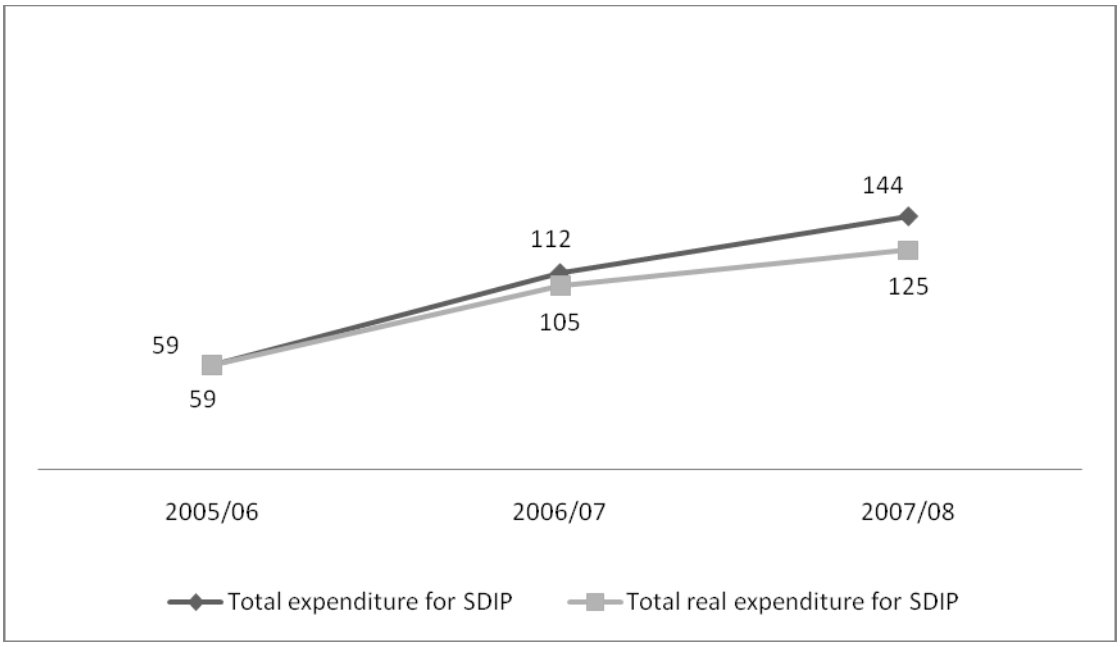
Figure 5.2: Cross-subsidization by wealth and caste



5.3 Demand-side financing

The government not only provides services at health facilities, but also covers the cost of transportation to the facilities for people who are at high risk, specifically those undergoing maternal care or treatment for Kala-azar. The facilities provide a given amount of money to consumers to increase utilization of health facilities through changing consumers' behaviour. This is a type of improved targeted intervention. Conventional health care financing fails to address the demand-side financing mechanism that is now popular in developing countries (Ensor and Ronoh, 2005). The Safe Delivery Incentives Programme (SDIP), a demand side-financing scheme, was launched in 2005. This programme provides cash payments as an incentive after delivery at a health institution. There are also incentives for health workers who attend deliveries at home or in institutions. The following figure shows a growing trend of demand side financing (SDIP) in real expenditure, at constant 2005/06 constant prices.

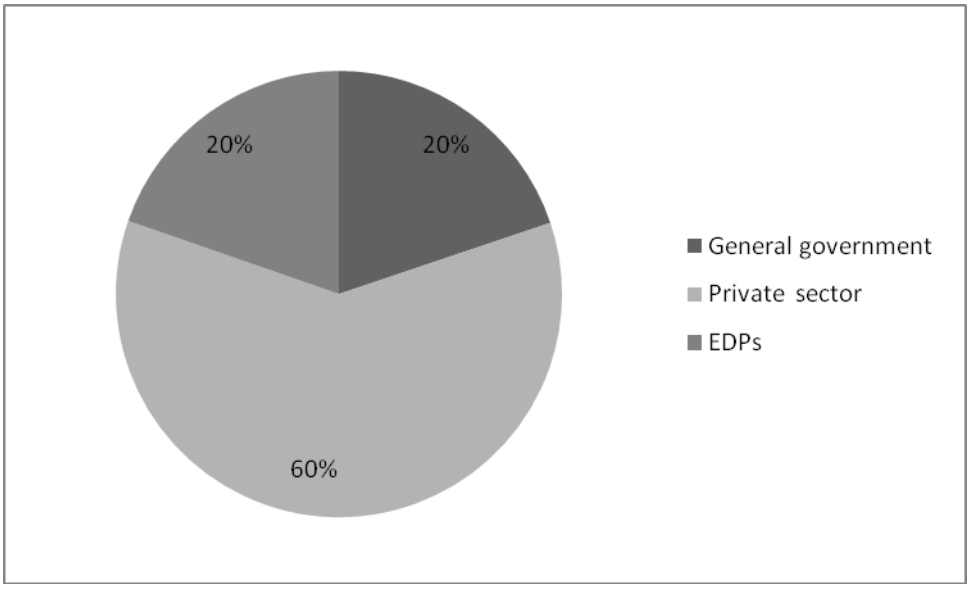
Figure 5.3: Real and nominal expenditure on SDIP (in millions of NRs.)



5.4 No risk pooling

When there is no risk pooling, individuals are responsible for paying their own health care costs through out-of-pocket payments (OOP). People who utilize services at public hospitals receive health services at subsidised prices, both those who utilize private health services, have to pay full price. The Nepal National Health Accounts (NNHA) showed that OOP contributed 60 percent of total health expenditure for 2004/05. OOP contributed 55 percent for 2005/06 as shown in the more recent NNHA, however this statistic seems questionable due to weaknesses in the methodology and data.

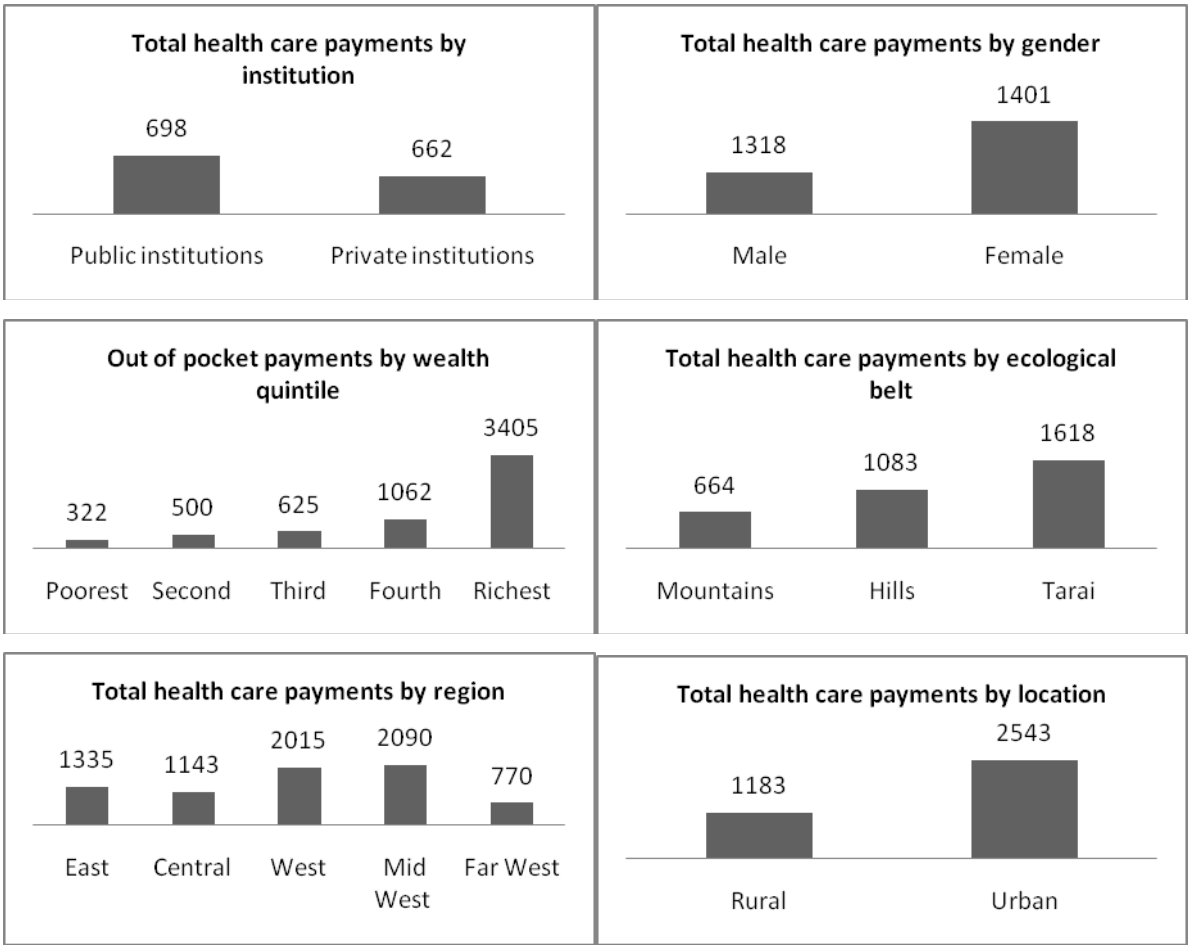
Figure 5.4: Sources of financing for 2004/05



Sources: MoHP (2009).

The following figures show the mean expenditure in 2003/04 for the last consultation for an acute illness episode by institution, gender, consumption quintile, and location.

Figure 5.5: Total health care payments



Sources: NLSS, 2004

The results demonstrate that the average out-of-pocket payment at public institutions (5 percent) is higher than at private institutions. The reason behind this is that a large percentage of people utilize drug stores as private institutions. Where facilities are available, utilization is high, and OOP is collected. In the Western and Mid-western regions, however, despite having very few health facilities, there is a surprisingly high amount of OOP collected.

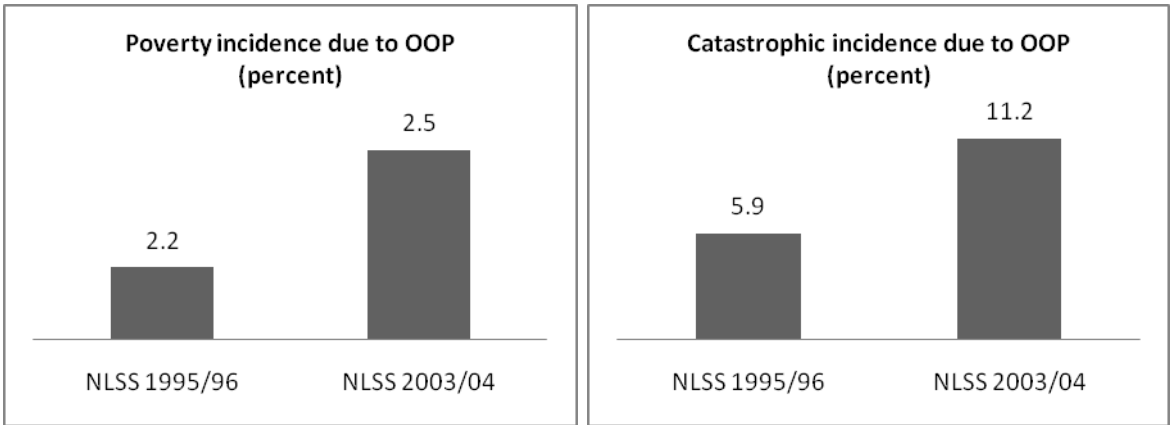
As a result of the unitary risk pooling mechanism set in place by the government, the size and number of pools in the health system are very limited, and there is no competition among pooling organizations. This means there are limited choices for the people as well. Furthermore, there are certain *moral hazards*.

On the other hand, the frequent presence of large indirect costs (travel and opportunity costs, for example) of health care imposes considerable barriers on access by the poor. Unitary risk pooling removes the usual economic barriers to consumption, so it is expected that utilization of services covered by the package will increase. The pooling mechanism offers greater equity in the health system, resulting in equal access to health care for all people in the risk pool, regardless of their personal circumstances. Most importantly, risk pooling transfers health care resources to the poor, who are more likely to benefit than the rich.

VI. Equity in Health Care Financing

Out-of-pocket payment is the principal means of financing health care in Nepal which has consequences for utilisation of health care and subsequently, for health. There are also potentially important consequences for household living standards and economic welfare. OOP can push non-poor families below the poverty line, and cause the poor to become hard-core poor. The poverty incidence in the following figure shows that 618,000 non-poor people (2.5 percent) become poor due to OOP. Similarly, OOP causes catastrophic incidence for 10 percent of households, with the result that over 2.7 million people (11.2 percent) experience financial shock or a loss in welfare. The results also show that both impoverishment and catastrophic impacts due to OOP are increasing over time.

Figure 5.6: Economic impact of OOP health care payments



Source: estimated

VII. Alternative Financing

The nature of the risk pooling arrangements is a matter of policy choice, which is heavily influenced by a nation's circumstances and its policy priorities. The health markets in Nepal are competitive, and in this unregulated, fee-for-service payment system, providers are able to maximize profits by increasing volume, through the use of high-cost technology, and by intensive resource use, increasing the overall cost of care. This necessitates designing alternative systems of financing health care with incentives to contain costs. Therefore, alternative health financing requires help to foster competition and choice in the risk pooling arrangements.

In this section, the paper explores alternative financing options that encourage more accountability, sustainability, better efficiency, and reduced cost. Three models that merit serious consideration are: i) community-based health insurance, ii) a targeted health policy, and iii) social health insurance. These models are able to capture the different levels of health care market. Community-based health insurance and a targeted health policy will capture the informal sector, while social health insurance will primarily capture the formal sector.

7.1 Community-based health insurance schemes (CHIS)

CHIS are based on the principle of solidarity. Typically, in such models, the community manages the setting and collection of premiums, the contents of the benefit package, criteria for copayments and exemptions, and, finally, the choice of provider(s). The benefit packages will be secondary care and providers include public hospitals, community hospital, NGO hospitals, and teaching hospitals.

At present, health insurance is a very small and insignificant part of health financing. This scheme will help to develop the health insurance market for secondary and tertiary care. To ensure that both the rich and the poor are part of the risk pool, the government will need to provide some subsidies, while microfinance organizations and NGOs will need to support this scheme to ensure access. Providing a subsidy under these conditions will enable incentives and build community solidarity. Since this is not mandatory scheme, the provision of income tax exemptions can be introduced to encourage people to sign on. The comprehensive package can be integrated and enforced in hospitals. Within the secondary and tertiary care markets, providers will be able to pick and choose what they want to provide and which rates they wish to charge.

7. 2 Target policy

Another innovative way of subsidizing the poor while at the same time ensuring that they get quality care is through the use of a targeted policy. Universal health services, along with essential drugs are provided by primary health care centres, health posts, and sub-health posts. Targeted free health services are currently provided by district hospitals to the poor, the

elderly, children, Dalits, and vulnerable people. Implementation of targeting health services will be improved through community diagnostics of the poor through income-generating organizations, community-based organizations, and other NGOs, among others.

7.3 Social health insurance

The government can introduce social health insurance for the formal sector by reallocating resources. Although the government has already mentioned pilot programmes to introduce social health insurance in the NHSP-IP, it has not yet been implemented. The resources allocated for secondary and tertiary care, along with resources spent on providing health care to government employees can be shifted to social health insurance. Such an insurance system will cover the entire formal sector, including private schools, industries, banks, and financial companies, among others. This system will be mandatory. For this purpose, a social health insurance fund, similar to an employer's provision fund can be created, and the government can generate new funds for health care. Modalities of this system can be developed further pending more research.

VIII. Purchasing Health Care Services

Purchasing refers to the transfer of pooled funds to providers on behalf of a population. A wide range of agencies may carry out purchasing. Key issues involve market structure and purchasing mechanisms, for example, contracting, provider payment, and monitoring. The same organization that is involved in the financing mechanism of pooling may also be involved in purchasing, thus there might be common activities for pooling and purchasing functions.

The commitment to fund both universal coverage and a comprehensive benefits package for secondary and tertiary care should be realistic. If we increase universal coverage, the government expenditure on secondary and tertiary care should be reduced. The funds for these services should be generated through fee-for-services, and access to these services can be ensured through the insurance system.

The key issues in the purchasing of services are:

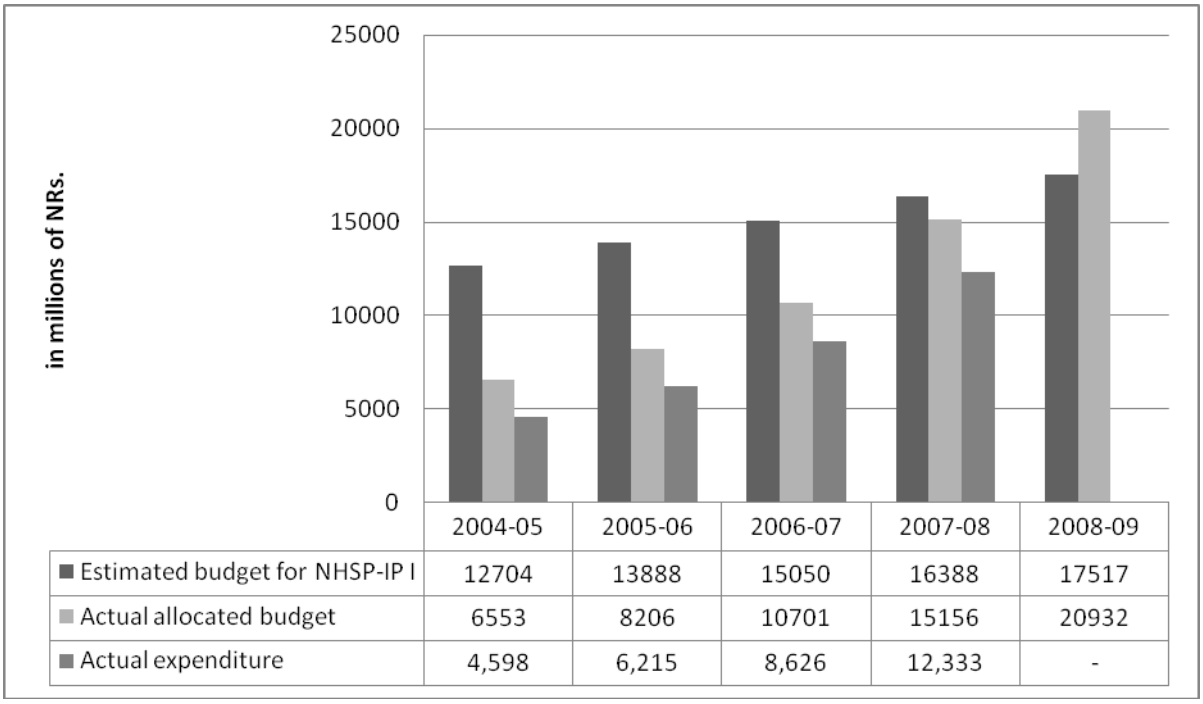
- **Universal free care**: Essential health care services packages are provided at PHCCs, HPs and SHPs free of cost for all. This package includes preventive care, clinical services, basic inpatient services, delivery services, and listed essential drugs. The government purchases the packages using general taxes. Cost effective methods are used to purchase the packages. Services packages can be determined by utilizing the concepts of need, demand, and supply of services.
- **Targeted free care**: Outpatient, inpatient, and emergency services and listed essential drugs at district hospitals are provided free of cost to the targeted population (poor, elderly, children, and vulnerable people). All services at district hospitals are provided at heavily subsidized prices to all.

- **Insurance system**: Health services at secondary and tertiary health care institutions are provided at subsidized prices; however, it this can still result in catastrophic expenses. The CHI system can be expanded to secondary and tertiary care. Microcredit financing institutions can expand their roles to introducing health insurance. This system will not be limited to public hospitals, but will also cover teaching hospitals, community hospitals, and private hospitals.

8.1 Allocation of resources to purchase services

A comparison of the estimated cost, actual allocated budget, and actual expenditure for the NHSP-IP I points the way for developing financial strategies for the NHSP-IP II. The allocated budget for the NHSP-IP in its first years was quite low compared to the estimated cost. In the last year, however, allocated budgets were higher than estimated costs.

Figure 8.1: Estimated, allocated, and expenditure under MoHP at 2004 constant price



	2004-05	2005-06	2006-07	2007-08	2008-09
Estimated budget for NHSP-IP I	12704	13888	15050	16388	17517
Actual allocated budget	6553	8206	10701	15156	20932
Actual expenditure	4,598	6,215	8,626	12,333	-

Sources: MoF (2009), RTI (2009), MoHP (2004); - = not available

8.2 Purchasing MDG-related services

Three Millennium Development Goals (MDGs) - 4, 5, and 6 (child health, maternal health, and HIV/AIDS, malaria, and other diseases, respectively) - out of eight are directly related to the health sector. The government purchases MDG-related goods and services with resources allocated to the development budget. The following figures describe the allocation of funds to these three MDGs. The burden of disease is based on estimates from the NHSP-IP I, and compared to the budget allocated for each MDG.

The government has a dedicated budget for the MDGs. In accordance with the burden of disease, the majority has gone to MDG 4. Over time, however, we see that the allocated budget is leaning more towards MGD 5, even though it constituted less than a quarter of the burden of disease within the EHCS packages.

Figure 8.2: Burden of disease in NHSP-IP

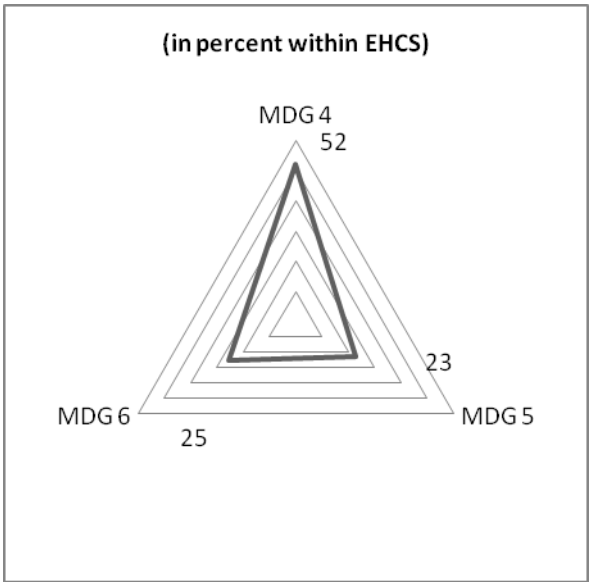
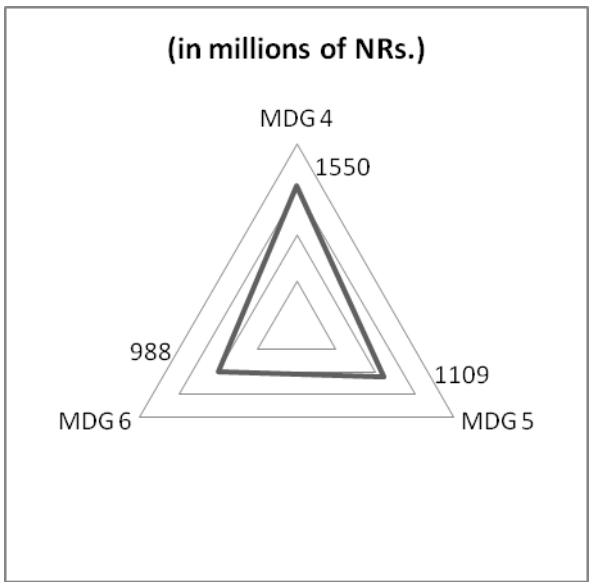


Figure 8.3: Allocation for MDGs, 2007/08



Sources: RTI (2009).

Figure 8.4: Allocation for MDGs, 2008/09

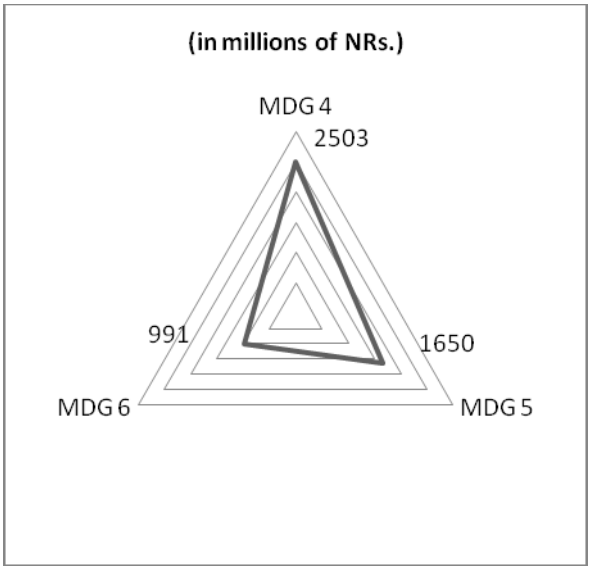
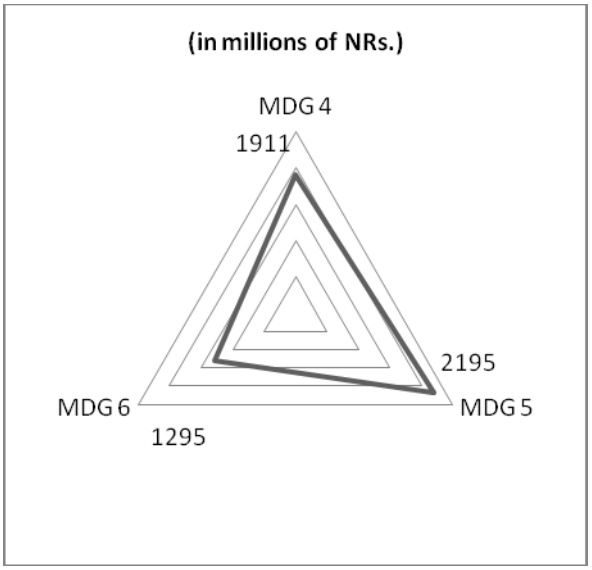


Figure 8.5: Allocation for MDGs, 2009/10



Sources: RTI (2009).

8.3 Purchasing essential health care services (EHCS)

The government has a clear financial strategy to purchase EHCS as committed in the NHSP-IP I. For other NHSP-IP outputs, however, the government is changing its strategy (see the following figures), for which it must develop clear financial strategies to purchase these services.

Figure 8.6: Health budget allocation, excluding EHCS 2006/07

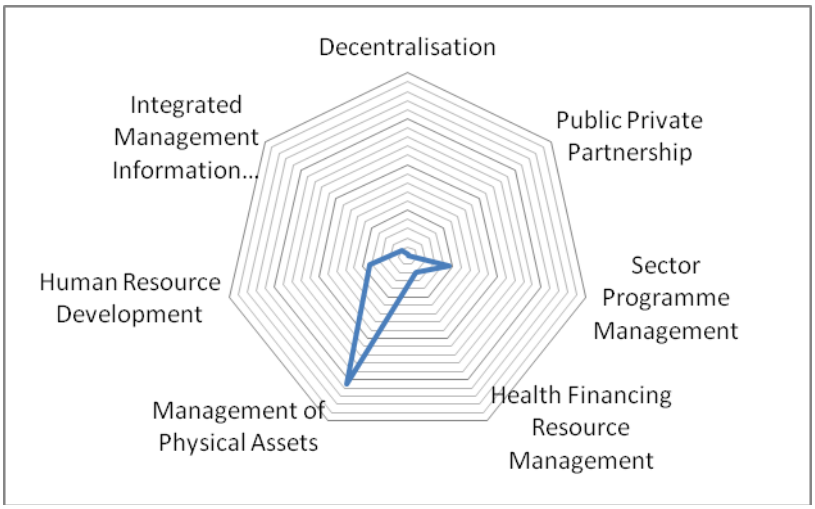


Figure 8.6: Health budget allocation, excluding EHCS 2007/08

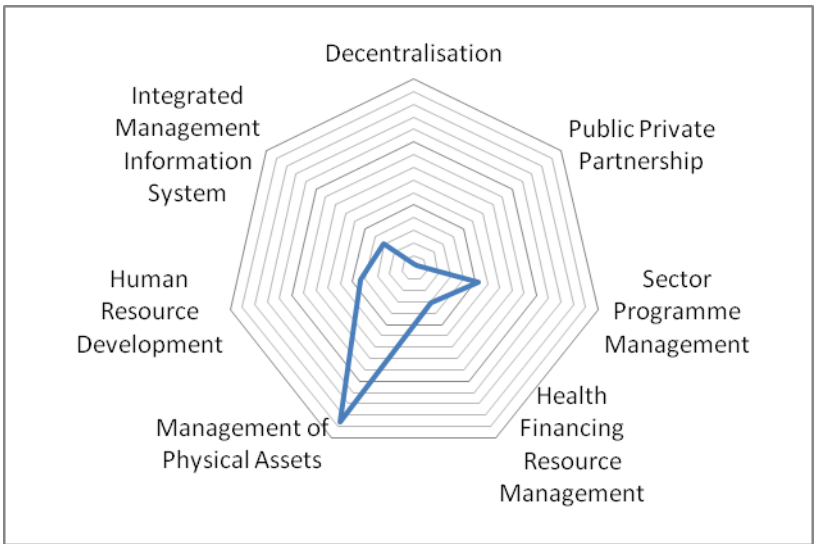


Figure 8.6: Health budget allocation, excluding EHCS 2008/09

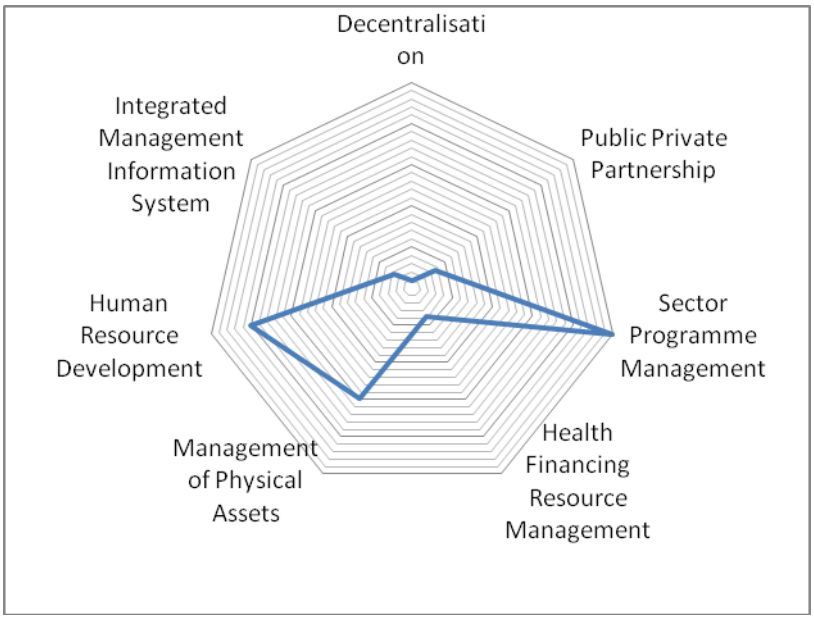
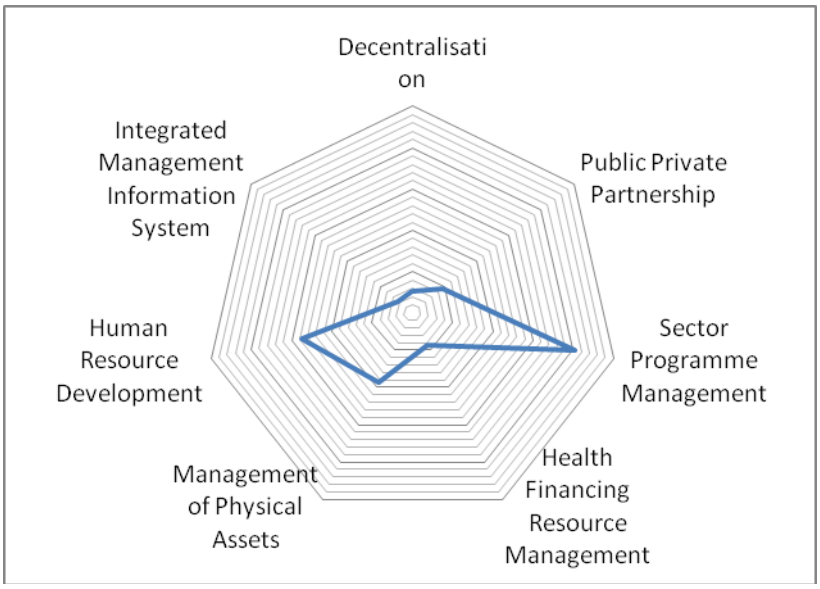


Figure 8.6: Health budget allocation, excluding EHCS 2009/10



Source: RTI (2009)

IX. Conclusions

The government should focus on ways to enforce collection of taxes from the sale of tobacco and alcohol to ensure sufficient revenue and to restore confidence in the health financing system. Furthermore, it must consider the full range of health financing functions and policies, rather than focusing on collection alone (contribution mechanisms). The evidence suggests that strategic resource allocation may be the best way to ensure that health resources match health needs.

Fiscal space for health care can be created in a number of ways, including general taxes, public private partnerships, augmenting absorptive capacity, and re-examining allocation priorities, among others. The most powerful way of creating fiscal space is to increase the percentage of revenue from alcohol and tobacco taxes earmarked for health care.

Designing purchasing and provider payment systems are an effective way of creating incentives to increase efficiency, quality, and productivity. The evidence suggests that policymakers can encourage administrative efficiency by minimizing duplication of functions and tasks, and by not confusing efficiency with expenditure control. Spending on health care should not be unconditional. Rather, it should always demonstrate value for money. This will increase absorptive capacity.

The government has focused on expanding CHI and introducing social health insurance schemes, but with the introduction of the free health care policy, this emphasis needs to be re-examined. Due the complexity of the health care market, a single policy of risk pooling is not sufficient. Market segmentation strategies might be a more appropriate policy to achieve access to and choices of health care services; for example, free care services for rural and remote areas, CHI for informal, semi-urban and urban areas, and social health insurance for the formal sector. Recent data from Nepal (NLSS 2004) and some African countries (Xu, et al, 2006) show that it is difficult to protect people from the catastrophic and impoverishing impact of health care costs through a free health care policy alone.

Allocation of resources and benefit packages for health services are the most important consideration when designing health care financing strategies because allocation determines the equity and efficiency of health production while the benefit package determines the sustainability of the health intervention.

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