



# Nepal at the Crossroads: Setting the Stage for Improved Social Health Protection

Final Report of a Joint Assessment of MoHP-GTZ



Health Sector Support Programme (HSSP)  
Ministry of Health and Population (MoHP) - Nepal





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# Imprint

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Improving health systems to enhance people's access to quality health care services is one of the primary concerns in the Nepalese health sector. In the recent years, the government of Nepal introduced different programmes for social health protection which have contributed to enhance peoples' access to health care services. Further, citizen's right to basic health services has also been stipulated in the interim constitution of Nepal. Nepal Health Sector Programme-Implementation Plan II has also an objective to increase access to and utilisation of quality essential health care services. However, in the absence of comprehensive prepayment and risk pooling mechanism, share of out-of-pocket payments in total health expenditure is still very high. This has an adverse impact on people's access to quality health care services.

Considering this fact, Ministry of Health and Population (MoHP) has currently taken initiatives for drafting a policy to improve social health protection (SHP) and health financing mechanisms in the country. For this purpose, assessment of existing social health protection mechanism and policy options for improving health financing were needed. This report has been prepared as a joint effort of MoHP and German Technical Cooperation (GTZ) after discussing with wide range of stakeholders. The report assesses the existing social health protection mechanisms in the country and proposes policy options for discussion. This is indeed an important step towards improving social health protection mechanisms and initiating the process for necessary policy reform.

The MoHP would like to appreciate the technical and financial support provided by GTZ for this important assessment including policy options and acknowledges the inputs from the members of the Steering as well as Technical Working Committees on social health protection. The study greatly benefited from the guidance, cooperation and efforts of Mr. Friedeger Stierle, Dr. Susanne Grimm, Ms. Franziska Fuerst, Ms. Jenni Kehler and Dr. Ghan Shyam Gautam. The MoHP would like to recognize and appreciate the work of Dr. Jan Bultman to complete the study. Special thank goes to Mr. Kabi Raj Khanal for his involvement in the whole process of this study. Last but not the least, MoHP would like to thank all those involved in the processes.

**Dr. Laxmi Raj Pathak**

Chief

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# List of Abbreviations

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
BP	Benefit Package
CBHI	Community Based Health Insurance
CBS	Central Bureau of Statistics
CIA	Central Intelligence Agency
CIM	Centrum für internationale Migration und Entwicklung
CSR	Corporate Social Responsibility
DfID	Department for International Development
DoHS	Department of Health Services
EDPs	External Development Partners
EHCS	Essential Health Care Services
FCHVs	Female Community Health Volunteers
FHSP	Free Health Services Programme
FHCS	Free Health Care Services
FNCCI	Federation of Nepalese Chambers of Commerce & Industries
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GFA	GFA Consulting Group GmbH
GoN	Government of Nepal
GTZ	German Technical Cooperation
HPs	Health Posts
HSSP	Health Sector Support Programme
IHP	International Health Partnership
ILO	International Labour Organization
IMF	International Monetary Fund
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)



KOICA	Korean International Cooperation Agency
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MoAC	Ministry of Agriculture and Cooperatives
MoE	Ministry of Education
MoF	Ministry of Finance
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoLJ	Ministry of Law and Justice
MoLTM	Ministry of Labour and Transport Management
MoWCSW	Ministry of Women, Children and Social Welfare
MTEF	Medium Term Expenditure Framework
NGOs	Non-government Organisations
NHA	National Health Accounts
NHRC	Nepal Health Research Council
NHSP – IP	Nepal Health Sector Programme - Implementation Plan
NLSS	Nepal Living Standards Survey
NMR	Neonatal Mortality Rate
NPC	National Planning Commission
NRs	Nepalese Rupees
NSC SP	National Steering Committee on Social Protection
NSPF	National Social Protection Framework
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
P4H	Providing for Health
PHCCs	Primary Health Care Centres
PPP	Public Private Partnership
RTI	Research Triangle Institute
SEARO	South East Asia Regional Office
SHI	Social Health Insurance

SHP	Social Health Protection
SHPs	Sub Health Posts
SLTHP	Second Long term Health Plan 1997 – 2017
SPTT	Social Protection Task Team
SWAp	Sector-wide Approach
TA	Technical Assistance
TB	Tuberculosis
THE	Total Health Expenditure
UNCDF	United Nations Capital Development Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VDCs	Village Development Committees
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

# Executive Summary

## Introduction

The Ministry of Health and Population (MoHP) of Nepal is seeking to expand social health protection (SHP) by improving health care financing and searching for appropriate ways to do this. To this end, MoHP and GTZ have started jointly to assess the current social health protection status and to outline various policy options, suiting the Nepalese context. This led to a dedicated effort in May 2010 during which representatives of MoHP, GTZ staff, a representative from the Providing for Health (P4H) Initiative as well as an international and a national consultant have together met various stakeholders, visited the districts, their health authorities and some of their health care facilities. This report reflects the findings of this joint effort and is meant to more explicitly and in-depth discuss policy options for health financing improvement, set preliminary priorities to form a basis for further engagement and explore the preferred option or options.

The report discusses (i) the current policy environment and its implications for changing current health financing mechanisms, (ii) the available fiscal space to expand revenues for the sector and by freeing up resources by enhancing efficiency in administration and health services delivery, (iii) the health financing and social health protection (SHP) context of Nepal, (iv) the preconditions for introducing new financial arrangement, (v) the policy options for new health financing arrangements, and it ends with some recommendations and suggestions for next steps.

The objectives of social health protection, i.e. (i) universal access to care, (ii) equity in financing, i.e. everybody contributes to his/her ability to pay, (iii) sustainability of the health financing system, (iv) adequate quality of health care services and (v) efficiency in health financing and health services delivery, are discussed with a focus on determining options for improving health finance. Fully achieving these objectives is difficult for any country in the world.

Assessment of Nepal's current status in achieving the SHP objectives shows that great improvements have been made with- among others the Free Health Services Programme, public health programmes and other programmes dedicated to specific health conditions and risks. Nevertheless, there is a commonly felt need to further improve access to affordable and efficiently delivered quality care to all Nepalese people while using cost-effective stewardship and administrative arrangements. Improved health financing mechanisms are seen as an important avenue to support the desired improvements in social health protection. Therefore several options are explored for further discussion which could actually help to achieve this. Those options are preceded by a description of the preconditions that should be addressed when embarking on new ways of financing health care.

## Preconditions

A number of preconditions would need to be met to make adequate use of any additional financial resources for the health sector as well as to increase the chances for positive results of an eventual new financing arrangement and to proceed from out-of-pocket (OOP) payments at the point of services to a prepaid scheme. Such preconditions are: (i) sufficient capacity to absorb change, (ii) finding the right time as to not jeopardize the ongoing reform with implementation of the Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2), (iii) getting the health sector relevant institutions right in light of the planned restructuring of the State, (iv) the prevention of

exclusion of citizens in case of new regionally oriented financing initiatives and when these citizens move to other jurisdictions (portability and no selection, based on health risks of potential enrolees), (v) establishing a purchasing function to improve access to care and efficiency in services delivery, (vi) improving governance, (vii) creating capacity for social marketing and empowerment of vulnerable groups, (viii) making sure that health services actually exist and function to offer newly financed services, (ix) having sufficient administrative capacity and funding, (x) impact on country's economy and (xi) achieving social consensus on the proposed direction of change. Realising some of these preconditions, e.g. purchasing and capacity building, require quite some effort and are undertakings in their own right.

## Policy Options

Several ways can be imagined to initiate methods for offering more equal access to care for the poor, to prevent them from impoverishment and to change the high out-of-pocket payments at the point of services into a prepayment scheme. Currently, around 55% of all health care expenditures are paid out-of-pocket. The out-of-pocket spending happens on an individual basis, i.e. in the direct relation between patient and health services provider. This means that a patient has to individually pay for the consumed health services while receiving such services and hence hampers access to health services. A large information asymmetry exists between the patient and the doctor. The patient cannot judge the competence and quality of the providers and has no time to shop around for the lowest price \ and cannot judge if the offered and provided care is appropriate. That's why channelling the current out-of-pocket payments at the point of services via a prepaid health financing mechanism and having a competent agency that mediates between the patient and the provider is important. All the discussed options require increased budget funding to ensure and improve access for the poor and to not leaving them behind in the implementation of any of the discussed health financing initiatives.

Options discussed in the paper are:

- 1. Providing Value for Money:** This option aims to use the current budget funding more effectively and efficiently, free up resources for expanding services while underpinning the need for further investments and budget contributions to bridge the gaps in coverage and equity in access. In essence this would mean establishing purchasing capacity and creating conditions for effectively using the purchasing function. This option is split in three sub-options.
- 2. Combining option 1 with Community based Health Insurance (CBHI):** This option keeps CBHI as pilots to look at their cost-effectiveness and added value in social marketing, revenue mobilisation, addressing local needs and social auditing, while addressing some of the flaws in current funding and governance systems in the general health system.
- 3. Expanding CBHI:** In this option, other communities will also be stimulated and supported to establish their CBHI and offer services on top of the current budget funded system - if CBHI is evaluated as cost-effective and of having an added value. This way CBHI could gradually expand into a national scheme while for now catering to existing differences in health needs, services availability, funding capacity and cultural preferences.
- 4. Triple Financing System:** This option offers equal access for the informal sector to team up and keep pace with the possibly proposed introduction of the health insurance schemes

for civil servants and the formal private sector (as discussed under the new Social Security Organisation Act). This mechanism would offer universally accessible supplementary benefits, currently not covered via the budget funded schemes. This triple financing system would, at least for the time being, accept separate funds flows and separate pooling from different sources and using different collection mechanisms. Over time, this system could be moved into a single financing system with universal coverage.

- 5. Covering the Kathmandu Poor via a Private Insurer:** This option offers the possibility of implementing and purchasing a government subsidised supplementary benefits package for poor in Kathmandu similar to CBHI packages elsewhere. Thus, this would test the involvement of private insurance management capacity on cost-effectiveness in the implementation of a social health protection programme for the poor.
- 6. Establishing a Health Insurance System for Migrant Workers and Their Dependents:** This option offers the possibility to voluntarily enrol in a health insurance scheme which will cover the necessary health care costs in the countries of work as well as for their dependents remaining in Nepal. Thus, this option would enhance the social health protection of Nepalese migrant workers and their families.

The various policy options are discussed with regard to their health system functions and evaluated by applying the following criteria: (i) increasing value for money (efficiency), (ii) increasing revenues in general, (iii) improving equity in funding of health services according to ability to pay, (iv) decreasing out-of-pocket payment at the point of services, (v) improving access to quality care, (vi) minimal increase of administrative capacity needs and of administrative costs, (vii) responsiveness to local needs, (viii) responsiveness to local fund raising capacity (in case of a choice for a more decentralised system), and (ix) taking into account locally available services. These criteria stem from the policy objectives mentioned, during the May meetings, by various stakeholders and cater for the current Nepalese context. Above all, they take into account the efficiency of implementing the respective options and their relative value for improving access to care for the poor.

The pros and cons of the options are discussed in detail and ranked in terms of complexity and estimated ease of implementation. The option for insuring migrant workers is somewhat outside of the more mainstream option as it focuses not on Nepalese residents in the first place although it would take care of dependents.

All options address, one way or the other, the policy questions that have been raised during the various meetings of the GTZ and the MoHP team: (i) they offer the possibility of gradually introducing a new health financing mechanisms, (ii) they focus on strengthening capacity and establishing a purchasing function, (iii) they are pro- poor, (iv) they keep the option of CBHI open but with a critical view on its cost-effectiveness, (v) they build on the current publicly offered Free Health Care Services (FHCS), (vi) they offer a perspective for people to use their cash transfers to enrol in CBHI and therewith move from individual to collective purchasing as well as (vii) they offer a perspective for the MoHP to engage in institutional capacity development of (supplementary) social health insurance for the formal sectors (public as well as private) as currently discussed under the new Social Security Organisation Act.

## **Recommendations and Next Steps**

The paper ends with a number of recommendations and suggestions for next steps, emphasizing the need for e.g. further discussing the options, engaging in a stakeholder dialogue including EDPs, evaluating the CBHI pilots before up-scaling, establishing a purchasing function and for strengthening the regulatory and administrative capacity.

# I. Introduction

## 1. Background

In the recent years, the Government of Nepal (GoN) has introduced various programmes to enhance people's access to health services and stipulated citizen's right to basic health services in the interim constitution. To improve the social health protection mechanism in the country, the Ministry of Health and Population (MoHP) has initiated a process to draft a policy on social health protection (SHP). Specifically, in February 2010 an inter-ministerial Steering Committee on social health protection chaired by the honourable Minister for Health and Population, Uma Kanta Chaudhari, was formed to develop a social health protection policy. The drafting process of the policy is led by the MoHP.

The German Technical Cooperation (GTZ), among other development partners, is providing technical support to this process. Between May 2<sup>nd</sup> to 18<sup>th</sup>, 2010 a team of MoHP representatives, GTZ staff, a P4H representative and an international and a national consultant engaged in a joint fact finding effort and policy dialogue with other stakeholders. This joint MoHP - GTZ effort was to assess the current status of the Nepalese health financing / social health protection system as well as outline various options for improving and expanding it.

## 2. Objective

The overall objective of the joint MoHP - GTZ effort is to assess the current social health protection status as well as to outline various policy options, suiting the Nepalese context.

## 3. Approach

It is clear that existing models used in other countries cannot simply be transferred to the Nepalese context as the health sector of Nepal has developed in a unique manner and context. The challenge for Nepal is to develop a system which suits its own socio-economic context, resource base, cultural values and challenging geography. Besides compiling and analysing the necessary technical information, national capacities need to be strengthened and a comprehensive and inclusive stakeholder process has to take place for discussing various policy options to further improve social health protection. Therefore during this mission a wide range of stakeholders has been consulted and representatives from MoHP have participated in the meetings during the joint fact finding effort, whenever it was possible.

Meetings were held with officials and staff of the Ministry of Health and Population (MoHP), Department of Health Services (DoHS), National Planning Commission (NPC), Ministry of Finance (MoF), Ministry of Local Development (MoLD), Ministry of Labour and Transport Management (MoLTM), World Bank (WB), World Health Organization (WHO), International Labour Organization (ILO), Department for International Development (DfID), Korean International Cooperation Agency (KOICA), Insurance Board, Insurers' Association, Federation of Nepalese Chambers of Commerce & Industries, District Development Committee and Village Development Committee. Additionally, different levels of government health facilities and offices such as sub-health post, health post,

primary health care centre, district health office, district hospital and community-based health insurance as well as a private hospital were visited. The list of persons met is attached as Annex 1.

The MoHP was briefed two times on the initial observations and preliminarily formulated policy options during the joint fact finding effort, midway and by the end of the joint effort. A midway briefing with the EDPs' Health Group has also taken place.

The main observations and recommendations of the team and the proposed next steps are summarized hereafter.



## II. Policy Environment

### 1. Terminology: Definitions and Observations

This chapter is to provide clarification on the conceptual understanding of the terminology used in this report and to provide insights on the terminology used in the Nepalese context, based on the observations by the MoHP – GTZ team.

In general, the terminology on health financing and social health protection tends to be ideologically charged and terms are often not clearly defined. There are different definitions of social health protection available; however the underlying concepts and elements are very similar. WHO defines social health protection as a system of affordable insurance or a government-funded programme that allows people to access essential health services without risking impoverishment or severe financial hardship<sup>1</sup>. At WHO the term is often synonymously used with “universal coverage”<sup>2</sup>, emphasizing the normative character of the term. ILO defines social health protection on a more operational level as “a series of public or publicly organised and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health”<sup>3</sup>.

The term social health protection is understood and used in this report along the common understanding of the Providing for Health (P4H) Partners (Germany, France, ILO, WHO and World Bank)<sup>4</sup>, which reconciles both concepts, as

- a system - based on pre-payment and financial risk pooling - that ensures equitable access to essential quality health services at affordable prices; whereas contributions to the system are based on capacity to pay and benefits are based on need and
- a set of measures against ill health related cost of treatment, social distress, loss of productivity, and loss of earnings due to inability to work.

The concept of social health protection has been just recently introduced and discussed in the Nepalese context. The team could observe that the terms social health protection and social health insurance were sometimes being used interchangeably, although health insurance is also understood as assurance of access to necessary health care and not necessarily as a payroll tax based funding system for health services for an enrolled population. However, this understanding varies among different partners. This versatile interpretation of the terminology is reflected in the name of the proposed social health protection / social health insurance policy which is using both

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<sup>1</sup> World Health Organization: Is There a Single Best System of Health Insurance? (<http://www.who.int/features/qa/35/en/>).

<sup>2</sup> Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.

<sup>3</sup> International Labour Office: Social Health Protection: An ILO Strategy towards Universal Access to Health Care. Social Security Department, International Labour Organization, Switzerland, 2008.

<sup>4</sup> Providing for Health (P4H) is an initiative that has been established and mandated to implement decisions taken by the G8 summits in Gleneagles (2005), St. Petersburg (2006), Heiligendamm (2007) and Toyako (2008) in support of strengthening health systems through social health protection for the whole population and particularly for the poor. The current core group comprises Germany, France, ILO, WHO and the World Bank.

terms. While social health protection as a normative concept could guide the direction of the policy, social health insurance is a potential implementation modality that would potentially go beyond the scope of a policy.

In the further development of the social health protection / social health insurance policy these different understandings have to be taken into account and clarified in order to have common understanding among all stakeholders including EDPs.

## **2. National Coordination Mechanisms for Policy Formulation related to Social Health Protection**

Currently, there are a number of national coordination mechanisms in place in which social protection and social health protection policies and relevant laws are being discussed and formulated. Different committees are under the leadership of different ministries / agencies and vary in their composition.

**Social Health Protection:** In February 2010 an inter-ministerial Steering Committee on Social Health Protection/Social Health Insurance chaired by the honourable Minister for Health and Population has been formed in order to develop a Social Health Protection/Social Health Insurance Policy. Members of this Committee are NPC, MoF, MoLD, MoGA, MoLTM, DoHS, FNCCI, National Insurance Board, Institute for Private Hospitals, WHO, KOICA and GTZ. A Technical Working Committee and a Core Team within the MoHP are supporting the drafting process<sup>5</sup>.

**Social Protection:** The National Steering Committee on Social Protection (NSC SP) chaired by the National Planning Commission (NPC) and represented by joint secretaries from MoF, MoE, MoAC, MoLTM, MoHP, MoLD and MoWCSW is currently working on the development of a consolidated national social protection framework. The objectives of the NSC SP are to review existing social protection interventions and their delivery systems, to identify and appraise various options of social protection along with financing and delivery mechanisms and the development of a comprehensive, consensual and consolidated framework by June 2010. The Committee is supported by the EDPs' Social Protection Task Team, specifically through technical assistance by ADB. Each involved ministry has set up an intra-ministerial task team to prepare their input to the framework. Within the MoHP a task team is working under the supervision of the Human, Resource & Financial Management Division to formulate the conceptual input.

**Revision of the Labour and Social Security Organisation Act:** Concurrently, a high level committee under the chair of the Revenue Secretary (MoF) for tripartite consultation has been formed consisting of different ministries (MoF, MoLTM, MoLD, MoLJ), trade unions (Trade Union Congress, All Nepal Trade Union Federation, General Federation of Nepalese Trade Unions) and employers associations (Confederation of Nepalese Industries, Nepal Chamber of Commerce and FNCCI). The committee will recommend on the revision of the Social Security Organisation and Labour Acts as well as on the management and utilisation of the 1% social security tax (as provisioned in the FY 2009/10 budget).

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<sup>5</sup> Members of the Technical Working Committee are MoHP, MoF, MoLTM, MoWCSW, MoGA, DoHS, Nepal Insurance Board, NHRC, Insurers' Association, RTI International, Karuna Foundation, GTZ.

### 3. National Policies and Plans

This section shortly outlines the national policy environment and framework conditions which will influence the formulation of any social health protection and health financing policy. Special attention needs to be paid to the current revision process of strategies, policies and laws, pertaining directly to the health sector but also more generically in light of a new Constitution, that might change the policy environment substantially. Until now, no explicit stipulation with regard to social health protection has been made in the existing policies, plans and strategies as the concept has been only recently discussed in the Nepalese context. However, there is scope and an acknowledged need for integrating the concept of SHP (definition, objectives and targets) in the current revision process of the national health policy and plans.

#### Interim Constitution

Nepal has initiated since 2006 a process of enhancing peace and of constitutional renewal. Currently Nepal is governed under an Interim Constitution and a new constitution was supposed to be promulgated by 28 May 2010. This deadline has not been met and the current Interim Constitution is extended by one year.

The Interim Constitution of 2007 proclaimed for the first time in Nepal's history that: "Every citizen shall have the right to basic health services free of cost from the State as provided for in the law".<sup>6</sup> However, no legal provision is in place till now that ensures citizens' right to basic health services and the term "basic" has not been clearly defined yet although the Free Health Services Programme (FHSP) can certainly be noted as a contribution.

The Interim Constitution warrants also the restructuring of Nepal into a democratic federal system and declared Nepal a 'Federal Democratic Republic State.' Under the existing administrative structure, Nepal is divided into 14 zones, 75 districts, 58 municipalities and 3912 Village Development Committees (VDCs). In the current constitution writing process, the nature of the administrative division under the federal structure and the mandate of the local governments have remained one of the major debates among the political parties. Administrative restructuring in the country can be expected to have a substantial impact on the health sector in terms of governance, resource allocation and its legal and policy environment. However no conclusive statements on the structural and organisational set up of the health sector can be made at the current point of time. Therefore, due attention should be given on possible changes in the governance and administrative structure while considering major reform process in the health sector as the country is presently in the transition period. Instead, strengthening current capacities and anticipating more generic health financing improvements are warranted and can be explored on implementation feasibility.

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<sup>6</sup> United Nations Development Programme: The Interim Constitution of Nepal 2063 (2007), As Amended by the First to Sixth Amendments. UN House, Pulchowk, 2009.

## **National Health Policy 1991**

The National Health Policy 1991 is the overall guiding policy framework for health sector development. The current policy is focusing in its objectives and strategies on strengthening the primary health care system and making effective health care services available at the local level. Health financing or social health protection as a particular point of attention is not being addressed in this policy. However, a Committee within the MoHP has recently been formed for revising the policy in the present context.

## **Second Long term Health Plan 1997 – 2017**

The aim of the Second Long term Health Plan 1997 – 2017 (SLTHP) is to guide health sector development for the improvement of the health of the population – especially of those whose health needs are often not met. It is also the purpose of this plan to provide guidance in developing appropriate strategies, programs, and action plans that reflect the national health needs and priorities. Currently, the MoHP is in the process of revising the SLTHP.

## **Three Year Interim Plan 2007/08 – 2009/10**

The Three Year Interim Plan 2007/2008 – 2009/10 is the national development plan that guides the overall planning procedures. This latest development plan has accepted health as a fundamental human right and gives emphasis on equitable access to health services. Currently the drafting process of the next Three Year Plan is taking place in which a whole chapter is dedicated to social protection.

## **Nepal Health Sector Programme-Implementation Plan II (NHSP – IP 2) 2010 – 2015**

The guiding document for planning the implementation of health sector programmes for a period of five years is the Nepal Health Sector Programme Implementation Plan. The last five year Nepal Health Sector Programme – Implementation Plan (NHSP-IP) 2005 – 2010 has expired in July 2010. The final version of successor NHSP-IP 2 is available in draft format and still needs to be endorsed by the government.

The NHSP-IP 2 provides the overall framework for planning and activities in the health sector for next five years (2010-2015). While NHSP-IP 2 strongly builds upon achievements of its predecessor NHSP-IP 1, it focuses on increasing access and utilisation of health care services as well as on the disparities between different income, gender, caste and ethnic groups.<sup>7</sup> Its three objectives are:

- 1) To increase access to and utilisation of quality essential health care services;
- 2) To reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors; and
- 3) To improve the health system to achieve universal coverage of essential health services.

NHSP-IP 2 clearly formulates targets and indicators on improving access for the poor and marginalised as summarized in the results framework in the annex of NHSP-IP. Two indicators are related to social health protection: (i) to foster increased utilisation of essential health services by

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<sup>7</sup> NHSP-IP 2: Vision, Mission, and Strategies for the Health Sector.

targeted groups, (ii) a comprehensive health care finance strategy will be developed and is expected to be approved by 2012.

Any social health protection policy needs to be aligned to and within framework of the NHSP-IP 2.

### **Health Sector Gender Equality and Social Inclusion Strategy (2009)**

Responding to the considerable inequalities in utilisation and health outcomes between different caste, ethnic and gender groups, the MoHP developed in 2009 a Health Sector Gender Equality and Social Inclusion Strategy, outlining objectives and strategies for gender equality and social inclusion (GESI). This strategy aims to create a favourable policy environment for integrating gender equality and social inclusion in Nepal's health sector. Therefore, any social health protection policy and its implementation need to be closely aligned to the objectives and activities of the GESI strategy.

### **Social Security Organisation Act and Labour Act Reform Process**

Given the high degree of inequality (Gini coefficient 0.41<sup>8</sup>) despite positive economic growth rates in the last years, improving and expanding social protection has received a fair amount of attention by the GoN and EDPs.

The Interim Constitution of 2007 stipulates the right to social security and the duty of the state to adopt a policy of providing economic and social security to the vulnerable and dispossessed. In line with this commitment the GoN is pursuing the ratification of ILO Convention No. 102 and possibly ILO Convention No. 158<sup>9</sup>. As ILO Convention 102 requires at least three social security branches including one long-term benefit, there are currently ongoing debates on the extension of social security to new areas such as unemployment and health. Therefore, GoN has, from the fiscal year 2009/10, introduced a 1% social security tax on the first slab of the taxable income of salaried people (public as well as private sector) to expand social security schemes<sup>10</sup>.

As mentioned earlier, a high level Committee under the chair of the Revenue Secretary of MoF for tripartite consultation has been formed consisting of different ministries, trade unions and employers' associations. The committee has the responsibilities to draft the Social Security Organisation Act which is foreseeing a own Social Security Authority, to recommend on the social security schemes that can be initiated from the 1% tax fund, and revise the Labour Act 1992 under which social security issues have been dealt with up to now<sup>11</sup>.

Since 2002 the International Labour Organization has been facilitating the discussions between the relevant stakeholders and is the main supporter of this process besides World Bank and DfID. So far agreement has been reached among employees and employers to focus on the following benefit schemes that should be developed: unemployment, sickness, accident and maternity. However,

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<sup>8</sup> Central Bureau of Statistics: Poverty Trends in Nepal (1995-96 and 2003-04). Central Bureau of Statistics, Government of Nepal, 2005.

<sup>9</sup> ILO Termination of Employment Convention No. 158.

<sup>10</sup> As per the proposal in the budget speech of 2009/2010.

<sup>11</sup> The need for revision of the Labour Act 1992, especially the part which deals with dismissal and retrenchment, has been long expressed by the private sector in order to allow more flexibility of the labour market.

there has been no in-depth discussion on the model of entitlement and payment method (in kind versus reimbursement) or on the institutional arrangements. The structure of the proposed Social Security Authority has not yet been defined, except for the board in which MoF, MoLTM, employees and trade unions would be represented. Even though two schemes (sickness and maternity) are linked to the health sector, MoHP has been not included so far in the current discussions on the structure of these schemes and it is not foreseen as a member of the board. While it was originally envisioned to reach out to the informal sector, discussion with employers and employees revealed that there is little acceptability for cross-sector solidarity.

In the meantime the collected money from the 1% payroll tax is put in a dedicated account at the National Treasury. It is very unlikely that the Social Security Organisation and Labour Acts formulation process will be finalised and passed by parliament before the new constitution is in place next year.

### **Insurance Act and Its Revision Process**

Another Act that is currently under revision is the Insurance Act of 1992. Already a preliminary draft of the revised act has been prepared. The draft act envisions a Nepal Insurance Authority (instead of current Insurance Board) to develop and promote insurance business as well as formulate standards and guidelines. One of the functions of the Authority is to provide necessary suggestions to the GoN to formulate national policies and regulations for the insurance sector. The draft also stipulates that those who are not certified by the insurance authority cannot carry out an insurance related business. The act aims at regulation of the for-profit insurance market, but so far does not address any specific provision with regard to cooperatives and CBHI.

## **4. Fiscal Space**

The purpose of this section is to provide an overview of fiscal space in Nepal. More in-depth analysis is needed to assess fiscal space for specific reform proposals. Fiscal space has been defined as "room in a government's budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy"<sup>12</sup>. In the context of mobilising additional funds for health, this also involves preserving conditions for economic growth such as international competitiveness of the labour force and possibilities for efficiency improvement.

**Fiscal Balance:** Fiscal constraints affect a country's ability to attain policy objectives or implement certain types of reforms. Countries with low fiscal deficits have more room to raise expenditure. On the other hand, a strong economy is needed to bear public debts. Nepal's macroeconomic outlook has been described as challenging by an IMF mission visiting Nepal early 2010. "After expanding by 4¾% in 2008/09, real GDP growth is expected to decelerate to 3% in 2009/10 due to a poor monsoon, softer remittances, and tighter monetary conditions"<sup>13</sup>. Although fiscal policy has

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<sup>12</sup> Heller, Peter; Back to Basics-Fiscal Space: What it is and how to get it, Finance and Development, IMF, Volume 42, Number 2, June 2005.

<sup>12</sup> International Monetary Fund: Statement of the IMF Staff at the Conclusion of the 2010 Article IV Discussions with Nepal: Press Release No. 10/74. March 2010 (<http://www.imf.org/external/np/sec/pr/2010/pr1074.htm>).

<sup>13</sup> International Monetary Fund: Statement of the IMF Staff at the Conclusion of the 2010 Article IV Discussions with Nepal: Press Release No. 10/74. March 2010 (<http://www.imf.org/external/np/sec/pr/2010/pr1074.htm>).

remained prudent, an ADB Assessment in 2009 states that risks are rising with a budget deficit at 1.9% of GDP in 2009 and a projected growth of budget revenue and expenditure in 2009/10 “entailing domestic borrowing of 3¼% of GDP”<sup>14</sup>. The Economic Survey (2009) stresses that both the domestic and external debts are on increase against the backdrop of a widening gap between expenditure and income<sup>15</sup>. Nepal’s total outstanding debt as share of GDP amounted to 41.6% in FY 2008/09 of which one third was domestic and two thirds foreign debt. Debt service (principal and interest payments) as share of recurrent expenditure amounted to 21.5% in FY 2008/09<sup>16</sup>.

Another fiscal pressure results from slowdown in the growth rate of remittances<sup>17</sup>. The need for foreign finance to pay for excess imports influences the external debt position. With weaker remittances and exports contracting<sup>18</sup>, the current account is projected to shift into a deficit of about 2% of GDP<sup>19 20</sup>. The widening of the current account deficit resulted in the drawdown of foreign exchange reserves<sup>21</sup>. Finally, sound macroeconomic management is also being challenged in FY 2010 by a number of developments in the money market. These include a liquidity crunch<sup>22</sup> and persistently high inflation as reflected in Consumer Price Index that remained in double-digits in January 2010, suggesting nonmonetary factors<sup>23</sup>.

The projected decrease in GDP growth would result in less proportional growth in domestic revenues (budget) and household income (for private out-of-pocket payments) - although the effect on public revenues could be compensated if the tax base is further expanded. Between 2008/09 and 2009/10, government allocations to health (GoN contributions excluding foreign funds) are still projected to increase from NRs 7.49 billion to NRs 9.97 billion<sup>24</sup>. However, the overall budget deficit may pose a constraint to further increase allocations to health. The level of external funding is already substantial with around half of the health budget funded from external aid. Nevertheless, additional external funds may be mobilised for health (e.g. Nepal has signed a compact with the International Health Partnership (IHP+) and additional donors are planning to contribute to the pooled funding).

**Tax Revenues:** Countries with a low tax burden have higher capacities to raise additional revenues through taxation. The average tax burden in the OECD countries is over 35%. Thus, if a country has

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<sup>14</sup> Asian Development Bank: Nepal - Assessment Letter for the Asian Development Bank. August 17, 2009.

<sup>15</sup> Ministry of Finance: Economic Survey 2008/09. Ministry of Finance, Government of Nepal, Kathmandu, 2009.

<sup>16</sup> Ministry of Finance: Economic Survey 2008/09. Ministry of Finance, Government of Nepal, Kathmandu, 2009.

<sup>17</sup> The workers' remittances increased only by 9.9% in the first eight months of 2009/10 compared to 58.9% growth in the corresponding period of the previous year (NRB, 2010).

<sup>18</sup> With reduced competitiveness from the appreciating Nepalese currency and domestic structural shortcomings, exports are likely to continue to decline in absolute terms.

<sup>19</sup> Asian Development Bank: Quarterly Economic Update Nepal. Volume VII No. 1, March 2010.

<sup>20</sup> According to World Bank PREM Guidance Note on the Financial Crisis 20, 11-11-08, a current account deficit is defined as “large” if it exceeds 3% of GDP.

<sup>21</sup> NRB's reserve declined by 17.1% in mid-march 2010 from a level of NRs 224.19 billion a year earlier (NRB, 2010).

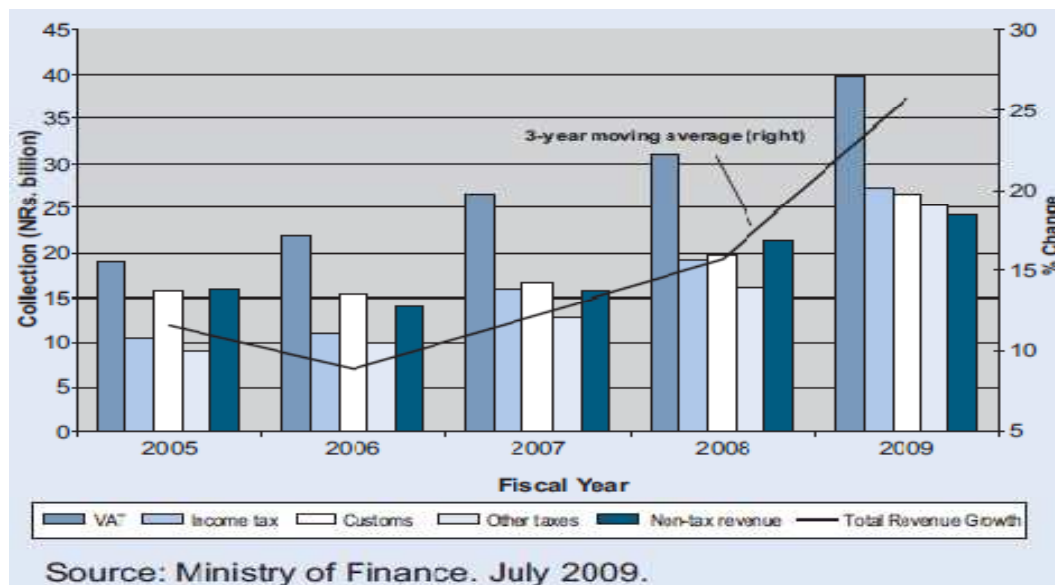
<sup>22</sup> The liquidity crunch is likely to be caused by a range of factors including decelerating remittances, heavy imports and excessive real estate and consumption related lending by commercial banks (ADB, 2010).

<sup>23</sup> Asian Development Bank: Quarterly Economic Update Nepal. Volume VII No. 1, March 2010.

<sup>24</sup> Ministry of Finance: Budget Speech 2009/10. Ministry of Finance, Government of Nepal, Kathmandu, 2010.

a tax burden significantly lower than that, there might be some fiscal space for increased domestic revenue collection. Total government revenue (tax and non-tax) represented 14.8% of GDP in FY 2008/09. Government tax revenue is projected at 12.2% of GDP and government non-tax revenue is projected at 2.6% of GDP in FY 2008/09 which marks a significant increase since FY 2005/06, when total revenue as share of GDP was at 11.1%<sup>25 26</sup>. Nepal's share of the public sector in total GDP is still low compared to other countries and thus suggests room for further expanding tax revenues. According to the IMF, for low-income countries, a tax ratio of 15% of GDP should be seen as a minimum objective<sup>27</sup>.

**Figure 1: Income Tax Revenue Exceeded Customs Tax for the First Time in 2009**



Source: Asian Development Bank: Quarterly Economic Update Nepal. Volume VII, No. 1, 2010.

In fact, the Government undertook a number of reforms on revenue mobilisation resulting in a record 32% growth in domestic revenue (excluding grants), and for the first time income tax collection exceeded customs revenue in FY 2009<sup>28</sup>. Given this success and the still low taxation base, further increases in domestic revenue mobilisation are likely - unless efforts to increase tax collection are offset by a decrease in GDP and taxable incomes.

<sup>25</sup> Ministry of Finance: Economic Survey 2008/09. Ministry of Finance, Government of Nepal, Kathmandu, 2009.

<sup>26</sup> Government revenue has not shown a steady growth rate in the past; it ranged from 3 to 32% in last eight years. In the first eight months of FY 2009/10, revenue mobilisation of the government grew by 25.6% compared to an increase of 38.6% in the corresponding period of the previous year. Nepal Rastra Bank (the Central Bank of Nepal): Current Macroeconomic Situation (Based on the Eight Months' Data of 2009/10). (<http://www.nrb.org.np/> accessed on 6 May 2010).

<sup>27</sup> Heller, Peter; Back to Basics-Fiscal Space: What it is and how to get it, Finance and Development, IMF, Volume 42, Number 2, June 2005.

<sup>27</sup> International Monetary Fund: Statement of the IMF Staff at the Conclusion of the 2010 Article IV Discussions with Nepal: Press Release No. 10/74. March 2010 (<http://www.imf.org/external/np/sec/pr/2010/pr1074.htm>).

<sup>28</sup> Asian Development Bank: Nepal - Assessment Letter for the Asian Development Bank. August 17, 2009.



The source of tax revenue is another indicator of fiscal space. Nepal's tax structure is dominated by indirect taxes<sup>29</sup>. This suggests that the potential of increasing direct taxes such as income tax is constrained by a narrow tax base. According to the Labour Force Survey 2008, 4% of the population is directly employed by a registered company or the government while 19% of the population is self-employed and is more difficult to tax (see Figure below). The current threshold, exempts a large group of employed population from contributing to income tax revenue – only since last year employment incomes below that threshold are also subject to an income tax of 1%. Moreover, gaps in tax administration and underreporting of income result in a reduced efficiency of tax collection<sup>30</sup>.

**The Labour Market Structure:** Estimates of the Labour Force Survey show that the structure of the labour market is dominated by self-employed persons who work without payment of a cash salary for their family business. These self-employed people work mainly in agriculture and account for 23% of the population and 47% of the active population. Consequently, direct taxes could potentially be raised at maximum from about a quarter of the total population (self-employed on own account, and public and private sector employees). Despite recent improvements in tax collection, the Labour Force survey suggests that only 4% of the population (less than 1 million employees) is relatively easy to tax as they are directly employed by a registered company or the government<sup>31</sup>. Information from available taxpayer registries and those listed in electronic statements of withholding agents indicates that 639,523 taxpayers paid income tax in fiscal year 2008/09. When relating this to an estimated 16.7 million active population (15-65 years)<sup>32</sup>, 3.8% of the active population has paid income tax (since not all withholding agents have filed electronic statements yet, the real number might be higher). Thus, both the Labour survey estimate and the available tax registry data suggest that the current basis for direct taxation is only around 4% of the population.

Taxation of income is a good indicator of how feasible and effective it is to introduce payroll tax as a mechanism to raise health revenues from large groups of the population. Payroll tax is raised as percentage of wage/salary and is directly transferred by the employer to a separate account for an earmarked purpose e.g. to create individual entitlements to health or other social security benefits. Payroll tax is deducted from the employee's pay (wages and salaries) or paid by the employer and often it is shared between employer and employee. While income tax and most other forms of taxes are general government revenues and subject to different budget priorities, payroll tax are earmarked to one purpose and less subject to budget cuts.

The above estimates confirm that the collection of contributions via a payroll tax in Nepal is constrained by a still very narrow tax base. Consequently, payroll tax offers a rather limited base for starting to raise and collect newly to be introduced health contributions and is not suited as a sole revenue collection mechanism to fund universal access to health services for the entire population

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<sup>29</sup> For FY 2008/09, the structure of revenue mobilization indicates 27.8% value added tax, 19% income tax, 18.6% customs duties, 4.3% registration fee, 2% vehicle tax and 17% non-tax revenues.

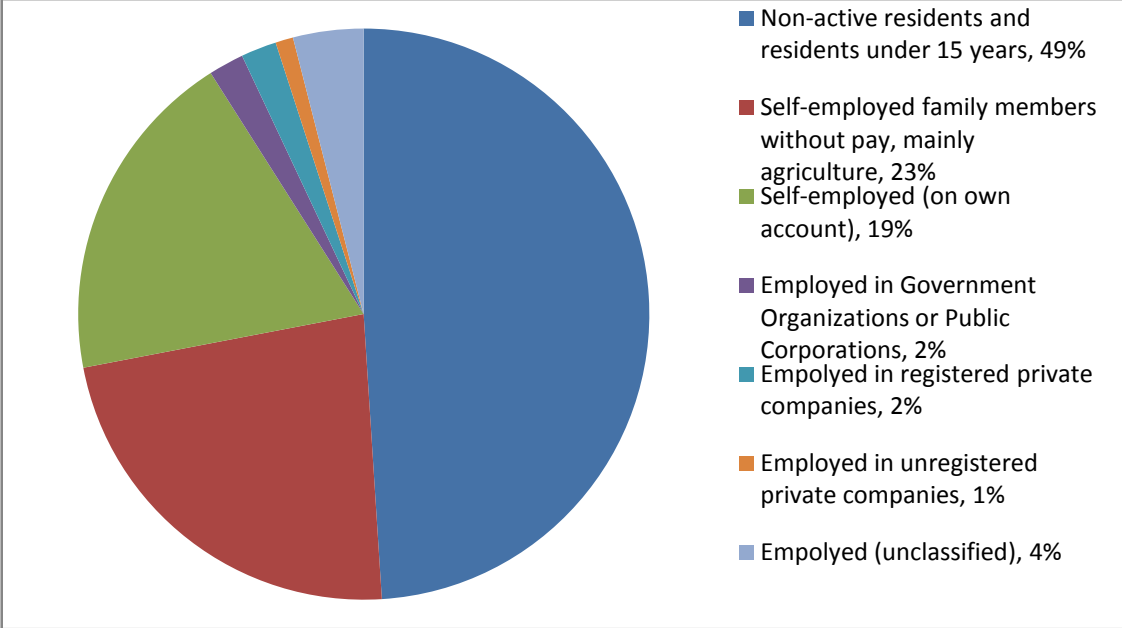
<sup>30</sup> In summary, income of individuals is subject to the following income tax rates: 1% on employment income up to Rs. 160,000; 15% on all incomes (employment, investment and business) ranging between Rs. 160,000 and Rs. 260,000; and 25% on all incomes above Rs. 260,000. Inland Revenue Department Nepal (<http://www.ird.gov.np> accessed on 11 May 2010).

<sup>31</sup> Central Bureau of Statistics (CBS): Nepal Labour Force Survey 2008. Central Bureau of Statistics, Kathmandu, 2009.

<sup>32</sup> CIA World Fact Book.

of Nepal. Continued reliance on general revenues (government budget funding) from all revenue sources seems critical to ensure that funding can be raised from the broadest currently existing revenue base to which all population groups contribute via direct and indirect (consumption) taxes and which has been expanding steadily in recent years.

**Figure 2: Residents of Nepal by Employment Status. Estimates as % of Population, 2008**



Source: Calculated from Nepal Labour Force Survey, CBS 2009<sup>33</sup>.

**Access to Foreign Aid:** The health budget already contains a significant amount of foreign aid (50% in FY 2008/2009 and 47% in FY 2009/2010)<sup>34</sup>, mainly in the form of grants. External grants swelled in recent years as donors sought to support Nepal during the post-conflict political transition. Although further increases of foreign aid for health are generally possible, the global financial crisis creates uncertainty about whether these allocations can be further increased or even sustained. According to WHO estimates, rest of the world funds/external resources for health represented 20.5% of total health expenditure and 52% of total government resources in 2008<sup>35</sup>. Since 1995, external funds have increased proportionally at the same pace as government resources<sup>36</sup>. In March 2010, an IMF mission visiting Nepal began discussions on a possible macroeconomic programme that could be supported by IMF financial resources.

<sup>33</sup> Central Bureau of Statistics: Nepal Labour Force Survey 2008. Central Bureau of Statistics, Kathmandu, 2009.

<sup>34</sup> RTI International: Budget Analysis 2008-09, Ministry of Health and Population. Research Triangle Park, NC, USA, 2008; and Ministry of Finance: Budget Speech 2009/10. Ministry of Finance, Government of Nepal, Kathmandu, 2010.

<sup>35</sup> World Health Organization: Health Expenditure Estimates 2010. ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

<sup>36</sup> World Health Organization: Health Expenditure Estimates 2010. ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

**Reprioritization and Efficiency of Expenditures:** Assessing fiscal space in search for more public resources for the health sector is not only about increasing taxes and/or the collection of taxes it is also about searching the health sector for the possibility of making savings by improving efficiency and spending the available monies more effectively. Efficiency of spending influences fiscal space in two ways. On the one hand, if inefficiencies can be removed by reprioritizing and rationalising expenditures, resources are freed and can be spent where they produce the highest value (e.g. reprioritizing health expenditure over military expenditure). On the other hand, efficiency of spending can be a precondition for mobilising additional resources for health. In Nepal, little analysis is currently available on efficiency of government health expenditures<sup>37</sup>. Currently, apart from some health programmes, Nepal's health financing system disposes of few mechanisms to budget, pay and report based on outputs. Hence, expenditure (and increases thereof) are not routinely compared and evaluated against outputs (such as drug dosages delivered) and it is difficult to say if the funds allocated have been spend effectively and efficiently.

Usually, even underfunded health systems have some room to improve efficiency. For instance, efficiency can be gained where there is: overutilisation of costly specialist care for cases that can be solved at the primary care level, underutilisation of health care facilities incurring fixed costs, the parallel provision of basic primary health care and disease-specific health programmes which often involves a fragmentation and duplication of administration and resources and relatively higher salaries for staff in those vertical programmes as well as the duplication of infrastructure by allowing doctors employed in the public system to work in separate private health facilities. Moreover, as outlined in the IMF report<sup>38</sup>, efficiency can be boosted by streamlining the implementation of programmes, reducing corruption, and improving governance. "Donors can help by paring conditionality, eliminating aid-tying, reducing administrative overheads, better coordinating spending in a sector, and reducing the administrative overload imposed on the limited number of recipient country programme managers".

## 5. Health Expenditure

According to WHO estimates, per capita government expenditure on health has increased from USD 3 to 8 (at average exchange rate) between 2000 and 2008. For comparison, the average government expenditure on health per capita among low income countries was USD 11 and among SEARO countries USD 15 in 2007<sup>39</sup>. Importantly, government expenditure accounted for only 39% of total health expenditure according to WHO estimates, while 61% of total health expenditure is estimated to be private expenditure in 2008. Of the private expenditure, 90% were paid out-of-pocket at the time of accessing health services<sup>40</sup>. Hence only 45% of total resources spent on health in Nepal were prepaid resources in 2008, indicating a large gap in financial risk protection

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<sup>37</sup> A Public Expenditure Review report is expected to be published by the World Bank by mid 2010.

<sup>38</sup> Heller, Peter; Back to Basics-Fiscal Space: What it is and how to get it, Finance and Development, IMF, Volume 42, Number 2, June 2005.

<sup>38</sup> International Monetary Fund: Statement of the IMF Staff at the Conclusion of the 2010 Article IV Discussions with Nepal: Press Release No. 10/74. March 2010 (<http://www.imf.org/external/np/sec/pr/2010/pr1074.htm>).

<sup>39</sup> World Health Organization: Health Expenditure Estimates 2010. ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

<sup>40</sup> World Health Organization: Health Expenditure Estimates 2010. ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

and potential inequities in the distribution of the financial burden. Total (public and private) per capita expenditure are estimated at USD 20 in 2008 (at average exchange rate) which is below the average expenditure of low income countries (USD 27) and of SEARO countries (USD 41) in 2007.<sup>41</sup>

Despite fairly steady economic growth in the past, significant improvements in revenue collection and an increase in the public funds allocated to health, the still low level of (prepaid) budget funding for health is likely to be inadequate for meeting health sector targets in the short and medium term, even if external aid continues to fund a substantial share. Achieving targets such as those related to the free health services programme, a reduction of the burden of private out-of-pocket expenditures for health, financial protection and improved geographical access to quality health services involves significant additional investments as well as replacing a significant part of current out-of-pocket payments through additional prepaid funding. Until mechanisms for collecting and pooling revenues have been strengthened (either within the current or via additional revenue collection mechanisms), available domestic revenues for health and savings from a more efficient allocation of resources are thus likely to fall short funding needs. However, the current level of out-of-pocket expenditures suggests that these funds can be eventually pooled and transformed into prepayment mechanisms for improved social health protection.

## **6. External Development Partners' Activities**

In the area of health financing and social health protection a number of EDPs are active and engaging in different activities. Harmonisation of EDPs' activities in the related areas could indeed create synergies between the various activities and helps to avoid duplication, competition and contradicting approaches with regard to new health financing arrangements.

Currently, two coordination mechanisms are in place where EDPs are able to harmonise their approaches.

- 1) The Social Protection Task Team (SPTT), which is a group of development partners, is active since 2006 and currently chaired by UNICEF and ILO (co-chair). Members are UNICEF, ILO, UNDP/UNCDF, WFP, ADB, World Bank, DfID and GTZ. The SPTT is to "support the government in the development of a strategic, integrated, and coherent National Social Protection Framework (NSPF)"<sup>42</sup>.
- 2) External development partners' Health Group is another coordinating mechanism to harmonise EDPs' activities in the health sector. This group consists of the 11 external development partners who take part in the SWAp.

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<sup>41</sup> World Health Organization: Health Expenditure Estimates 2010. ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

<sup>42</sup> The Development Partner Social Protection Task Team: A Briefing Note, March 2010.

### III. Assessment of the Health Financing and Social Health Protection Status

This chapter describes the health financing system in Nepal and social health protection (SHP) coverage. Uncovering factors that impact on access to health services and impoverishment due to accessing services is an important basis for developing targeted and effective actions to improve SHP. However, available resources did not permit a comprehensive, all inclusive and in-depth review of all factors. Therefore, this chapter focuses on main aspects that are relevant for improving SHP by using available assessment reports and points out the aspects which may need further exploration.

Based on the available information, system performance is analysed against policy objectives. The following set of health financing objectives reflect the contribution of health financing system to social health protection and universal coverage<sup>43</sup> (see Annex 3 for measurements that relate to each of the proposed health financing policy objectives).

- Promoting universal protection against financial risk
- Promoting a more equitable distribution of the burden of funding the system
- Promoting equitable use and provision of services relative to the need for such services
- Improving transparency and accountability of the system to the population
- Promoting quality and efficiency in service delivery
- Improving efficiency in the administration of the health financing system.

After sections covering “Financial Risk Protection and Equity in Finance” and “Equity in Access to Health Services”, the health financing system is described via four sub-functions- revenue collection, pooling and allocation, purchasing, and benefit package- in relation to the above objectives.

As mentioned above, not all factors can be discussed in great detail. For example, quality of care is only mentioned briefly in the options section of chapter IV but quality of services certainly is an aspect that needs further exploration. Adding more financial resources or endorsing new health financing mechanisms does make much sense if minimum services delivery standards cannot be adhered to or if main conditions are not met, such as sufficient and sufficiently qualified staff and a physical infrastructure and equipment being absent or not appropriate. Efficiency is briefly mentioned in the section on fiscal space. A more comprehensive review and discussion of efficiency in health care services delivery is certainly useful but beyond the scope of this paper, given the short time available.

The following sections summarise some information available from existing documents. A more in-depth analysis is necessary which require additional data collection and review.

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<sup>43</sup> Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

## 1. Financial Risk Protection and Equity in Finance

According to WHO estimates, only 45% of total resources spent on health in Nepal in 2008 were prepaid and pooled and thereby provide financial risk protection. These resources consist mainly in general revenue and external funding and to a lesser extent of NGOs and private health insurance funds. Equity in the distribution of the financial burden is ensured to some extent through progressive elements in taxation. The remaining 55% of total health expenditure are estimated to be out-of-pocket payments. These 55% represent a large gap in financial risk protection, involve inequities in the distribution of the financial burden and create financial barriers to access services. Out-of-pocket payments are made directly at the time of accessing health services and therefore provide no risk pooling (insurance). Also, out-of-pocket payments might represent a high-"catastrophic" - share of household (total or non-subsistence) spending or even lead to impoverishment or non-access. Generally, out-of-pocket payments tend to be the most regressive (inequitable) form of health financing as they tend to be charged independently (i.e. not proportional) to a person's capacity to pay.

One measure of equity in health spending is private health expenditure as share of capacity to pay (household consumption expenditure) by different income groups. The latest available national data show that on average, the poorest income quintile spent 3.7% of the household consumption expenditure on health in contrast to 7% spent by the richest income quintile in 2003/04, largely on curative and tertiary care<sup>44</sup>. Importantly, while the above percentage suggests equity (the poor pay a smaller share of their incomes) there is evidence that poor patients were unable to afford some of the health services they needed and consequently made less direct payments<sup>45</sup>.

A more recent study of the Micro-Insurance Academy in two districts shows not much difference in health expenditure as percentage of consumption among different consumption quintiles,<sup>46</sup> it suggests a significant financial burden of out-of-pocket payments in these two districts (per-capita annual healthcare expenditure as a share of the per-capita annual consumption varied from 6.58% in the poorest quintile to 7.98% in the richest quintile)<sup>47</sup>.

Access to health services has improved since 1995 (44.8% in 1995/96 – 61.8% in 2003/04), but 43% of the poorest quintile have not consulted any type of health service compared to 27% of the richest group<sup>48</sup>. The Micro Insurance Academy study also found that no treatment was sought in

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<sup>44</sup> Central Bureau of Statistics: Nepal Living Standards Survey 2003/04 Statistical Report. Central Bureau of Statistics, National Planning Commission Secretariat, Government of Nepal, Kathmandu, 2004.

<sup>45</sup> See findings from Demographic and Health Survey presented further below in this report.

<sup>46</sup> Dror, David M. & Rolf Rademacher, editors: Financial Inclusion Opportunities for Micro Health Insurance in Nepal; An Exploratory Analysis of Health Incidence, Costs and Willingness to Pay in Dhading and Banke Districts of Nepal. Micro Insurance Academy, New Delhi, 2010. This study shows that per-capita annual healthcare expenditure as a share of the per-capita annual consumption varied from 6.58% in the poorest quintile to 7.98% in the richest quintile.

<sup>47</sup> Dror, David M. & Rolf Rademacher, editors: Financial Inclusion Opportunities for Micro Health Insurance in Nepal; An Exploratory Analysis of Health Incidence, Costs and Willingness to Pay in Dhading and Banke Districts of Nepal. Micro Insurance Academy, New Delhi, 2010.

<sup>48</sup> Central Bureau of Statistics: Nepal Living Standards Survey 2003/04 Statistical Report. Central Bureau of Statistics, National Planning Commission Secretariat, Government of Nepal, Kathmandu, 2004.

11% of the cases of illness from any allopathic provider<sup>49</sup>. Two dominant underlying reasons behind this factor were reported as illness not considered serious (54%) and financial reasons (29%), the latter illustrating the access problems of the poor. Similarly, according to the Demographic and Health Survey (2006), an overwhelming majority (86%) of women in reproductive age expressed at least one problem in accessing health care for themselves (94.7% in the lowest income quintile and 73.9% in the highest income quintile)<sup>50</sup>. Finding money to pay for treatment was mentioned as access problem by 49.1% of women belonging to the lowest income quintile and by 23% of women belonging to the highest income quintile.

## 2. Equity in Access to Health Services

Besides the general state health care system offering essential health care benefits to all and additional benefits to some population categories, parallel health systems exist in Nepal that result in additional benefits, choice and sometimes in services of higher quality available to selected groups. For instance, parallel health systems provide services free of charge or discounted for employees and officials of different ministries, including defense and police at certain hospitals (see also section on resource allocation below).

**Financial Access:** According to the Nepal Living Standards Surveys, access to health services has improved from 44.8% in 1995/96 to 61.8% in 2003/04. However, 43% of the poorest quintile had not consulted any type of health service compared to 27% of the richest group in 2003/04<sup>51</sup>. As cited above, according to the Demographic and Health Survey (2006), an overwhelming majority (86%) of women in reproductive age expressed at least one problem in accessing health care for themselves (94.7% in the lowest income quintile and 73.9% in the highest income quintile). Finding money to pay for treatment was mentioned as access problem by 49.1% of women belonging to the lowest income quintile and by 23.0% of women belonging to the highest income quintile. A survey by the Micro Insurance Academy revealed that two dominant reasons for not seeking care from any allopathic provider were “illness not considered serious” (54%) and “financial reasons” (29%)<sup>52</sup>. These three surveys suggest substantial access barriers, inequity in access to health services between income groups and financial barriers to access health services which particularly affect the low income groups.

**Physical Access:** Besides financial access barriers, a number of other access barriers exist which especially affect disadvantaged and marginalised groups. A recent study by RTI reveals that there is vast gap between poor and rich households in terms of physical access to health facilities<sup>53</sup>.

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<sup>49</sup> Dror, David M. & Rolf Rademacher, editors: Financial Inclusion Opportunities for Micro Health Insurance in Nepal; An Exploratory Analysis of Health Incidence, Costs and Willingness to Pay in Dhading and Banke Districts of Nepal. Micro Insurance Academy, New Delhi, 2010.

<sup>50</sup> Ministry of Health and Population, New ERA & Macro International Inc.: Nepal Demographic and Health Survey 2006, Ministry of Health and Population, New ERA, and Macro International Inc., Kathmandu, 2007.

<sup>51</sup> Central Bureau of Statistics: Nepal Living Standards Survey 2003/04 Statistical Report. Central Bureau of Statistics, National Planning Commission Secretariat, Government of Nepal, Kathmandu, 2004.

<sup>52</sup> Dror, David M. & Rolf Rademacher, editors: Financial Inclusion Opportunities for Micro Health Insurance in Nepal; An Exploratory Analysis of Health Incidence, Costs and Willingness to Pay in Dhading and Banke Districts of Nepal. Micro Insurance Academy, New Delhi, 2010.

<sup>53</sup> RTI International: Pro-Poor Health Care Policy Monitoring Household Survey, Report from 13 Districts, Research Triangle Park, NC, USA, 2010).

Percentages of the poorest and the richest households having health post and sub health post as the nearest health facility are respectively 89 and 45. In contrast to this, percentages of the poorest and the richest households who have government hospitals as the nearest health facility are respectively 3 and 45.

**Access to Basic Health Services:** After the interim constitution made a provision of right to basic health services, Free Health Services Programme was introduced in a phase wise manner. However, local level public health facilities, in which rural population is mainly relying, are often inadequately resourced and distribution of facilities and health personnel are not properly linked to the local health needs. Dominance of incremental budgeting for allocating the financial resources and the practice of historical staffing tend to maintain the existing inequalities in accessing health services. The impact of the Free Health Services Programme, initiated in 2007, on access is too early to assess properly. Preliminary findings data suggest that utilisation and demand for drugs went up as the flow of patients has increased after the introduction of the Free Health Services Programme<sup>54</sup>.

**Knowledge of Available Services:** Not only physical access matters, people need to know where they can go and what services are available for them and at what costs. An information gap among the different segments of the population implies that social marketing is not adequate. To take an example, a study by RTI found that overall only 60% of respondents have heard of free health care services. Stratification by groups of respondents indicates that only 43.9% of the poorest quintile and 51.1% of Muslims<sup>55</sup> have heard of free health care services.

### 3. Revenue Collection

The sub-functions of revenue collection look into the institutions involved in collecting health revenue, contribution methods<sup>56</sup>, funding sources and beneficiaries. In Nepal, national health accounts data are available only up to the fiscal year 2005/06. Therefore, this section mainly relies on more recent estimates from the World Health Organization (WHO). However, there are discrepancies between the data available from national authorities and the WHO estimates mainly explained by the national health accounts methodology and definitions used in WHO estimates.

Government expenditure accounted for only 39% of total health expenditure according to WHO estimates, while 61% of total health expenditure is estimated to be private expenditure in 2008. Of the private expenditure, 90% were paid out-of-pocket at the time of accessing health services.

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<sup>54</sup> RTI International: Assessing Implementation of Nepal's Free Health Care Policy: Third Trimester Health Facility Survey Report. Research Triangle Park, NC, USA, December 2009.

<sup>55</sup> According to population census of 2001, Muslims consist of 4.3% of the total population in Nepal and they have relatively poor human development status in the country. Nepal human development report 2009 finds that human development index is lowest for Muslims (0.401) and Dalits (0.424) among the seven main caste and ethnic groups.

<sup>56</sup> "Contribution mechanisms: general (i.e. unearmarked) tax revenues, payroll tax revenues that are usually earmarked for compulsory health insurance (often called "social health insurance contributions"), voluntary prepayment (usually for voluntary health insurance) and direct out-of-pocket payment at the time of service use". Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).



Hence, only 45% of total resources spent on health were prepaid in 2008, indicating a large gap in financial risk protection and potential inequities in the distribution of the financial burden.

In Nepal, total government revenue as share of GDP is still low compared to other countries. Government allocations to health depend on the size of the public sector – which is comparatively low at 14.8% of GDP in 2008/09 - and the share of health in total government spending - about 7% in 2009/10. The health share in the budget reflects the government's priority for the health although there is also an increase in external aid since the Sector Wide Approach was established<sup>57 58</sup>.

### **Box 1: Key Indicators on Health Expenditure and Revenue Collection**

#### Volume of Health Expenditure

Total health expenditure: 4.9% of Gross Domestic Product (GDP) (2008, NHA<sup>59</sup>)

General government (MoHP) expenditure as % of GDP: 1.5% in FY 2008/09<sup>60</sup>

Per capita total expenditure on health: USD 20, out of which government expenditure on health was USD 8 per capita (2008, NHA)

#### Composition of Total Health Expenditure (THE) (2008, NHA)

Private sector: 61.0% of THE.

An estimated 91% of private expenditure is out-of-pocket payments

Government: 39.0% of THE

External aid: 20.5% of THE (partly accounted as public and partly as private expenditure)

NGOs: 6.6% of THE

#### Revenue Collection

Size of the public sector: Total government revenue (tax and non-tax) represented 14.8% of GDP in FY 2008/09<sup>61</sup>.

Government budget to health: 6.53% of total government budget in FY2009/10<sup>62 63</sup>.  
Approximately 40% of alcohol and tobacco tax goes into a Health Tax Fund for TB and cancer related activities.

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<sup>57</sup> For comparison, other social services receive 11%, education 16%, local development 9% of the budget. Ministry of Finance: Budget Speech 2009/10, Government of Nepal, Kathmandu, 2010.

<sup>58</sup> According to WHO estimates (using National Health Accounts definitions for calculation), the total of general government expenditure was 20% of GDP in 2008 and the share of health in general government expenditure was 9.5% in 2008.

<sup>59</sup> NHA stands for World Health Organization (WHO) estimates of national health expenditure ([www.who.int/nha](http://www.who.int/nha) accessed on 19 May 2010).

<sup>60</sup> Ministry of Finance: Economic Survey 2008/09, Government of Nepal, Kathmandu, 2009.

<sup>61</sup> Ministry of Finance: Economic Survey 2008/09, Government of Nepal, Kathmandu, 2009.

<sup>62</sup> Ministry of Finance: Budget Speech 2009/10, Government of Nepal, Kathmandu, 2010.

<sup>63</sup> The WHO health expenditure estimates calculate an expenditure ratio based on a broader definition that includes also health expenditure by other Ministries than MoHP: General government expenditure on health as % of general government expenditure 9.5% (2008, NHA)

## 4. Resource Pooling and Allocation

“In its most generic sense, pooling of funds refers to the accumulation of prepaid revenues on behalf of a population. Funds for health care are pooled by a wide variety of public and private agencies, including national health ministries, decentralised arms of health ministries, local governments, social health insurance funds, private for-profit and not-for-profit insurance funds, and community-based non-governmental organisations. Agencies that redistribute funds between pools (e.g. for risk-adjusting the premium income of competing insurance funds) also provide a pooling function. Changes in the way that funds are accumulated can affect not only the extent to which people are protected against the financial risk of using health care, but also equity in the distribution of health resources, the ability of systems to provide incentives for efficiency in the organisation of service delivery, and efficiency in the overall administration of the health system.”<sup>64</sup> The level of pre-payment and pooled funds defines the purchasing power (e.g. of a third party payer) to buy efficient quality services on behalf of the population of and for whom the monies are being collected and pooled.

**Pooling of Funds:** In Nepal, pooling of prepaid resources is ensured for 39% (2008) of total health expenditure at the national level through funding from general tax revenue and external aid. The remaining 61% of total health expenditure are estimated to be private health expenditure of which 90% are out-of-pocket payments. Thus, more than half (55%) of total health expenditure involve no risk pooling. Less than a third of the government health sector budget is allocated to district-level pools (district health budgets) based on historical budgeting by line-item and risk-adjusted formula.

Additional small pools exist in the form of voluntary health insurance (provider based schemes, health cooperative model and community health insurance run by the government). Currently, government run community health insurance schemes are in six districts which cover only selected Village Development Committees (VDCs) of the respective districts. The coverage of those schemes is quite low; it ranges from 3 to 20% of the catchment population in fiscal year 2008/09. However, there is no pooling of financial resources through a national social health insurance fund.

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<sup>64</sup> Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

### **Box 2: Community based Health Insurance (CBHI) Schemes in Nepal**

CBHI is currently piloted in Nepal as a new health financing arrangement with the aim to improve pre-payment of services, to improve and extend the health care services and to have more community participation. There exist six such schemes. The joint assessment team (MoHP-GTZ) visited one of them, the Dumkauli CBHI scheme. This was found a very interesting scheme which was managed by a highly motivated team of health care providers and community representatives, working in and from a new building with adequate equipments, and with a committed supervisory board.

Obviously, the MoHP-GTZ team could not do an in-depth assessment of this CBHI initiative and of the 5 others. A separate and comprehensive evaluation is necessary, possibly done together with other new CBHI initiatives planned to be supported by KOICA. However, one feature of the Dumkauli initiative is striking and worth mentioning in light of the discussion of new financial arrangements: its high administrative costs which happen to equal the costs of the extra benefits offered to the members of the scheme and for which it gets MoHP subsidy. These high administrative costs of CBHI in Dumkauli raises the question if CBHI should be further expanded in the same way. There is also concern that such subsidy is not an equitable use of state revenues because of the differences in entitlements between enrolees and non-enrolees. Government subsidy will need to be continued and increased if enrolment goes up and maintenance of physical infrastructure and replacement of equipment make new investment necessary.

In essence, more people would benefit from the additional government money if the scheme would be abolished, because administrative costs could be used for extending the extra benefits to more people. Enrolment in CBHI would need to go up and administrative costs to go down in order to make the CBHI initiative viable from a purely cost-effective point of view. That is, the question of the financial and managerial sustainability of such initiatives needs to be answered regarding the administrative costs and capacity. However, the success of CBHI cannot only be measured in terms of cost-effectiveness. The involvement of the local community in the initiative, its responsiveness to local needs, its social auditing and the motivated staff of the health centre are important values in themselves, worth preserving. Another positive feature of CBHI is that people get used to the idea of insurance in general and health insurance in particular.

Currently CBHI initiatives have no legal backing because of the absence of a license from the Insurance Board. The Insurance Board has drafted an amendment on the current Insurance Act and posted it on its website for comments. MoHP could confer with MoF to be involved in the further processing of the Insurance Act amendment to make sure that CBHI and social health insurance will be properly regulated and MoHP can exercise its mandate on health policy with regard to the use of health insurance as a health policy instrument.

**Resource Allocation:** MoHP accounts for 70% of total government spending on health, followed by Ministry of Finance (14%), Ministry of Education and Sport (10%). Most of the MoHP budget goes to the Department of Health Services as it is the implementing agency at the central level and MoHP is responsible for the activities such as planning & coordinating with sector ministries, overall administration, monitoring and evaluation. At the regional level, the Directors of Regional Health Directorate are responsible for technical backstopping as well as programme supervision. Some regional and zonal hospitals have been given decentralised authority through the formation of

boards<sup>65</sup>. There are District (Public) Health Offices to implement and monitor the EHCS packages at PHCCs, HPs, SHPs. District Development Committees and Village Development Committees also have some shared functional responsibility for delivery of health services<sup>66</sup>. The budget allocated to districts has been increased in recent years but it still accounts for less than one third of the total government health expenditure.

**External Assistance:** A Sector Wide Approach for health is in place since 2004, involving 11 development partners. DfID, World Bank and AusAID join resources for the health sector into a pooled fund, while other donors provide parallel funding based on the Health Sector Strategy, jointly developed by MoHP and all EDPs. GAVI Alliance, KfW and the Global Fund are scrutinising for a possible channeling of their resources through the pooled fund in future.

## 5. Purchasing and Provider Payment

“Purchasing refers to the transfer of pooled funds to providers on behalf of a population. Together with pooling, purchasing enables coverage to be provided for individuals. Key issues in purchasing have to do with the agencies that implement this sub-function, the market structure of purchasing, and the mechanisms used to purchase.”<sup>67</sup>

Several countries have introduced some form of purchasing within the public sector including Sweden (beginning in several county councils in 1990), Finland (1993) and the United Kingdom (1991). Southern Europe also has several examples. For instance, in Spain, a number of regions such as the Basque country and Catalonia have adopted a system of purchasing. In Italy, purchasing relationships exist but are limited to teaching hospitals with trust status in certain regions and the degree of implementation varies greatly between them<sup>68</sup>. Many of the transition countries in the former Soviet bloc have also introduced single payers as part of their health financing reform and are changing budget funding for health insurance while also establishing the health insurance agency as a purchaser<sup>69</sup>. Countries differ in the nature of the purchasing agent, its political and technical accountability including the composition of the purchasing boards or the degree of political direction, the population group covered and the range of purchaser responsibilities. Similarly, the financial contractual and regulatory performances differ substantially<sup>70</sup>. The experience in the transition countries clearly shows that the effectiveness of a purchaser is very much dependent of its mandate, of the regulatory environment and of the context in which it has to function.

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<sup>65</sup> Nepal Health Economics Association: Health Financing and Expenditure Review (based on a WHO template).

<sup>66</sup> Nepal Health Economics Association: Health Financing and Expenditure Review (based on a WHO template).

<sup>67</sup> Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

<sup>68</sup> J. Figueras, R. Robinson, E. Jakubowski, editors: Purchasing to Improve Health Systems Performance, European Observatory for Health Systems and Policies Series, 2005.

<sup>69</sup> Kutzin, J, C. Cashin & M. Jakab, editors: Implementing Health Financing Reform: Lessons from Countries in Transition. World Health Organization Regional Office for Europe and the European Observatory on Health Policies and Systems, (2010 forthcoming).

<sup>70</sup> J. Figueras, R. Robinson, E. Jakubowski, editors: Purchasing to Improve Health Systems Performance, European Observatory for Health Systems and Policies Series, 2005.

**Purchasing:** After financial resources have been pooled, the money can be used to pay for the health care services. There is no separation between purchaser(s) and service providers in Nepal, i.e. public health service providers are owned by the state and receive state budget allocations to deliver services and to pay salaries to health care workers. This integrated model is opposed to a purchaser/provider split where an autonomous purchaser selects the health care providers to be contracted. The integrated model has an inherent conflict of interest, i.e. the owner of the facilities may want to protect the interests of its facilities and of its staff in these facilities even if this is not necessary for the health care of the population it has to cater for, and even if better and more efficient ways of delivering the health services would be available. A separation between purchaser and provider can help avoiding this conflict of interest and contribute to more effective and efficient resource allocation. This has been a reason in several countries to make a split between purchaser and providers of services to enhance efficiency and quality of care. Currently, to a limited extent, the MoHP contracts consultancy services or providers to implement certain health programmes.

**Paying Providers:** MoHP and its subordinate organisations, from central to district level, pay prospectively via line item budget allocation and global budgets for most services. For some programmes (e.g. Safe Delivery Services), the prices/fees/charges of health services delivered are paid retrospectively on the basis of cases actually treated. Prospective payment via line-item budget means that state health care providers are allocated a budget irrespective of the volume and quality of services they actually provide. Such system has no incentives for improving provider performance in terms of efficiency and quality of service provision. In addition, budget rules usually require any unspent money to be reallocated elsewhere which does not motivate service providers to save money and it does not allow for reinvestment of savings. It gives also not much flexibility to health care managers to hire and fire staff within civil service rules, one of the key factors for efficient use of scarce resources. On the other hand, the quite substantive share of out-of-pocket payments is paid according to number and scope of services actually provided. The drawback of such private direct payments is that limited state control of private sector practice exists to ensure rational use of services and drugs and service quality as well as that limited or no protection is offered to patients against inappropriate care and unnecessarily high charges.

**Distribution of Health Human Resources:** Ensuring the continuous availability of health personnel in the public health facilities, particularly in remote areas, is a historic problem in Nepal. Recently a bill for the Protection and Management of Health Workers and Health Institutions, 2009, has been presented to the Legislative Parliament Secretariat<sup>71</sup>. Health personnel are allowed to do private practice when not on duty. To overcome human resources shortages, the MoHP has initiated to procure services of selected private sector providers/specialists. For example, private health institution can get approval from the government to provide for treatment and operation services to the women suffering from uterine prolapse for which they will be reimbursed by the government as per the defined unit cost.

**Health Care Providers' Network:** Of all health facilities in the country, 13.4% are private (3.1% for profit mostly in urban areas; 10.3% I/NGO mostly in rural areas<sup>72</sup>). Under MoHP, as of 2008/09, there are 4,408 health institutions consisting of 97 hospitals, 210 primary health centres, 702 health

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<sup>71</sup> Ministry of Finance: Progress Report of Sector Ministries 2008/09, Government of Nepal, Kathmandu, 2009.

<sup>72</sup> Department of Health Services: Annual Report 2007/08. Department of Health Services, Government of Nepal, Kathmandu, 2009.

posts, 3,106 sub health posts and 293 ayurvedic clinics equipped with 91,680 skilled manpower<sup>73</sup>. Non-state investment in the health sector has been substantial, though happening almost entirely in urban areas. There are 13 privately run medical colleges, 17 NGOs run hospitals, 17 private eye hospitals, 87 private research centres, hospitals and nursing homes, 39 pharmaceutical industries of Nepalese origin and 240 foreign based pharmaceutical companies, 40 diagnostic laboratories and research centres and two radio therapy facilities<sup>74</sup>.

**Performance Review:** Besides regular review mechanisms as part of the budget allocation process, the Health Economics and Financing Unit of the Ministry of Health and Population plans to regularly update the database of National Health Accounts, contribute to Public Expenditure Reviews and provide input on economic and costing analysis for the preparation of MoHP budget proposals to the Ministry of Finance as outlined in the NHSP-IP 2. There is also a guideline prepared for integrated supervision in 2009 which aims to support health institutions of different levels in delivering quality health services by effectively carrying out integrated supervision of health services programmes. Moreover, every year since 2005 the government and external development partners participate in a Joint Annual Review (JAR), in May and December, to discuss the performance in the health sector and the annual workplan and budget (AWPB).

## 6. Benefit Package

The benefit package can be considered as “those services, and means of accessing services, that the purchaser(s) will pay for from pooled funds. This definition implies that what is not in the package (fully or partially) must be paid for (fully or partially) by patients, within or outside the publicly funded system.”<sup>75</sup>

Since 2008, all health services available at health posts, sub-health posts and primary health care centers including listed essential drugs are free of charge to all. Additionally, listed essential drugs are available free of cost to all citizens at district hospitals. All other services provided by district hospitals are free of charge for targeted groups (ultra-poor, poor, helpless, disabled, senior citizens and female community health volunteers)<sup>76</sup>. Delivery services (+allowances for transport) are free

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<sup>73</sup> Ministry of Finance: Progress Report of Sector Ministries 2008/09, Government of Nepal, Kathmandu, 2009.

<sup>74</sup> Ministry of Health and Population, Nepal Health Sector Programme- Implementation Plan II (NHSP -IP 2) 2010 – 2015, Final Draft. 2010.

<sup>75</sup> Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

<sup>76</sup> Free Health Service Programme Guideline has defined these targeted groups as follows.

**Ultra-poor / Poor:** On the basis of economic condition, patients are defined as follows. If yearly income from the patient's family lands or other wealth, business or professions, is

- enough for feeding for less than six months, they are considered as ultra-poor.
- enough for feeding for at least six months and more but less than one year, they are considered as poor.

**Helpless:** Helpless person or patients are those who have no supporting family, guardians, or other helping person (can be determined on the basis of observation / evaluation of the health staff involved in the treatment).

**Persons with disability (differently able):** as per definition of Government of Nepal.

**Senior citizen:** Nepali citizen above 60 years of age (verified on the basis of Nepali citizenship or other certificate with attached photo and date of birth).

for all at government facilities. Details of the benefit packages of major programmes of SHP are listed in Annex 2. The final version of NHSP-IP 2 points at a referral mechanism to be developed for Nepal to facilitate more efficient use of the higher levels of health services. High share of the out-of-pocket expenditure in total health expenditure (55% in 2008) suggests that demand for a substantial amount of health services are in addition to the free health care benefits which is potentially provided with insufficient price, quality and safety control.

It takes time and effort to analyse the various reasons for sub-optimal performance of the health financing system. However, analysis of functions and institutions of a health financing system is a precondition for designing suitable and effective reform measures. Since Nepal has not undergone system-wide reforms of its health financing system, detailed analysis might be needed to proceed with reform design. In-depth diagnosis would guide next steps and streamline further discussion and prioritization of national policy objectives for reforms in order to tailor and evaluate different reform instruments against these national priorities.

This chapter has indicated that challenges exist to improve access to health services but also that options and support are available to actually improve resource use and access to services. Strengthening the purchasing function is one of them. However, to make effective use of new financial arrangements, several aspects of the current system need to be considered as the pre-conditions for new financial arrangement.

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**Female Community Health Volunteer:** Persons working as a Female Community Health Volunteer and having identity card.

## IV. Preconditions

It is relatively simple to design some new financial arrangements that could possibly solve the problems discussed in the previous chapter. However, main concern is whether Nepal is ready to actually make such changes. This chapter discusses preconditions for policy reform towards new financial arrangement in the health sector.

To make adequate use of any additional financial resources for the health sector and increase the chances for positive results of an eventual new financing arrangement and to proceed from OOP payments at the point of services to a prepaid scheme, a number of preconditions would need to be met. Realising some of the hereafter described preconditions are undertakings in themselves, necessary and worth investing in to make any new financial arrangement feasible:

### 1. Sufficient Capacity

It is needed to build sufficient capacity at the national and the local government level to absorb the proposed changes. Even a small scale initiative raises the question if it is possible to scale up to the District, Regional and National level. Any initiative would need to be reviewed on:

- 1) Objective: is the initiative meant to
  - i. Test a totally new idea which has not yet been tested elsewhere.
  - ii. Test the feasibility of an approach that has been proven to be effective elsewhere and for the national implementation of which Nepal has the capacity? Such initiative could deal with questions around national cost-effectiveness, acceptance by the public, administrative arrangements etc.
  - iii. Start the gradual implementation of a new approach of internationally proven value, which is cost-effective under Nepalese circumstances and feasible but cannot be implemented overnight, to monitor the results and adjust the implementation arrangements if necessary.
- 2) Its feasibility on the national level: politically, culturally, human resources availability, financially, physical infrastructure and sustainability.
- 3) Capacity to monitor and evaluate the results and to adjust.

### 2. Adequate Timing

Adequate timing of proposed system changes is important as to not negatively interfere with existing GoN initiatives and the implementation of the NHSP-IP. Given the limited capacity and the many activities foreseen in the NHSP-IP, any big change could undermine ongoing reform initiatives. This would result in a waste of money and efforts and may subsequently endanger EDPs' commitment to the health sector in Nepal. Any new initiative meant for scaling up should therefore be carefully tuned to the existing direction of reform and it should be subject to dialogue with the EDPs.

### 3. Getting the Institutions Right

It is necessary to get the institutions right in the new structure of the GoN. The implementation of new structures and institutions as a consequence of the new Constitution will take time and effort. The results of the restructuring will, to a great extent, influence the possibilities to shape the health financing system. Given the current uncertainties about the future structures and institutions, a



region or district focused approach could be useful. Such approach could also take into account the differences in purchasing power of its population, in culture and in the availability of health care facilities. However, the possibility to over time scale up to the national level should always be considered.

#### **4. Portability**

Especially in case the development of new financing mechanisms is left to relatively small areas and not in a uniform way, then the issue of portability may arise: has the citizen, participating in the scheme, the same entitlements if he/she moves to another area where another or no additional scheme is in place. Will the person who moves to another area with a different scheme be faced with exclusions because of his medical condition, i.e. can the local schemes apply risk selection methods? Can local schemes exercise a waiting time policy for new enrollees, i.e. do new enrollees have to wait for a number of months and pay contributions before they can start utilising health care services? Portability is a big issue in e.g. the USA where people may lose their entitlements and are faced with the exclusion of pre-existing medical conditions if they move to another State or change employers and having to move to another health plan. Therefore universal coverage and universal entitlements should be the ultimate aim and risk selection and waiting time procedures should be avoided as much as possible. Adequate national regulation needs to take place to avoid such risk selection in case different schemes with different packages of benefits are introduced in different areas of a country. Risk selection would also diminish the mobility of the labour force.

#### **5. Establishment of a Purchaser or Purchasing Function**

A purchaser or purchasing function should be established to optimise the use of resources in all options, i.e. assuring that patients, covered by the defined health financing system, have timely access to quality care, provided in an efficient way and for an affordable and sustainable price. This is one of the first options which MoHP may want to consider for improving SHP and it can be seen as a pre-condition for implementing one or more of the other options mentioned in the next chapter. Purchasing is discussed in this chapter in more detail in order to highlight the significance of this pre-condition and how it could work.

In Nepal, purchasing is absent or at best existing in embryonic form and fragmented over various actors. For example MoHP and District bodies make judgement on the allocation of resources to e.g. hospitals, based on the proposals of these hospitals. However the decisions are often based more on the existing budget envelop and existing norms than on objective health needs of the population. An objective assessment of these health care needs should ideally be translated into an optimal volume of services of different levels and types. The current allocation model cannot be called purchasing. There is no selection of providers, types and volumes of services for a circumscribed population, based on their health needs. By not having such a purchasing function and an agency that does the purchasing, Nepal and its residents are not getting value for money in health care services. A purchaser or a purchasing function within the existing administrative structure can be established and effective in a tax funded system, in a contribution based health insurance system and in a mixed system of budget and contribution funding.

A purchasing agency is an autonomous institution outside the existing administrative structures. The establishment of an autonomous purchaser most likely requires a specific legal Act. Advantages of this solution include a high level of effectiveness and power, as the purchasing agency would be very independent. Another, easier option is the establishment of a purchasing

function within existing administrative structures. A possible unit to take on this function requires the necessary knowledge and skills on purchasing. Undue interferences by the management and being also in charge of the health care providers are a danger in this form of administration and might hamper effectiveness. This means that a split between purchaser and provider is to be made. A new agency could make a new start with new staff, new incentive structures and new energy to take the new task.

The following tasks or functions can be assigned to a purchasing agency.

- 1) **Collection of Contributions:** The responsibility of contributions collection, in e.g. a general social health insurance or community based health insurance (CBHI) system can be assigned to the purchasing agency. The collection of contributions can be done by or on behalf of the purchaser via e.g. the internal revenue office. This is efficient for the collecting agency as well as for the contributors.
- 2) **Pooling and Administration of Funds:** Not only insurance based contributions can be transferred into one pool but also money from the state budget. For a health insurance system aiming to offer universal coverage of the population and for a CBHI to be viable and to cover the poor segments of the informal sector, budget funding is necessary as is the case right now for most CBHI. The funds can be posted in the Treasury, preferably in a special account which can only be used by the purchaser for the payment of legally defined purposes.
- 3) **Ensuring the Rights of the Citizens and/or Insured:** The purchaser can take the responsibility of ensuring the rights of the citizens and/or insured by, among others, contracting a sufficient number of qualified providers as close as possible to where people live or otherwise within reach of the insured, balancing distance and efficiency against affordability; sometimes acting as a broker between patient and provider to assure timeliness and suitability of the needed services and by adequately dealing with complaints of insured and appeals against the decisions of the purchaser.
- 4) **Ensuring Appropriate Spending:** Ensuring appropriate spending of its funds as regards administrative and health services costs is also a function of the purchaser. The purchaser will be responsible for its fund management and needs to be provided with the necessary tools to do this, like skilled staff and business support systems.

Besides these, contracting and selection of health services providers and reviewing their performance are the core functions of a purchaser to realise the objectives of a health care system as discussed below.

- 5) **Contracting:** Contracting is a purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period. A negotiated contract with the selected provider is the instrument which reflects the agreement reached between the two parties, laid down in a formal document and signed by them.

Different from incidentally buying non-medical goods or services, a contract with a health care provider is most of the time done for a longer period. There will be an option for prolongation of contract in case there is still need for the services and the parties in the

contract are mutually satisfied about the performance of the other party, or for cancellation of contract if parties are not satisfied.

- 6) Selection of Providers:** For the purpose of contracting providers, it is necessary to make the careful selection of private and/or public health care services providers and of their services in sufficient quantity and of sufficient quality to serve the health care needs of the citizens or the insured in a certain area. Selection of services can also focus on specific medical interventions and on the volume of services. Such selection assumes that some oversupply of public and private providers and/or their services exists. In Nepal this may only be the case in Kathmandu and a few other cities where private providers are around and competition between providers could take place. An active selection and contracting policy can stimulate providers to offer better services when they have to compete with each other for a contract.

Even if there is no competition and a provider is the sole provider in a certain area then the purchaser can still critically review the appropriateness and quality of the offered services as well as the adequacy of the referrals.

- 7) Implement Payment Systems:** Part of the contract between the purchaser and the provider is the kind of payment system used to reimburse the provider. The purchaser should be capable of choosing and managing provider payment systems, aiming at transparency, accountability, provider performance and appropriate care and efficiency. The purchaser should also have capacity for adjusting payment systems of different levels of care to promote cooperation between providers at different levels of care while avoiding perverse incentives.

- 8) Claims Review:** The purchaser will have to review claims before it pays the provider. The purchaser will look at:

- i. Eligibility of claims: It is important to review the claims to check their eligibility in terms of a) whether the provided services are part of the benefits package, b) whether the beneficiary is entitled to this care and c) whether the conditions for receiving the services are being met by the beneficiary.
- ii. If the submitted claim is based on the agreed fee for the services performed.
- iii. If there are any signs of fraudulent behaviour, e.g. claiming for non-performed interventions.

- 9) Provider Performance Review:** The purchaser will need to look at the following elements:

- i. Appropriateness of provided care (i.e. as compared with e.g. referral standards and medical protocols).
- ii. Charging of inappropriate co-payments or inappropriate amounts.

A number of purchasing functions at e.g. MoHP or at a district level could focus on the above tasks 3) through 10) albeit not always as effective as an autonomous purchasing agency could be, due to the above mentioned reasons. A precondition for purchasing without a new legal and independent agency is sufficient flexibility to change budget allocation rules, budget execution rules, retention and reinvestment of savings by providers, reorganising line item budget, etc. to develop purchasing as a function in the existing system.

The decision to start with a purchaser or a purchasing function can be implemented in a gradual way. However, to be effective and to act efficiently it is necessary that the purchaser has some financial clout and preferably can contract all levels of care as to control the appropriate use of health care providers and to avoid unnecessary use of high levels of care. The District level would therefore be a good level to start although top-level hospitals in Kathmandu would eventually be out of reach for the District purchaser. But, this can be solved by optimising the use of a referral mechanism, supported by disincentives such as a copayment in case of non-referred use of health services on an unnecessary high level, and by the introduction of the need for the patient to receive a pre-authorisation from the purchaser before the client seeks care in Kathmandu in case these services are covered by the particular scheme.

For the establishment and success of a purchaser or a purchasing function, a precondition would be a more autonomous position for the health care providers to manage their resources efficiently and to engage into contracts with the purchaser. Management capacity building at e.g. the hospital level is therefore necessary.

If such a purchaser is established and the pre-conditions are met then Nepal may increase its chances of getting value for money from its health care providers.

## **6. Improve Governance: Responsibility, Transparency and Accountability**

Payers and consumers of health care want to have:

- Clearly defined responsibilities in e.g. fund management, in ensuring access to health services and in the delivery of health services.
- Transparency in fund allocation and fund use for health services.
- Health financing agencies and health services providers to be accountable for adequate resource use and appropriate care.

These objectives are not yet fully realised in Nepal's health system. For example, although the cost of drugs has increased after the introduction of decentralised procurement<sup>77</sup>, it is not known if the number of available drugs dosages also has gone up. However, shortages of drugs are still reported. Output based reporting of budget execution, which could give the answer, is not practised in Nepal's health sector. Such reporting would indicate what is actually delivered, i.e. what were the outputs during the year, covered by the report, e.g. the number of admissions, the number of people treated in outpatient care, the number of surgical interventions (eventually broken down in specific surgeries), the number of drugs dosages delivered etc.

Pumping extra money into the health system and/or starting a new funding mechanism such as social health insurance (SHI) or expanding existing initiatives such as CBHI, and/or introducing contracting and output-based payment systems would be potentially wasteful if governance is not improved.

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<sup>77</sup> RTI International: Budget Analysis 2009-10, Ministry of Health and Population. Research Triangle Park, NC, USA, 2009.

## **7. Capacity for Social Marketing and Empowerment of Vulnerable Groups**

The introduction of a new health financing arrangement as such is not enough. The population needs to know that this is happening and that it provides better chances for them to access health services. The earlier mentioned limited awareness of the Free Health Services Programme shows the need for providing adequate information. Another problem in the implementation of new health or health financing programmes is always to have the target population to accept such new programme and participate in it. Many factors play a role in the process of gaining the trust of the population and making it open to new methods of prevention. The same is true for the introduction of a new health financing scheme such as insurance to a population not familiar with the concept and may get dissatisfied if no immediate rewards are provided e.g. in case they are not sick<sup>78</sup>.

Capacity for social marketing is necessary to prepare the population to accept new ideas and methods and to sustain these. Social marketing uses advertisement and marketing techniques of the commercial sector to achieve social goals. As has been noted during the visit to the Dumkauli CBHI scheme, there is a great need for social marketing and a lot of effort has to be made to increase enrolments and prevent drop outs. This is costly, despite the use of volunteers, adding to the factors that administration costs of the CBHI equal the revenues from the charged contributions. A reality observed at the Dumkauli scheme where the contributions collected just cover the administrative cost while the actual health services are fully funded from state budget sources transferred to the CBHI. Although local involvement and social mobilisation will remain key in the realisation of e.g. CBHI and other schemes or initiatives, strengthening capacity for social marketing and empowerment of vulnerable groups will make these easier and more cost-effective. Such capacity will need to be build, not necessarily in government (national or local). It can also be done by a qualified non-government organisation.

## **8. Strengthening Health Services Delivery to the Target Population**

It is obvious that necessary health services and providers need to be available to offer quality care as best as possible under Nepalese circumstances for any new health financing arrangement which aims to extent access to health care. Specific initiatives such as introducing or changing a scheme or a system should be able to integrate into current arrangements, i.e. not lead to further fragmentation of the health services, and foster continuity of care.

Availability of health care facilities does not necessarily mean that they can adequately function. Absence of health staff and absence of necessary equipment or the supplies make the actual access to care illusory. For an example, more than 10% of the sanctioned positions for SHPs and HPs were not filled in each of the three surveys carried out by RTI<sup>79</sup>. Similarly, the percentage of SHPs and HPs with stock outs of essential drugs longer than a week ranged from 66 to 85 in different surveys<sup>80</sup>. Any new initiative should therefore carefully assess the delivery side, adjust to

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<sup>78</sup> Dror, David M. & Rolf Rademacher, editors: Financial Inclusion Opportunities for Micro Health Insurance in Nepal; An Exploratory Analysis of Health Incidence, Costs and Willingness to Pay in Dhading and Banke Districts of Nepal. Micro Insurance Academy, New Delhi, 2010.

<sup>79</sup> RTI International: Assessing Implementation of Nepal's Free Health Care Policy: Third Trimester Health Facility Survey Report. Research Triangle Park, NC, USA, December 2009.

<sup>80</sup> RTI International: Assessing Implementation of Nepal's Free Health Care Policy: Third Trimester Health Facility Survey Report. Research Triangle Park, NC, USA, December 2009.

necessary standards before offering promises to the population and undertake the necessary restructuring or optimisation of the service delivery system and staffing. The investment needs and the recurrent costs that come with investments need therefore be calculated and the funds made available. Despite of increasing demand and needs for health care services, investment in health infrastructure, services and their quality has not received due priority at present. So, this topic deserves attention before a new initiative is implemented.

## **9. Administrative Capacity and Funding**

The Dumkauli CBHI scheme, discussed in chapter III, shows that administrative capacity needs to be available to run any new initiative. Available capacity and the additional costs of establishing and running a new scheme would need to be estimated and evaluated on feasibility and cost-effectiveness. Important elements would be the necessary extra human resources, the need for training, for business support systems such as information technology and communication equipment and internet connectivity.

## **10. Impact on Economy**

Any new health financing initiative could have an impact on the local or national economy, especially if funds need to come from companies and their employees. This has an impact on labour costs in the formal sector, which can be harmful for the competitiveness of companies. Such possible effect would therefore need to be estimated.

## **11. Social Consensus**

Reaching social consensus among all the main stakeholders at the level of society, e.g. among employers, employees, civil society, health workers, political parties and officials will be key to the sustainability of a new health financing mechanism. Any new health financing initiative should have the consent of the concerned stakeholders and have them involved in set up, monitoring and evaluation, not only to foster their commitment, cooperation and contribution but also to facilitate the possibly scaling up of an initiative to the regional and national level.

Options for new financial arrangements are explored in the next chapter.

# V. Policy Options

## 1. Overview

Currently around 55% of all health care expenditures are paid out-of-pocket<sup>81</sup>. This hampers access of the poor, even if they receive cash transfers which they can use for health services consumption. The spending of this 55% share takes place on an individual basis, i.e. in the direct relation between patient and health services provider, meaning that the patient individually purchases services. A large information asymmetry exists between the patient and the doctor. The patient does not possess the level of information required to judge on the competence of the provider and the quality of services consumed. On top the patient usually has no time to shop around for the lowest price because he/she is in urgent need of care and cannot judge if the offered and provided care is appropriate. If out-of-pocket payments are channelled via a prepaid system, then the organiser of the system, the fund holder can negotiate on behalf of the patient for better care and reasonable fees. This will help protecting patients in general and poor patients more specifically from sub-optimal and inappropriate care and from overcharging by the providers. In the meantime, efficiency gains can be achieved, especially if any new funding would be combined with existing funds in a limited number of fund pools and used for joint purchasing of services.

This chapter discusses on the thinkable options to acquire equitable access to health care for the population. The proposed options are discussed with regard to the different system functions:

- 1) Collection of funds/contributions
- 2) Pooling
- 3) Fund management
- 4) Purchasing
- 5) Benefit package
- 6) Performance review
- 7) Supervision & auditing (focusing on good governance and accurate and complete financial reporting by the providers and the local governments)

### Criteria for Reviewing Options

In order to evaluate the various options and their relative value for improving access to care for the poor, the following criteria are proposed:

- 1) Increasing value for money (efficiency)
- 2) Increasing revenues in general
- 3) Improving equity in funding of health services according to ability to pay
- 4) Decreasing out-of-pocket payment at the point of services

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<sup>81</sup> 2008 data accessed from WHO website: [www.who.int/nha](http://www.who.int/nha). Nepal national health accounts has however estimated OOP expenditure to be 50% of THE for the year 2005/06.

- 5) Improving access to quality care
- 6) Minimal increase of administrative capacity needs and of administrative costs
- 7) Responsive to local needs
- 8) Responsive to local fund raising capacity (in case of a choice for a more decentralised system)
- 9) Taking into account locally available services

The above criteria stem from the policy objectives as mentioned during the meetings of the MoHP/ GTZ team with the various stakeholders, cater for the current Nepalese context and take into account the efficiency of implementing the respective options. The application of the criteria will be done by estimation, i.e. indicating the likely effect in relation to the specific criteria.

The first seven criteria are universally applicable throughout the country. The criteria 8 and 9 accept the differences between the various regions, districts, municipalities and communities as a given albeit temporarily. Differences in local fund raising capacity can be equalised via general budget transfers, which can be one of the options to improve health services funding. Limitations in availability of services can be compensated by either the expansion of services or by offering suitable transport facilities to elsewhere available services, which can also be the focus of one or more of the proposed options.

Criteria 1) and 2) are closely related and somewhat overlapping. Efficiency improvement frees up money that can be used for expanding services. Efficiently provided care is mostly also of better quality. So, priority should be given to efficiency improvement, which also helps in making a better case for additional funding if the payers know that it will be well spend.

### **Ranking of Options**

The options described hereafter are ranked from least complex to most complex and therewith also from best feasible to least feasible and from lowest administrative costs to highest administrative costs. The specifics are reflected in the tables, inserted in each option.

## **2. Option One: Expanding Budget Funding and Providing Value for Money**

***Gradually increasing state budget contributions and using the current budget funding more effectively and efficiently, freeing up resources for expanding services while underpinning the need for further investments and budget contributions to bridge the gaps in coverage and equity in access.***

Aim: to provide an efficient solution to the problems as discussed in the previous chapters.

Spending more money on health care does not make much sense unless value for money can be assured. It is important to show that currently available resources are well spent and that their use is optimised as well as that additional resources will be used in a cost-effective way. This option is the most direct way to success because it does not require big changes, except for establishing a purchasing function and improving governance of and in the system. However these activities are seen as a pre-condition for any option.

So this option would invest in the following activities:



- 1) Measures to optimise budget allocation across the country and across levels of care and health services.
  - i. A more optimal budget allocation would take into account the differences in health needs and health care costs between the districts, the impact of the geography on access to services. It means that such budget is not based on incidentally available capacity of services, e.g. on the number of beds, because such capacity may not be adequate (either too much or too little) for responding to the needs of the citizens in the area.
  - ii. Conditional block grants or cash transfers from the national to the local level provide incentives to the local governments to deliver the services according to the provided conditions. Actual performance of local government can be monitored according a few health outcome indicators such as maternal mortality rate (MMR) and neonatal mortality rate (NMR) and according to outputs. For the latter, a shift should be made from input to output based budget reporting, which would make visible what actually is provided for the money spent, which in turn could lead to reallocations.
  - iii. Providing clarity about what kind of services and health interventions, paid from the budget are available for whom and on what kind of conditions (such as copayment or referral) and to make sure that the current benefit package, including the FHSP can be implemented.
- 2) Establishment of purchasing capacity<sup>82</sup> at the central (e.g. MoHP) and/or district level assuming some of the purchasing tasks as mentioned in chapter III.5 and further elaborated in chapter IV.5, the section on pre-conditions, and e.g. review the actual performance of the providers. However this capacity should be preferably established through an independent agency, contracting and reviewing the health care services on behalf of the sources of health care funds, i.e. the national and local governments as well as eventual other payers such as a CBHI. Such agency would be more effective and less bothered by potential conflicts of interest as argued in the previous sections on purchasing.
- 3) Grant some limited measure of freedom to the public providers and especially the hospitals to more manage their financial and human resources. This way, they could increase efficiency and become answerable to the purchaser by having the necessary tools to take their share in optimising the use of resources. Obviously, autonomy needs to be accompanied with guarantees for good governance, making sure that the money is well spent on eligible categories of spending in a transparent and accountable way.

In other words, this option entails a split between purchaser, currently the national and district authorities, and the provider of services, currently also the national and district authorities.

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<sup>82</sup> Here, establishment of purchasing capacity basically refers to designing more purchasing tasks for example based on the review of the actual performance of the providers when there is no provision for a separate purchasing agency. But the preferable option is the establishment of an autonomous agency which would be more effective and less bothered by potential conflicts of interest.

Exploring and establishing the necessary changes in the budget rules will be necessary so that budget formation and allocation can better follow the health needs and that health care providers get the necessary managerial and financial autonomy to improve performance.

These regulatory changes will all take time but are anyway useful to pursue in order to be prepared for the purchasing and health insurance initiatives.

As regards the system functions:

1. Collection of funds/contributions	No changes in the current collection.
2. Pooling	No changes in the current pooling system.  NB: the CBHI fund pools will remain separate for as long as the pilots are running.
3. Fund management	Health needs based allocation and output based reporting.
4. Purchasing	Will be realised by a new purchasing agency or a newly established purchasing function in current structures.
5. Benefit Package	Will be clarified and designated health care services and specified interventions will be delivered.
6. Performance review a. Of providers b. Of local government	a. Will be done by the purchaser, not hampered by a fragmented funding system. b. Will be done by MoHP, MoF and MoLD, using output based budget reporting.
7. Supervision & auditing	Will be done in a coordinated way (to avoid duplication) by the Auditor General, MoHP and the Districts.

Reviewing this option against the proposed criteria:

1. Increasing value for money (efficiency)	a. Via purchaser and clear description and delineation of health services benefits. b. Via conditional block grants to local governments c. Output based budget reporting.
2. Increasing revenues	Via efficiency measures more money available for direct health services expenditures.  Future extra revenues can be spend more effectively and efficiently.
3. Improving equity in funding of health services	No direct improvement. However, as indicated in the next cell, some indirect improvement.

according to ability to pay	
4. Decreasing out-of-pocket payment at the point of services	The above will help in lowering the OOP payments because more services, including drugs and supplies will be available and will not have to be bought directly by the patient <sup>83</sup> .
5. Improving access to quality care	Efficiency improvement, focus on outputs and expected increase in drugs and supplies will improve quality of care.  Further improvements will need to come from investments in physical infrastructure, equipment, health human resources improvement and upgrading clinical practice.
6. Minimal increase of administrative capacity needs and of administrative costs	Increase in administrative capacity necessary for establishing purchaser but limited costs because of absence of new schemes or fund flows.
7. Responsive to local needs	Via improved needs based planning and budgeting.
8. Responsive to local fund raising capacity	No, because no extra fund raising activities.
9. Taking into account locally available services	For a start, but needs based planning and budgeting will assist in equalising the level of services.

This option can be split in separate sub-options, from less to more complex. The sub-options can also be seen as a gradual way to implement an autonomous purchaser:

**Sub-option 1a: Improvements in the existing budget system**

This sub-option would work on the elements mentioned in point ‘1)’ in activities (see above).

**Sub-option 1b: Establishing a new purchasing function (with additional budgetary flexibility) in the existing administrative entity/entities**

This option would focus on the aspects as mentioned in point ‘1)’, possibly to be combined with point ‘2)’ (see above).

**Sub-option 1c: Establishing a new separate purchasing agency (purchaser provider split)**

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<sup>83</sup> The MoHP-GTZ initiated and GFA implemented study discusses on options for improving drug procurement and supply management. GFA: Essential Drug Procurement and Management in Nepal, Current Challenges and How to Address Them. GTZ HSSP study summary. Kathmandu, November 2009; and Stoermer, M. et al: Essential Drug Procurement and Supply Management System in Nepal- Options for Improvement. GTZ/GFA Consulting Group GmbH, HSSP study. Kathmandu, 2009.

The role of a purchaser and its tasks are extensively discussed in chapters III and IV.

Establishing an independent purchaser is legally possible in Nepal and can best be done via a specific law, which can regulate mandate, governance structure, funding, supervision, reporting and auditing.

It needs to be re-emphasised that just adding more budget funds to the system would not guarantee improved access to better health services, especially for the poor. So, anyway a need exists for strengthening the current capacity and mechanisms and to achieve the preconditions as formulated in the previous section.

NB: In this option, there is no focus on CBHI but the currently existing CBHI schemes can remain in their current function as pilots. However the initiative should be properly evaluated on cost-effectiveness. The planned KOICA supported and expanded CBHI initiative and evaluation should be closely observed. In case these initiatives do not show any difference on the criteria, proposed in this paper for the evaluation of option, then they should be reconsidered and either stopped or changed to become more cost-effective. The Dumkauli results so far raise serious questions about the financial sustainability as the revenue of contributions equals to the administrative costs.

### 3. Option Two: Dual Financing System

***Combines option 1 with CBHI but only by way of initiative.***

Aim: to address some of the flaws in current funding and governance system of CBHI.

In coordination with the activities in option 1, this option will focus also on the use of CBHI in social mobilisation, revenue collection, community outreach and social auditing/monitoring and targeting of the poor. A purchaser or a purchasing function, to be established in the CBHI initiative areas but not necessarily geographically restricted to these areas, will do the purchasing of CBHI covered services and can logistically and administratively support CBHI. It is hoped that such initiative would improve the cost-effectiveness of CBHI and to have a positive balance between revenues and administrative costs of CBHI.

This option will invest in the following activities:

- 1) All activities, mentioned in option 1.
- 2) Developing support capacity for CBHI to expand in the current CBHI initiative regions, in close cooperation and coordination with the KOICA supported CBHI activities and planned evaluation.
  - i. Purchasing of health services on behalf of CBHI
  - ii. Administrative support for administration, contribution collection and logistics of CBHI

As regards the system functions:

1. Collection of funds/contributions	Current collection will be supplemented with collection of CBHI contributions.
2. Pooling	CBHI contributions will be pooled together with budget

	funds but remain visible via the revenue and administrative expenditures.
3. Fund management	Health needs based allocation and output based reporting, combined with demand based payments for consumed CBHI benefits.
4. Purchasing	Will be realised and done jointly for budget and CBHI benefits.
5. Benefit Package	Will be clarified, including the CBHI benefits, and designated health care services and specified interventions will be delivered to eligible beneficiaries.
6. Performance review a. Of providers b. Of local government	Will be done by the purchaser of all providers, offering budget and CBHI covered services, and will be further done by the Boards of CBHI, by MoHP, MoF and MoLD, making also use of output based budget reporting as well as the usual legally necessary activities.
7. Supervision & auditing	Will be done in a coordinated way (to avoid duplication) by the Auditor General, MoHP and the Districts.

Reviewing option 2 against the proposed criteria:

1. Increasing value for money (efficiency)	<ul style="list-style-type: none"> <li>a. Via purchaser and a clear description and delineation of health services benefits, including the CBHI benefits.</li> <li>b. Via conditional block grants to local governments.</li> <li>c. Output based budget reporting.</li> <li>d. Purchaser enhanced value of CBHI expenditures and relatively lower administrative costs.</li> </ul>
2. Increasing revenues	<ul style="list-style-type: none"> <li>a. Via efficiency measures more money available for direct health services expenditures.</li> <li>b. Effort to increase enrolment in CBHI and therewith generating more revenues, hopefully more than the administrative costs for generating these revenues.</li> <li>c. Future extra budget revenues can be spend more effectively and efficiently.</li> </ul>
3. Improving equity in funding of health services according to ability to pay	No direct improvement. However, as indicated in the next cell, some indirect improvement.
4. Decreasing out-of-pocket payment at the point of services	a. The above will help in lowering the OOP payment because more services, including drugs and supplies will be available and will not have to be bought directly by the

	<p>patient.</p> <p>b. Members of the CBHI schemes will have a decrease of their OOP payment for the CBHI covered services and to the extent that these are covered.</p>
5. Improving access to quality care	<p>a. Efficiency improvement, focus on outputs and expected increase in drugs and supplies will improve quality of care.</p> <p>b. Further improvements will need to come from investments in physical infrastructure, equipment, health human resources improvement and upgrading clinical practice.</p> <p>c. CBHI enrolees will have better access to quality care.</p>
6. Minimal increase of administrative capacity needs and of administrative costs	<p>a. Increase in administrative capacity necessary for establishing purchaser but limited costs because of absence of new schemes or fund flows.</p> <p>b. Taking over administrative and purchasing tasks of CBHI will reduce administrative costs of CBHI against minimal costs increase for the purchaser, because of economies of scale.</p> <p>c. In case the tedious manual administration of CBHI, which as such seems excellent in Dumkauli, would be supported by information technology, then this would require some investments but could free up health human resources at the provider side.</p>
7. Responsive to local needs	<p>a. Via improved needs based planning and budgeting.</p> <p>b. CBHI provides extra options to cater the covered services to the local needs by e.g. offering transport to health facilities.</p>
8. Responsive to local fund raising capacity	Not, as regards the budget funded care, but yes as regards the CBHI part.
9. Taking into account locally available services	<p>a. For a start, but needs based planning and budgeting will assist in equalising the level of services over time.</p> <p>b. CBHI offers the option for enrolees to also make use of services outside the immediate community area.</p>

It has to be noted that the inclusion of CBHI in this option should really be seen as an initiative, which can be stopped if no results are achieved and administrative costs would still equal revenues. CBHI has some advantages such as its grass roots level based support, social mobilisation and social auditing but it has also all the disadvantages: it cannot do without budget subsidies, it has high administrative costs, it is voluntary and therewith is prone to moral hazard and dropout, and it still does not attract the poorest of the poor.

#### 4. Option Three: Expanding Community Based Health Insurance

***Other communities will be stimulated and supported to also establish their CBHI that offer services on top of the current budget funded system - given that CBHI is evaluated as cost-effective and of having added value.***

Aim: to gradually expand CBHI into a national scheme while for now catering to differences in health needs, services availability, funding capacity and cultural preferences.

The current CBHI initiatives might, after a thorough evaluation of the current modalities either be abandoned because of negative cost-effectiveness or a choice might be made for the optimal cost-effective model and gradually be expanded. The currently uniform (universal) budget funded benefit package, together with the CBHI funded will go next to each other but as much as possible integrated via the single purchaser while local payment capacity will be matched by tailored GoN budget back up. Such single purchaser is distinct from a situation of multiple purchasers, each of them buying separately some services and mostly from the same providers. Fragmentation of the purchasing function will give less clout to the various purchasers than a single one would have in negotiating prices. Fragmentation of purchasing would also make the provider performance review less effective because the information about the providers will be diluted over the various purchasers. A single purchaser on the national level can have satellite purchasing agencies on the district level.

This option will

- 1) Invest in all activities as mentioned in option 1 (budget funded services, i.e. the FHCS will continue to exist in this proposal).
- 2) Perform a thorough evaluation, in collaboration with the KOICA team, of the cost-effectiveness of the various CBHI initiatives and present the results for a go or do not go decision as regards winding down the initiatives or to continue them and gradually expand their scale and distribution over the country.
- 3) Invest in all activities as mentioned in option 2.
- 4) Develop more detailed guidelines for establishing and operating CBHI, including for member and financial administration, for BP design, logistics and for M&E.
- 5) Develop training modules for board and staff members of CBHI and for volunteers who are engaged in social mobilisation and social marketing of the schemes and in enrolment of members.

As regards the system functions:

1. Collection of funds/contributions	Current collection will be supplemented with collection of CBHI contributions and extra budget support as stimulus.
2. Pooling	CBHI contributions will be pooled together with budget funds but remain visible via the revenue and administrative expenditures.
3. Fund management	Health needs based allocation and output based reporting, combined with demand based payments for

	consumed CBHI benefits.
4. Purchasing	Will be realised and done jointly for budget and CBHI benefits.
5. Benefit Package	Will be clarified, including the CBHI benefits, and designated health care services and specified interventions will be delivered to eligible beneficiaries.
6. Performance review a. Of providers b. Of local government	Will be done by the purchaser of all providers, offering budget and CBHI covered services, and will be further done by the Boards of CBHI, by MoHP, MoF and MoLD, making also use of output based budget reporting performs the usual legally necessary activities.
7. Supervision & auditing	Will be done in a coordinated way (to avoid duplication) by the Auditor General, MoHP and the Districts.

Reviewing option 4 against the proposed criteria:

1. Increasing value for money (efficiency)	<ul style="list-style-type: none"> <li>a. Via purchaser and clear description and delineation of health services benefits, including the CBHI benefits.</li> <li>b. Via conditional block grants to local governments.</li> <li>c. Output based budget reporting.</li> <li>d. Purchaser enhanced value of CBHI expenditures and relatively lower administrative costs, further supported by the nationally developed guidelines.</li> </ul>
2. Increasing revenues	<ul style="list-style-type: none"> <li>a. Via efficiency in health services delivery measures more money available for direct health services expenditures.</li> <li>b. Effort to increase enrolment in CBHI and therewith generating more revenues.</li> <li>c. Future extra budget revenues can be spend more effectively and efficiently.</li> </ul>
3. Improving equity in funding of health services according to ability to pay	No direct improvement. However, as indicated in the next cell, some indirect improvement.
4. Decreasing out-of-pocket payment at the point of services	<ul style="list-style-type: none"> <li>a. The above will help in lowering the OOP payments because more services, including drugs and supplies will be available and will not have to be bought directly by the patient.</li> <li>b. Members of the CBHI schemes will have a decrease of their OOP payments for the CBHI covered services and to the extent that these are covered.</li> </ul>
5. Improving access to quality care	<ul style="list-style-type: none"> <li>a. Efficiency improvement, focus on outputs and expected increase in drugs and supplies will improve quality of</li> </ul>



	<p>care.</p> <p>b. Further improvements will need to come from investments in physical infrastructure, equipment, health human resources improvement and upgrading clinical practice.</p> <p>c. CBHI enrolees will have better access to quality care.</p>
6. Minimal increase of administrative capacity needs and of administrative costs	<p>a. Increase in administrative capacity necessary for establishing purchaser but limited costs because of absence of new schemes or fund flows.</p> <p>b. Taking over administrative and purchasing tasks of CBHI will reduce administrative costs of CBHI against minimal costs increase for the purchaser, because of economies of scale.</p> <p>c. Supporting the administration of CBHI by information technology would require some investments but could free up health human resources at the provider side.</p>
7. Responsive to local needs	<p>a. Via improved needs based planning and budgeting</p> <p>b. CBHI provides extra options to cater the covered services to the local needs by e.g. offering transport to health facilities.</p>
8. Responsive to local fund raising capacity	Not, as regards the budget funded care, but yes as regards the CBHI part.
9. Taking into account locally available services	<p>a. For a start, but needs based planning and budgeting will assist in equalising the level of services over time.</p> <p>b. CBHI offers the option for enrolees to also make use of services outside the immediate community area.</p>

In case the CBHI option is chosen to gradually implement on a nationwide scale then CBHI will most likely have to be seen as a temporary phenomenon in a country on its way to a more universal scheme which has either a budget funded, a health insurance or a mixed system.

As is mentioned in option 2, CBHI has some advantages such as its grass roots level based support, social mobilisation and social auditing but it has also many disadvantages: it cannot do without budget subsidies, it has high administrative costs, it is voluntary and therewith is prone to moral hazard and dropout, and it still does not attract the poorest of the poor. It has therefore to be seen as a temporary solution.

## 5. Option Four: Triple Financing System

***Offering equal access for the informal sector to team up and keep pace with the eventual introduction of the health insurance schemes for civil servants respectively for the formal private sector in offering supplementary benefits, not covered via the current budget funded schemes.***

Aim: one universally accessible supplementary benefits package (BP) funded from different sources and via different collection mechanisms and option to, over time, move to a single system with universal coverage.

This option prevents that the informal sector stays behind and that especially the poor in the informal sector will not be confronted with relatively reduced access to health care in case the formal sector (civil and private) go ahead with their supplementary health insurance schemes as it might be suggested in the new Social Security Organisation Act. The discussions around the new Act have not yet touched upon topics such as the package of benefits and the institutional aspects (i.e. which institution will be responsible for these two schemes, if they materialise). This option offers the possibility for MoHP to engage with the stakeholders in these schemes and propose (i) a harmonised benefits package, (ii) a benefits in kind system instead of a reimbursement system, (iii) a joint implementation by a single institution, which could act as the single purchaser, and (iv) joint supervision and auditing. The MoHP and its counterparts in the other schemes such as other ministries and organisations of employers and employees, could therewith prevent some of the disadvantages of the otherwise fragmented funding via a single purchaser which would have much more clout vis-à-vis the health services providers than 3 or more separated purchasers.

This triple financing scheme could have the following features:

- Formal sector based
  - Civil services (includes police/army etc, i.e. all persons and their dependents who are directly or indirectly paid from the budget)
    - Wage based, ultimately paid from budget even if optionally a split has been made between employer and employee.
    - Benefits package (BP) similar as in the other schemes
  - Private formal sector
    - Wage based contributions
    - Similar BP
- Informal sector based
  - Flat rate contributions
  - GoN budget transfers for the poor
  - GoN budget transfer for any shortages in the informal sector

- Similar BP

### **Box 3: Financing Aspects for the Coverage of Informal Sector**

Most countries with a large informal sector face serious difficulties in achieving universal coverage of the population in a mandatory national scheme. Therefore, generous budget subsidies are needed to supplement the contribution payment obligation from the vulnerable categories of the population such as the poor, children and students, unemployed, etc. However, that does not mean it could not be initiated. Success is dependent of institutional and enforcement capacity and of fiscal space.

Further, the large informal sector will make it difficult to raise an income dependent contribution due to the character of this sector. Since there will be no formal job and thus it will be difficult to raise taxes from informal wages and even more difficult from income. This means that a flat rate would need to be charged. Such flat rate needs to be individually collected and is thus more costly than a collectively charged contribution paid directly by the employer. To make it possible for the poor to enrol, the amount needs to be low which means that the rich in the informal sector also pay such a low rate and receive the same benefits. This cannot be seen as fair and equitable payment.

The basic benefits package of essential health services, as currently available for all in the public health care facilities, will remain. The other supplementary benefits will come on top of the basic package. Over time these packages, i.e. basic and supplementary packages can be integrated in one national mandatory scheme for which budget support will remain essential.

This initiative would invest in the following activities:

- 1) Creation of coordination and joint management capacity for the three schemes.
- 2) All activities as mentioned in option 1 (budget funded services will continue to exist in this proposal).
- 3) Creation of a joint autonomous purchaser who will, on behalf of all three schemes:
  - i. Collect the contributions and budget transfers.
  - ii. Jointly pool and administer the funds.
  - iii. Purchase the services of the health care providers (public and private).
  - iv. Fulfil all duties of a purchaser, as indicated in the previous chapter.
  - v. Offer support to CBHI, as indicated in option 2. Although CBHI can be incorporated into the scheme for the informal sector and it should be if the scheme for the informal sector is or will become mandatory. However, this may be difficult to implement because of Nepal's large informal sector.
  - vi. Establish and foster a national dialogue about the future of health care financing to reach consensus about the future direction and formation of the Nepalese health care system.

Once started, these schemes most likely will not be abolished or unwind unless they can be incorporated in one national scheme. That is why, especially for this option a national dialogue with all levels of implementation and civil society and preferably national consensus is key for success. The MoHP should make sure that it is part of these parallel developments as to not miss out on

integration opportunities. Such MoHP effort will thus require high level interventions, preferably by the Health and Population Minister him/herself and to make it a subject of discussion at the Cabinet of Ministers level.

As regards the system functions:

1. Collection of funds/contributions	The two formal sector schemes will be the easiest in collection of contributions via the employers. The contributions for the informal sector in general are more difficult and costlier to collect. Collection effectiveness will also lag behind the other two schemes. However, the single purchaser option will provide the most efficient solution.
2. Pooling	All contribution flows will be pooled together with budget funds in one single pool but remain visible via the revenue and expenditures administration as to be transparent and accountable to the various categories of contributors to the scheme.
3. Fund management	Joint fund management will happen by the single purchaser under a joint Board, representing MoHP, MoF, NPC, Employers and Employees. Health needs based allocation of funds and output based reporting, combined with demand based payments for consumed health insurance benefits.
4. Purchasing	Will be realised and done jointly for budget and insurance benefits.
5. Benefit Package	Will be clarified, including the CBHI and benefits from the formal sector insurances. Covered health care services and specified interventions will be delivered to eligible beneficiaries.
6. Performance review a. Of providers b. Of local government	Will be done by the purchaser of all providers, offering budget and health insurance covered services, and will be further done by the Boards of CBHI, by MoHP, MoF and MoLD, making also use of output based budget reporting as well as performing the usual legally necessary activities
7. Supervision & auditing	<p>Will be done in a coordinated way (to avoid duplication via an integrated control tower) by the Auditor General, the concerned ministries, the Districts and the independent private chartered accountants and/or their firms.</p> <p>To keep the burden of auditing and its costs for all actors in the schemes at provider and payer side as limited as possible, integrated auditing is necessary, following the auditing protocols agreed between all parties as to fulfil</p>

	their respective legal and institutional obligations.
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Reviewing option 3 against the proposed criteria:

1. Increasing value for money (efficiency)	<ul style="list-style-type: none"> <li>a. Via single purchaser and clear description and delineation of all services benefits, including the health insurance funded benefits.</li> <li>b. Via conditional block grants to local governments.</li> <li>c. Output based budget reporting.</li> <li>d. Single purchaser enhanced value of expenditures and relatively lower administrative costs than can be expected while running separate schemes.</li> </ul>
2. Increasing revenues	<ul style="list-style-type: none"> <li>a. Via efficiency measures more money available for direct health services expenditures.</li> <li>b. Effort to increase enrolment in CBHI and therewith generating more revenues, hopefully more than the administrative costs for generating these revenues.</li> <li>c. Future extra budget revenues can be spend more effectively and efficiently.</li> </ul>
3. Improving equity in funding of health services according to ability to pay	If all schemes were implemented and the formal sector percentage of wage based contributions will be matched by budget subsidies for the informal sector then equity in funding will have enormously been increased. However, a flat rate contribution for the informal sector will not be equitable, because it is income independent.
4. Decreasing out-of-pocket payment at the point of services	For all categories of society, including the poor, OOP payments will decrease most profoundly.
5. Improving access to quality care	<ul style="list-style-type: none"> <li>a. Efficiency improvement, focus on outputs and expected increase in drugs and supplies will improve quality of care.</li> <li>b. The supplementary schemes via the single purchaser will all contribute to quality improvement albeit that this is also dependent of parallel actions to be supported by MoHP, such as the systematic development of clinical protocols and prescription guidelines, continuous professional development support by mandatory re-licensing or re-validation of diploma's and licenses etc, and eventually by an accreditation system.</li> </ul>
6. Minimal increase of administrative capacity needs and of administrative	This option will demand the most extensive investments in administrative capacity and thus be the most costly option. If the schemes would operate totally independent of each

costs	other, then the consolidated costs would triple.
7. Responsive to local needs	<ul style="list-style-type: none"> <li>a. Via improved needs based planning and budgeting of services directly funded from the budget.</li> <li>b. CBHI provides extra options to cater the covered services to the local needs by e.g. offering transport to health facilities.</li> <li>c. The other health insurance schemes will be universal and as such not responsive to local needs although the purchaser can make sure that the covered services will be purchased to suffice the local needs.</li> </ul>
8. Responsive to local fund raising capacity	Not, as regards the budget funded care and formal sector insurance schemes, but yes as regards the CBHI part.
9. Taking into account locally available services	<ul style="list-style-type: none"> <li>a. For a start, but needs based planning and budgeting will assist in equalising the level of services over time.</li> <li>b. CBHI offers the option for enrolees to also make use of services outside the immediate community area.</li> <li>c. The national formal insurance schemes will as such not do this, but the purchaser can do.</li> </ul> <p>The national insurance schemes may thus lead to a situation in which universally levied and equal contributions will be charged but that the insured will in practice face differences in access to services.</p>

## 6. Option Five: Covering the Kathmandu Poor via a Private Insurer

***Private insurer implements and purchases a GoN subsidised supplementary benefits package in Kathmandu, similar to CBHI packages elsewhere.***

Aim: to test the involvement of private insurance management capacity on cost-effectiveness in the implementation of a social health protection programme for the poor.

This option would invite private insurers to become active in the health sector. This sector is until now almost ignored by the private insurers. The reasons for their less interest in this market is said to be due to the lack of good governance and oversight of the health sector, manifesting itself in uncontrollable fraudulent behaviour of individuals claiming the reimbursement of health services related costs from their insurer and hospitals seemingly willing to sign off on any medical costs claim. However, this is to some extent a consequence of the reimbursement system the insurers use. If they would move, in this initiative, towards a system of benefits in kind with the insurer as purchaser of services from contracted providers, then the insurer would have more tools to control the claims of health services providers.

This option would test the management capacity of the private sector in dealing with health services and also entuse private insurers into the health sector.

This option would invest in:

- 1) Establishment of purchasing capacity at a private insurer, as elaborated in the section on pre-conditions. The health insurer would act as an independent agency, contracting and reviewing the health care services on behalf of the MoHP, funded from the regular public funds for the health sector and offering the same package that is available from the budget in the Districts, complemented with the services that are part of the GoN subsidised CBHI system. The private insurer would enrol the citizens and levy a specific contribution from them.
- 2) Granting a measure of autonomy to the public providers to freely manage their financial and human resources to become adequate counterparts of the purchaser and to take their share in optimising the use of resources. Obviously, autonomy needs to be accompanied with guarantees for good governance, making sure that the money is well spent on eligible categories of spending in a transparent and accountable way.

In other words, this implies a purchaser-provider split.

- 3) Identifying the poor, who would be eligible to the extended benefits package and receiving GoN subsidised care.

As regards the system functions:

1. Collection of funds/contributions	Current collection will be supplemented with collection of CBHI contributions by the private insurer.
2. Pooling	CBHI contributions will be pooled together with budget funds in a special account of the private insurer.
3. Fund management	By the private insurer.
4. Purchasing	Will be realised and done jointly for budget and CBHI benefits.
5. Benefit Package	Will be clarified, including the CBHI benefits, and designated health care services and specified interventions will be delivered to eligible beneficiaries
6. Performance review of providers	Will be done by the private insurer of all providers, offering budget and CBHI covered services, and will be further done by MoHP and MoF, making also use of output based budget reporting as well as performing the usual legally necessary activities.
7. Supervision & auditing	Will be done in a coordinated way (to avoid duplication) by the Auditor General, MoHP and the Districts

Reviewing option 5 against the proposed criteria:

1. Increasing value for money (efficiency)	<ul style="list-style-type: none"> <li>a. Via purchaser and a clear description and delineation of health services benefits, including the CBHI benefits.</li> <li>b. Output based budget reporting.</li> <li>c. Purchaser enhanced value of CBHI expenditures.</li> </ul>
2. Increasing revenues	<ul style="list-style-type: none"> <li>a. Via efficiency measures more money available for direct health services expenditures.</li> <li>b. Effort to increase enrolment in CBHI and therewith generating more revenues, hopefully more than the administrative costs for generating these revenues.</li> <li>c. Future extra budget revenues can be spend more effectively and efficiently.</li> </ul>
3. Improving equity in funding of health services according to ability to pay	No direct improvement. However, as indicated in the next cell, some indirect improvement
4. Decreasing out-of-pocket payment at the point of services	Members of the scheme will have a decrease of their OOP expenditure for the CBHI covered services and to the extent that these are covered.
5. Improving access to quality care	<ul style="list-style-type: none"> <li>a. Efficiency improvement, focus on outputs and expected increase in drugs and supplies will improve quality of care.</li> <li>b. Further improvements will need to come from investments in physical infrastructure, equipment, health human resources improvement and upgrading clinical practice.</li> <li>c. CBHI enrolees will have better access to quality care.</li> </ul>
6. Minimal increase of administrative capacity needs and of administrative costs	<ul style="list-style-type: none"> <li>a. Increase in administrative capacity necessary for establishing purchaser at private health insurer who has no specific experience with the health sector.</li> <li>b. Costs can be reduced by using administration manuals of current CBHI initiatives and by using informational technology.</li> </ul>
7. Responsive to local needs	<ul style="list-style-type: none"> <li>a. Via selective contracting from public and private providers.</li> <li>b. Additional benefits package provides extra options to cater the covered services to the local needs by e.g. offering transport to health facilities.</li> </ul>
8. Responsive to local fund raising capacity	Not, as regards the budget funded care, but yes as regards the additional benefits part.
9. Taking into account locally	Purchaser will focus on contracting of local services.



available services	This means that no specific restrictions exist because Kathmandu offers the broadest array of services of Nepal.
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This option will be a challenge for a private insurer who is interested in the health care market to establish a purchasing function and to enter into contracts with providers, because the Nepalese insurers have very limited experience with this.

It may also become a starting point for the private insurer to engage in a supplementary private health insurance, offering services that are not covered by the public system of health financing and for which there will be a growing market when the economy shows further growth. Although private health insurance is not catering to the poor it will lead to changing a part of the OOP expenditure into a prepaid scheme. However, no risk pooling and cross-subsidising between the poor and the rich will take place. However, participants in such scheme should be legally demanded to pay a solidarity contribution into the public schemes of which the poor will profit.

This option would also provide a possibility for MoHP to closely look at the governance aspects and quality of care of the public and private providers and to cooperate with the private insurer with the aim to take away the current negative image of the providers. It may also provide inputs to MoHP to improve its regulations of the public and private hospitals as regards governance and quality of care as well as to improve the tools for enforcement of the regulations. Currently the insurers perceive the enforcement of regulations, including using the judiciary system, as impossible. They see the role of MoHP as insufficient in controlling the providers. That is why they are not interested in the health sector.

So, one of the monitoring items would be the development of appropriate regulations for the private as well as the public health sectors. Another challenge for the private insurer will be the enforcement of a referral system and engagement in the organisation of continuity of care from primary to secondary and tertiary care.

## **7. Option Six: Establishing a Health Insurance System for the Nepalese Migrant Workers and Their Dependents**

***Migrant workers will be offered the possibility to voluntarily enrol in a health insurance scheme which will cover their necessary health care costs in the countries of work as well as their dependents remaining in Nepal.***

Aim: to enhance the social health protection of migrant workers and their families and to stimulate Nepalese citizens to take on work abroad.

Although the migrant workers may not be that much poor, their families may be and their risks of impoverishing health care costs could also be high, dependent on the level of labour and social protection in the countries where the migrants work.

Many countries have either bilateral treaties or participate in multilateral treaties to mutually protect their workers and citizens who need health care when working or travelling in the counterpart countries. In case such treaties do not exist, voluntary health and accident insurance is an option.

Such option can either be left to the private insurers to develop or a government agency can take the initiative.

In e.g. the Philippines, which has also a large number of citizens who work abroad or at sea, the Philippine Health Insurance Corporation (PhilHealth) offers this possibility for migrant workers and their families. This option is seen as important because of the high revenues for the country by way of remittances.

To start such scheme, government subsidy will be necessary for setting it up, doing the social marketing and paying for the services. Although a contribution can be charged and such contribution will most likely have to be a flat rate because the contribution will not be levied by the employers abroad. Using an income based rate, levied via the Nepalese revenue services, might also not be realistic.

Migrant workers are of different abilities from non-skilled manual labourers to highly skilled and university trained people. However, a flat rate will have to be set at such level that it can be paid by lowest paid migrants who are also most vulnerable to catastrophic health care costs. Social targeting can be tried in combination with different flat rate amounts for different social/income categories.

Costs of overseas care and abuse of the system, including fraud, are difficult to control, because providers cannot be contracted unless some areas have a large concentration of Nepalese workers. But even then it is difficult unless a special counsellor is attached to the Nepalese Embassy or Consulate in these countries. So, a fixed reimbursement level for common interventions combined with a maximum reimbursement per year is the obvious solution.

Bilateral treaties with the countries that have the highest numbers of Nepalese workers could be considered, aiming to agree on wider social and legal protection to these workers. Exploring the support of ILO seems a useful step.

This option would invest in:

- 1) Exploring the interest, willingness and capacity to pay among migrant workers.
- 2) Mapping of countries and places with high concentrations of migrant workers.
- 3) Studying the arrangements of other developing countries in social health protection for migrant workers.
- 4) Designing a proposal for voluntary health insurance for migrant workers and their dependents, including the benefits package, estimated costs of such package, proposal for flat rate contribution and government subsidies.

As regards the system functions:

<p>1. Collection of funds/contributions</p>	<p>A new system will need to be designed and established.</p> <p>Teaming up with a Nepalese insurer preferably linked with an international insurer with a portfolio in target states or with experience in cross border care insurance. Such insurer could be engaged in a public private partnership to</p>
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	perform a number of functions.
2. Pooling	Will require a separate fund pool in which all voluntary contributions flow, together with eventual GoN subsidies.
3. Fund management	Fund can be administered by special government agency or by contracted insurer.
4. Purchasing	Will be difficult to realise, except eventually in areas with high concentrations of migrant workers and with the support of Nepalese embassies or consulates.  As a consequence, a limited reimbursement system should be considered.
5. Benefit Package	Limited to acute care on primary and secondary level of care, and limited as regards the levels of reimbursement per event and per 12 month period.
6. Performance review	Is limited and can only be based on the information provided to the insured, together with the bill, unless a provider can be contracted which is accredited by an international accreditation body.
7. Supervision & auditing	Will be dependent of the implementing body and can be done by an external chartered accountant in case of a contracted insurer and/or by the Auditor General and MoHP.

Reviewing this option against the proposed criteria:

1. Increasing value for money (efficiency)	N.A.
2. Increasing revenues	Yes, but only partly for the Nepalese health sector as regards the home-staying dependents of the health workers, in case the benefits package offers more than what is covered from the budget and an additional contribution is paid.
3. Improving equity in funding of health services according to ability to pay	N.A.
4. Decreasing out-of-pocket payment at the point of services	No. Migrant workers will have to pay first themselves and can get it reimbursed afterwards.
5. Improving access to quality	N.A.

care	Further improvements will need to come from investments in physical infrastructure, equipment, health human resources improvement and upgrading clinical practice
6. Minimal increase of administrative capacity needs and of administrative costs	Increase in administrative capacity necessary for establishing new body for insurance abroad. Running a reimbursement system, as will be the case, is more costly than a benefits in kind system.
7. Responsive to local needs	N.A.
8. Responsive to local fund raising capacity	N.A.
9. Taking into account locally available services	N.A.

It will be noted that this option is quite different than the other proposed options. However, this option fits into SHP schemes in a global economy, in which Nepal is a partner.

## 8. Summary and Additional Remarks

The above discussed options address different policy questions in the following ways: (i) they offer the possibility of gradually introducing a new health financing mechanisms, (ii) they focus on strengthening capacity and establishing a purchasing function, (iii) they are pro-poor, (iv) they keep the option of CBHI open but with a critical view on its cost/effectiveness, (v) they build on the current publicly offered Free Health Care Services (FHCS), (vi) they offer a perspective for people to use their cash transfers to enrol in CBHI and therewith move from individual to collective purchasing as well as (vii) they offer a perspective for the MoHP to engage in institutional capacity development of (supplementary) social health insurance for the formal sectors (public as well as private) as currently discussed under the new Social Security Organisation Act.

First four options (1 – 4) are geared towards creating universal coverage while options 5 and 6 focus on improving access for groups in particular need. All options aim at efficiency improvement which subsequently can lead to better quality of services and to freeing up resources for expanding the package of benefits for the insured. The extent to which these options facilitate in achieving the SHP objectives is dependent of the necessary capacity to implement these options. The capacity requirements increase from option 1 to 6.

Fiscal space is available for some gradual expansion of the current health care system, which should be done in parallel with efficiency improvement as an important tool for increasing fiscal space and quality of care.

The political environment in Nepal is volatile and the future structure of the State has not yet been set via the adoption of a new Constitution. Even if this new Constitution will be adopted soon, it will take time before the new structure will be implemented and institutions are adjusted to this new structure and have achieved the necessary capacity. The current lack of clarity and uncertainty about the future structure and the time needed for capacity building of the institutions may be the biggest constraint for moving forward with the initiatives.

Option 6, the establishment of a health insurance mechanism for migrant workers, is not dependent of the new Constitution and State structure and can be seen as a standalone project. However, such insurance will require quite some research before a decision can be taken about its funding, its contribution rates and benefits package. Nevertheless it is worth exploring because of the high number of migrant workers.

Fulfilling the preconditions, mentioned in chapter IV, will take time. Starting with establishing a purchasing function might therefore be the best option to pursue. In the meantime, the current CBHI initiatives can be thoroughly evaluated and the new, KOICA supported, CBHI initiatives can be included in the evaluation.

## VI. Recommendations and Next Steps

The previous chapters highlight the current health financing system and social health protection status in Nepal in the context of identifying the problems, discussing the elements of the health financing system, using internationally adopted objectives of a health financing system and suggesting a number of options to improve the system. Important findings are reflected hereafter, indicating the need for change:

**Policy Environment:** At the national level, a number of coordination mechanisms are currently engaged in discussing social protection and social health protection related issues and in formulating framework, policies and relevant laws. Similarly, there are also coordination mechanisms to harmonise the approaches and activities of the EDPs. Presently some key documents such as the national health policy and the second long term health plan are in the process of revision while the NHSP IP 2 provides overall framework for implementation of health sector programmes for the next five years. Therefore, policy formulation process in social health protection needs to be aligned to these developments and contexts.

**Fiscal Space:** Fiscal space determines the possibility for the government to increase funding for the sector. The room to significantly raise government allocations to health via budget funding is influenced by several factors. On the one hand, the expected deceleration of GDP growth to 3% in 2009/2010, the overall budget deficit of 1.9% in 2009 (entailing borrowing) suggest limited room to increase state health spending. On the other hand, recent successes in expanding the tax base suggest further room to strengthen general revenue collection. The level of external funding is already substantial with around half of the health budget funded from external aid. Nevertheless, additional external funds may be mobilised for health and additional donors are planning to contribute to the pooled funding.

**Financial Risk Protection:** In 2008, only an estimated 45% of health expenditures were prepaid and pooled thereby provided financial risk protection to the population of Nepal. A remaining 55% of total health expenditure was estimated to be out-of-pocket payments which represent a large gap in financial risk protection, involve inequities in financing and create financial access barriers.

**Inequities in Access:** Despite improvements in access to health services between 1995/96 and 2003/04 (NLSS) still 43% of the poorest and 27% of the richest quintile had not consulted any health service when needed in 2003/04. Besides financial access barriers, surveys suggest problems of physical access to health facilities and gaps in information.

**Revenue Collection:** Government expenditure accounted for only 39% of total health expenditure according to WHO estimates, while 61% of total health expenditure is estimated to be private expenditure in 2008. Of the private expenditure, 90% were paid out-of-pocket at the time of accessing health services. Hence only 45% of total resources spent on health in Nepal were prepaid resources in 2008, indicating a large gap in financial risk protection and potential inequities in the distribution of the financial burden. Government allocations to health are constrained by the size of the public sector - 14.8% of GDP in FY 2008/09 – which compares low to other countries. Moreover, allocations depend on the share of health in total government spending - about 7% in 2009/10.

**Pooling:** In Nepal, pooling of prepaid resources is ensured for 39% of total health expenditure at the national level through funding from general tax revenue and external aid (2008). Private expenditure was 61% of total health expenditure (2008), of these 90% is estimated to be out-of-pocket payments. Thus, more than half (55%) of total health expenditure involves no risk pooling. Less than a third of the health sector budget is allocated to district-level pools (district health budgets) based on historical budgeting by line-item and a risk-adjusted formula.

**Purchasing:** There is no separation between purchaser(s) and service providers in Nepal. For most services, MoHP and its subordinate-organisations pay prospectively via line item budget allocation and global budgets. Hence, budgets are to a large extent allocated irrespective of the volume and quality of services and thus offer little performance incentive to service providers. On the other hand, the quite substantive share of out-of-pocket payments is paid directly from patients to service provider per service rendered and allows limited state control on rational use of services and drugs, quality and safety of services.

**Benefit Package:** Since 2008, all health services available at health posts, sub-health posts and primary health care centers including listed essential drugs are free of charge to all. Additionally, listed essential drugs at district hospitals are available to all citizens. All other services provided by district hospitals are also free of charge for targeted groups. Delivery services (+allowances for transport) are free for all at government facilities. High share of the out-of-pocket expenditure in total health expenditure (55% in 2008) suggests that demand for a substantial amount of health services are in addition to the free health care benefits which is potentially provided with insufficient price, quality and safety control.

A number of preconditions have been discussed which are important to successfully adopt major changes in health financing. Subsequently, different policy options have been explored based on feasibility and possible impact on health financing reform objectives. After all, discussing in-depth on the policy options, setting preliminary priorities and exploring the preferred option or options are important towards improving social health protection and health financing status. Hereafter follow some recommendations and next steps.

## 1. Recommendations

MoHP is recommended to:

- 1) consider the pre-conditions as formulated in this paper and to see if and by when these can be met, before making a decision on one of the discussed options for new arrangements in health financing.
- 2) review the discussed options for health financing reform on feasibility in the Nepalese context and on their potential impact on achieving the objectives of the SHP.
- 3) take a comprehensive view on health financing and on all parallel actions of stakeholders outside MoHP and to therefore enter into a dialogue with employers and employees, with the MoF and the MoLTM to discuss their plans for the establishment and implementation of social health insurances for the private respectively the civil sector. The MoHP may want to ensure that it can have a say in the benefits package, the way entitlements will be organised (in kind or as a reimbursement system) and in the mandate and organisation of the purchasing agency, thus fulfilling its own mandate and looking for synergies with the desired health financing changes.

4) conduct further studies and research on the following topics:

i) Management Capacity in Districts

Decentralisation has been demanding on the management capacity of Districts. A study into the actual capacity and performance could uncover eventual gaps and propose solutions and actions towards capacity building. Topics are e.g. services planning, financial planning and budget execution, provider performance review, administrative infrastructure and procurement.

ii) Legal Environment and Amendments

All suggested options for health financing improvement have to take place in the current legislative framework which could be identified as either a straightjacket or as having too many holes in it, making proper stewardship of the current and proposed options difficult or in need of supplementary regulations, e.g. in case of the establishment of a purchasing function at a new independent government agency. Linking health financing regulations with adjacent areas such as insurance, quality of care and auditing are some of the topics to explore. So, legal arrangements need to be explored.

iii) Evaluation of Community Based Health Insurance

It is advised to carefully evaluate the ongoing CBHI pilots on aspects such as coverage, administrative efficiency and the necessary budget subsidies in case CBHI are considered to scale up. Teaming up with the activities planned by KOICA on CBHI piloting could be of advantage.

5) choose a gradual approach for implementing one of the discussed new health financing arrangements and to take into account the complexity of the various options, ranked in order of complexity in this paper, when making a decision.

6) timely engage with the Ministry of Finance about the amendments of the Insurance Act, on which the Insurance Board is currently working, in order to ascertain that CBHI and social health insurance will be properly regulated and their operations supported by the planned new Act instead of being hampered by the amendments.

## **2. Suggested Next Steps**

Because of the political dynamics and the ongoing dialogue with MoHP a flexible approach will be necessary and the following suggested next steps would therefore need to be seen preliminary and intermediary steps, to be adjusted in dialogue with MoHP:

### **1) Stakeholder Dialogue by MoHP**

Crucial to the further process on developing a social health protection policy and/or any reforms in health financing will be an inclusive stakeholder dialogue and consultation initiated by the MoHP and the supporting EDPs.



### **i. Inter-ministerial**

As any social health protection intervention and health financing reform will depend on factors beyond the health sector as well as influence other factors, a comprehensive stakeholder dialogue among the different ministries should take place. Given the major potential reforms that might change the legal environment for health financing through the revision of the labour and social security laws and their implementation will have substantial impact on the health sector. Therefore, MoHP is strongly encouraged to actively participate and co-shape the ongoing discussions between MoF, MoLTM, employers' associations and trade unions.

The Technical Working Committee as well as the Steering Committee on Social Health Protection/Social Health Insurance provides another important forum in which further steps and developments should be presented and discussed.

### **ii. Private Sector**

Some options proposed in this report rely majorly on the collaboration of the private sector. Without support from the employees and the employers any initiative towards a contributory health insurance scheme as proposed in Option 4 will be fruitless. At the same time any purchasing agency that will contract private providers needs to incentivise the private sector and engage in negotiations with the private health care providers.

### **iii. Looking for Synergetic Support from other EDPs**

EDPs are currently supporting various partners in different areas of social protection. Coordination mechanisms on the EDPs' side are the Social Protection Task Team and the EDPs' Health Group. There is certainly scope for further harmonising the support from different EDPs to create synergies. The social health protection strategy that is supported by GTZ and WHO needs to align and fit into the development of the health financing strategy that World Bank is supporting. Similarly, revision process of the labour and social security laws supported by ILO as well as DfID and the World Bank should be eventually linked with the ongoing developments in the health sector regarding social health protection.

## **2) Suggested Implementation Activities: Training and Capacity Building**

As follow-up activities to the joint effort and the report a number of activities in training and capacity building are recommended to take place. These could be successively organised as workshops or trainings in Nepal on an as needed basis, and need to be further discussed with MoHP. Other EDPs could also be involved in the organisation of such workshops and/or provide expertise.

### **i. Purchasing and Contracting**

The added value of purchasing and contracting in the Nepalese context and how such model would look and how to implement it are topics for explanation and discussion. This can be done by organising an interactive workshop with officials and staff of various ministries, representatives of some of the Districts and the CBHI pilots, representatives of trade unions and employers' organisation and some of the EDPs.

## **ii. Regulation of Health Insurance**

Private health insurers, have under certain conditions, the potential to improve social health protection, but also the potential of harming the overall system. In order to ensure that private providers for health insurance contribute to national health and social health protection objectives, government must play an important stewardship role by regulating and supervising the private health insurance sector. The interplay between private insurers and health officials on topics like licensing, accreditation and supervision of providers is another important topic to discuss during a workshop with representatives of MoHP, MoF, Insurance Board, insurers and some selected health services providers (private as well as public).

## **iii. Public Private Partnership (PPP)**

The model of PPP has come in many variants and can be imagined in financing of health services, in investing in the physical infrastructure of health care as well as in the actual delivery of services and services support activities. Exploring the variants that focus on financing of services and the potential role of private insurers and private investors as well as the legal framework to facilitate a constructive role of insurers and investors in the health sector would be beneficial for government and insurers, whose representatives should be invited for such workshop, together with representatives of the private and public providers.

## **iv. International Experiences: Mongolia, Kirgizstan, India, Cambodia, Philippines**

Although no foreign health systems in general and health financing systems in particular can be copied to Nepal, it is useful to consider exploring some foreign experiences and learn about successes and failures, about factors that promote or impede as such good options for health financing. All five countries have gone through and are still in the midst of health financing reform processes while focusing on different elements such as achieving universal coverage via social health insurance, provider payment system reform, aligning financial reforms with rationalisation of services delivery, using purchasing and contracting of providers, having health equity funds, and implementing a scheme for migrant workers. Discussions on some of the elements in more depth could enrich the debate and facilitate the process of making initial choices to direct further health financing developments in Nepal.

## **v. System Aspects of Quality**

Improving health financing is a necessary condition but not sufficient in itself to improve access to quality care for the Nepalese citizens. The role of financiers and purchasers in facilitating quality of care developments, in paying for quality and in reviewing the performance of health services providers against quality standards is important for future policy making and implementation of a fruitful health financing initiative. Many actors and factors ultimately decide about the outcome of the health care process for the individual patient. They form a chain of which the strength is dependent of its weakest link. So, a balanced approach to quality of care improvement and assurance could be discussed with an eye on the development of the different instruments for quality improvement and assessment. While doing this, importance should be given on the role of health finance in e.g. the development of a national strategy on health care quality improvement, the purchasing of

pharmaceutical care and the development of clinical practice guidelines and medical protocols which could serve clinical decision making and the provider performance review process.

### **3) Activities towards Social Marketing<sup>84</sup> and Empowerment of Vulnerable Groups**

Developing a social health protection policy and having a clear vision on objectives and targets are essential for improving social health protection. Similarly, activities under the policy level can help to achieve social health protection goals by supporting vulnerable groups to overcome access barriers. According to a study only 60% of the people are aware of the benefits of free health care with Muslims (51%) being least aware; and particularly low knowledge among Dalit women (44%)<sup>85</sup>. Identifying factors that prevent vulnerable groups from utilising health care as well as addressing them through social marketing campaigns and using their leaders in such campaigns will have major effects on the appropriate utilisation of health care. Activities in this area will also contribute to achieving the second objective of NHSP-IP 2<sup>86</sup>.

### **4) Factsheets, Information Materials in English and Nepali**

Some of the concepts introduced in the report might be new to some stakeholders as well as in the context of the Nepali health system. In order to familiarise the various stakeholders with these concepts, information material in form of factsheets in English and Nepali might be helpful.

#### **i. Purchasing**

Information factsheet on the role of purchasing in regard to quality and efficiency as well as requirements for establishing a purchasing function in the Nepalese context would be helpful.

#### **ii. Re-imburement versus in-kind Health Services Financing Systems**

The actual choice for one or the other system has serious consequences for realisation of access to health care services, for the capacity to review provider performance and for administrative costs. Establishing new or expanding current health financing systems would benefit from understanding the difference between these two systems.

#### **iii. Risk Equalisation, Fund Allocation**

Many countries face difficulties in the distribution of financial resources over the various local jurisdictions. In the Nepalese context, it needs to be examined that whether the existing capacities for health services delivery and the budget allocation system based on e.g. the numbers of hospitals, hospital beds and staff are appropriate and equitable or the differences in health risk and health care costs should play a role. Although Nepal has a bottom up health finance planning system, further exploration of more sophisticated systems and the necessary capacity could make sense.

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<sup>84</sup> Social marketing: achieving social goals by using commercial advertisement tools.

<sup>85</sup> RTI International: Pro-Poor Health Care Policy Monitoring. Household Survey Report from 13 District, Research Triangle Park, NC, USA, April 2010

<sup>86</sup> One indicator for the second objective reads: Utilisation of essential health care services (outpatient, inpatient, especially deliveries, and emergency) by targeted groups, and disadvantaged castes and ethnicities at least proportionate to their population by 2015

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## VIII. Annexes

### Annex 1: List of People Met

During the joint assessment, MoHP- GTZ Team met following people.

#### **Ministry of Health and Population (MoHP)**

##### Policy, Planning & International Cooperation Division (PPICD)

LR Pathak (Chief Specialist)

Kabiraj Khanal (Under Secretary)

Baburam Marasini (Coordinator, Health Sector Reform Unit)

##### Human Resource & Financial Mgt. Division

Surya P. Acharya (Joint Secretary)

Yogendra Gauchan (Under Secretary)

Prabha Baral (Statistical Officer)

#### **Ministry of Finance (MoF)**

Krishna Hari Baskota (Secretary, Revenue)

Keshav P. Acharya (Chief Economic Advisor)

#### **Ministry of Labour and Transport Management (MoLTM)**

Purna Chandra Bhattarai (Joint Secretary)

#### **Ministry of Local Development (MoLD)**

Somlal Subedi (Joint Secretary)

#### **National Planning Commission (NPC)**

Gyanendra K. Shrestha (Under Secretary)

Shankar P. Kharel (Under Secretary)

#### **Department of Health Services (DoHS)**

##### Monitoring, Evaluation & Quality Section, Management Division

Lokraj Paneru (Chief Medical Superintendent)

Rita Joshi (Public Health Administrator)

##### Health Management Information System

Pawan Ghimire (Section Chief)

Primary Health Care Revitalization Division,

BS Tinkari (Director)

Achyut Lamichhne (Public Health Administrator)

**District Health Office, Nawalparasi**

Madan Shrestha (Public Health Administrator)

**District Hospital, Nawalparasi**

RS Deep (Medical Superintendent)

**District Development Committee Office, Nawalparasi**

Lilaram Giri (Chief, Account Section)

Mohan Gyawali (Programme Officer)

Pushkar Kafle (Programme Officer)

**District Administration Office, Nawalparasi**

Balkrishna Panthi (Chief District Officer)

**Dumkauli Community-based Health Insurance, Nawalparasi**

Jiwan Shrestha (Focal Person for CBHI)

Hiralal Khanal (Coordinator, Insurance Working Committee)

**Bharatpur Hospital, Chitawan**

NK Singh (Medical Superintendent)

Jayendra Paudel (Account Officer)

**Jogimara Sub Health Post, Dhading**

Ramesh Aryal (SHP In-charge)

**Mahadevbeshi Health Post, Dhading**

Bednath Baral (HP In-charge)

**Village Development Committee Office, Syuchatar**

Devendra Bahadur Karki (Secretary)

**National Insurance Board**

Phatta Bahadur K.C. (Chairperson)

Anil R. Bhattarai (Director)

**World Health Organization**

Lin Aung (WHO Representative)

Gunawan Setiadi (Public Health Administrator)

**World Bank**

Albertus ( Bert) Voetberg (Lead Health Specialist)

Roshan Darshan Bajracharya (Senior Economist)

**International Labour Organization**

Shengjie Li (Country Director)

**Department for International Development (DfID)**

Rebecca Calder (Social Development Advisor)

Natasha Mesko (Maternal Health and Nutrition Advisor)

**Korean International Cooperation Agency**

Young-Ah Doh (Resident Representative)

Vikas Rawal (Programme Officer)

Chang-yup Kim (Professor, School of Public Health, Seoul National University)

Jung-Myung Cho (Assistant Manager, Health Team)

Sun-Hee Park (Volunteers Programme Manager)

**RTI International**

Robert Timmons (Team Leader, Health Sector Reform Support Programme)

**National Business Initiative**

Catrin Froehlich (CIM, CSR Expert)

**Federation of Nepalese Chambers of Commerce & Industries**

Employers' Activities & Industrial Relations

Hansa Ram Pandey (Director)

Employers' Council

Roman Awick (CIM, Labour Law & Industrial Relations Expert)

**Insurers' Association**



Deep Pandey (Chairperson)

**Kathmandu Model Hospital**

Basanta Maharjan (Director, Community Health Development Programme)

**Centre for Policy Studies and Rural Development (NGO)**

SR Paudel (Chairperson)

**Consultant on Legal Framework**

Ramesh Badal (Advocate)

**German Technical Cooperation (GTZ)**

Health Sector Support Programme

Friedeger Stierle (Manager)

Susanne Grimm (Team Leader)

Revenue Administration Support Project

Thomas Taraschewski (Manager)

## Annex 2: Benefit Packages

### A. Major Health Service Programmes for SHP and Benefit Packages

SN	Programme name	Guiding policy/document	Service providers	Benefit package	Beneficiaries	Remarks
1	Free Health Services Programme	Free Health Services Programme Guideline	Public health facilities (SHPs, HPs, PHCCs, district hospitals)	<b>All available services</b> in SHPs, HPs and PHCCs including listed essential drugs (SHPs: 22+3; HPs 33+3; PHCCs: 35 types) are provided free of cost	Universal: all citizens	NRs 5 to 15 per patient is paid to SHPs, HPs and PHCCs for the free services they provide
				<b>Listed essential drugs</b> (40 types) are provided free of cost from 25-bedded (district) hospitals	Universal: all citizens	NRs 15 to 100 per patient is paid to district hospitals for outpatient and inpatient services they provide
				All available services of district hospitals are provided free of cost	Targeted groups: ultra-poor, poor, helpless, disable, senior citizen and FCHVs	
				<b>Free health services</b> from all public hospitals to all referred patients of targeted groups from district hospitals and respective health facilities	Targeted groups: ultra-poor, poor, helpless, disable, senior citizen and FCHVs	This is not in practice however
2	Aama Suraksha Programme	Aama Suraksha Programme Operational Guideline	Public and specified private including community health	<b>Free delivery services</b> at public & other specified facilities plus transportation allowances	Universal: all women receiving delivery services at specified health	The programme also provides NRs 1000 to NRs 7000 reimbursement to

			facilities	(NRs 500 in Terai, NRs 1000 in Hills and NRs 1500 in mountains) for institutional deliveries	facilities	facilities for each delivery services they provide.
			Public health workers	<b>Free delivery services at home</b> by trained health worker	Women receiving delivery services from public health workers at home	For this service, health workers are provided NRs 200 per case as an incentive
3	Community Health Insurance Programme	Operational Booklet for Community Health Insurance	PHCCs in six districts	Services are provided through PHCCs which are either upgraded to assure the services beyond the benefit package of free health services programme or have referral services within the benefit package or both	Enrolees of the scheme (enrolment is voluntary)	For example, beyond the free health services benefit package, additional services available in Dumkauli PHCC are X-ray, Ultrasound, ECG, safe abortion, 15- 20 types of additional tests, and ambulatory service
4	Uterine Prolapse Treatment Programme	Operational Guideline on Treatment and Operation for Uterine Prolapse Problems	Approved public and private including community health facilities and their camps	<b>Free diagnosis, primary treatment, ring pessarium and operation services</b> (plus transportation allowances- Mountains: NRs 3000; Hills: NRs 2000; Terai NRs 1000- to those who receive operation service)	Universal: women suffering from uterine prolapse problem	Screening camps (in coordination with regional health directorate and district health office) are held at local level for diagnosis, prevention and primary treatment of uterine prolapse. For operation services, health facilities are paid Rs 15000 per operation service they provide (if the services are extended through camps, they will be provided additional amount (Mountains:

						NRs 7000: Hills: NRs 5000; Terai NRs 3000))
5	Financial Support Programme for the treatment of specified diseases to targeted groups	Operational guideline on financial support for the treatment of underprivileged citizens	Public health facilities	<b>Free service delivery</b> for the patients of Cancer, Heart and Kidney diseases	Targeted: people of above 75 and below 15 years of age and endangered ethnic groups	For this purpose, MoHP provides fund to the hospitals
				<b>Free services</b> up to the amount of NRs 50,000 to the patients of Cancer, Heart, Kidney and other catastrophic nature of diseases	Poor	
6	Valve replacement to the poor heart patients		Public health facilities	<b>Replacement of valve free of cost.</b>	Poor: up to 500 patients in a year	By definition, poor are those who can not manage (from their land, or other wealth, business or profession) to feed themselves for the whole year. District administration office is given the primary responsibility of identifying the poor. Hospitals can also identify poor based on the information that patients provide
7	Free treatment to the victims of peoples' movement/conflict period		Public health facilities	<b>All health services free of cost</b>	victims of people's movement/conflict period	

8	Hospital based additional programmes	Such programmes are defined by the hospitals themselves	Public/community hospitals	Many hospitals provide <b>additional benefits</b> (e.g. free food to the patients) to their patients	Universal or targeted as per the decision of hospital development board	Hospitals usually receive budget from the government to finance such programmes based on their proposal and they may also use local/own fund as necessary
11	Nutritional food support programme	Operational guideline is in progress		<b>In-kind benefits</b>	Pregnant women and infants	This scheme is only in <i>Karnali Zone</i>
12	Nutrition/transportation support for TB patients		Public and approved private including community health facilities	<b>Cash transfer</b> of NRs 1400 per patient	Universal: TB patients	

## B. Health Services Available in District and Sub-district Level Health Facilities

### Box 1: Health Services Available in SHPs

#### a) Curative Health Services:

- Listed 22 types of essential drugs.
- Additional 3 types of essential drugs if delivery services are available in the SHPs
- Necessary drugs / materials needed for Dressing and Suture.
- Delivery related services. General treatment services.

#### b) Referral services

c) **Public Health Related Services** e.g. family planning, immunization, nutrition, tuberculosis, leprosy, HIV/AIDS etc

### Box 2: Health Services Available in HPs

#### a) Curative Health Services:

- Listed 32 types of essential drugs.
- Additional 3 types of essential drugs if delivery services are available in the HPs.
- Necessary drugs / materials needed for Dressing and Suture.
- Delivery related services.
- General treatment services.

#### b) Referral Services

c) **Public Health Related Services** e.g. family planning, immunization, nutrition, tuberculosis, leprosy, HIV/AIDS etc

### Box 3: Health Services Available in PHCCs

#### a) Emergency and Outpatient Services

- **Diseases Investigation Services**
  - Blood for TC, DC, Hb, Blood Sugar, ESR
  - Stool for RE/ME
  - Urine for R/ME)
  - Aldehyde Test, MP, CT, Gram's Stain, AFB Stain, Blood Sugar, Blood Urea, Semen Analysis
  - Stool RE/ME
- **Curative Services**
  - All listed essential drugs
  - Necessary drugs / materials needed for Dressing, Suture and Plaster
  - Delivery related services
  - General treatment and operation services

#### b) Referral Services

c) **Public Health Related Services** e.g. family planning, immunization, nutrition, tuberculosis, leprosy, kala azar, HIV/AIDS etc

#### **Box 4: Health Services Available in 25 Bedded (District) Hospitals**

##### **a) Emergency services**

- Diseases investigation services
  - Blood for TC, DC, Hb, Blood Sugar, Blood Urea
  - Urine for RE/ME
  - Plain X-ray
- Curative services
  - All essential listed drugs which are available in 25 bedded hospitals
  - All necessary drugs and other materials needed for Dressing, Suture and Plaster

##### **b) Inpatient care services**

- Diseases investigation services
  - TC, DC, Hb, ESR, Platelets Count, BT, CT, Blood Grouping and RH Type
  - MP, MF, VDRL, Rh Factor, Pregnancy Test
  - Aldehyde Test, Gram's Stain, Creatinine, LFT, AFB stain, Blood Sugar, Blood Urea, Uric Acid
  - Stool for RE/ME, Stool for Occult Blood
  - Urine for RE/ME, Urine for Bile Salts, Bile Pigments, Acetone
  - Semen Analysis
  - Plain X-ray
- Curative services
  - All essential listed drugs available in 25 bedded hospitals
  - Normal operation available in 25 bedded hospitals
  - Emergency Obstetric Care (if available)
  - General bed services

##### **c) Outpatients care services**

- Diseases investigation services
  - TC, DC, Hb, ESR, Platelets Count, BT, CT, Blood Grouping and RH Type
  - MP, MF, VDRL, Rh factor, Pregnancy Test
  - Aldehyde test, Gram's Stain, Creatinine, LFT, AFB Stain, Blood Sugar, Blood Urea, Uric Acid
  - Stool for RE/ME, Stool for Occult Blood
  - Urine for RE/ME, Urine for Bile Salts, Bile Pigments, Acetone
  - Semen Analysis
  - Plain X-ray
- Curative services
  - All essential listed drugs which are available in 25 bedded hospitals
  - Normal operation available in 25 bedded hospitals
  - All necessary drugs / materials needed for Dressing, Suture and Plaster
  - Services including normal and complicated delivery services

##### **d) Referral Services**

**e) Public Health Related Services** e.g. family planning, immunization, nutrition, tuberculosis, leprosy, kalazar, HIV/AIDS etc

**Note on referral services:** Free health care guideline states that the patients should be referred to upper level health facility if the patients cannot be treated in that hospital due to the complexity of the diseases and inability of available medicines and resources. Similarly, priority should be given while providing services to the patients referred from lower level health facilities and feedback should be provided. Referral services also include the follow-up monitoring of the referred patients returned back after the necessary treatment.

**B1: Public Health Services Programme:** Following public health services are provided from SHPs, HPs, PHCCs and district hospitals **free of cost to all the citizens.**

SN	Health Service Programmes	Implementing Institutions			
		Hospital	PHCCs	HPs	SHPs
1	Family Planning Programme (contraceptives)	✓	✓	✓	✓
2	Family Planning Programme (permanent)	✓	✓		
3	National Immunization Programme (Routine and Supplementary)	✓	✓	✓	✓
4	Nutrition Service Programme	✓	✓	✓	✓
5	Safe Motherhood Programme (pregnant, maternity and delivery)	✓	✓	✓	✓
6	Tuberculosis Control Programme	✓	✓	✓	✓
7	Leprosy Elimination Programme	✓	✓	✓	✓
8	Integrated Management of Childhood Illness	✓	✓	✓	✓
9	Epidemiology Diseases Control and Management	✓	✓	✓	✓
10	Senior Citizen Service Programme	✓	✓	In coordination of district	
11	Social Inclusion and Referral Services	✓	✓	✓	✓
12	Health Education Promotion Programme	✓	✓	✓	✓
13	Malaria Control Programme (66 districts from Hills and Terai)	✓	✓	✓	✓
14	Kalazar Elimination Programme (12 districts from Eastern and mid-Terai)	✓	✓		
15	Filaria Elimination Programme (66 districts from Hills and Terai)	✓	✓	✓	✓
16	HIV/AIDS and STD Control Programme	✓	✓	✓	✓
17	Outreach Clinic Programme		✓	✓	✓
18	Mobile Health Services (need based depiction from centre)				
19	Female Community Health Volunteers Programme		✓	✓	✓
20	Community Drug Programme	✓	✓	✓	✓
21	Community Health Insurance Programme (currently piloted only in 6 PHCCs)		✓		
22	Integrated Health Information System Programme	✓	✓	✓	✓
23	Logistic Management Information System Programme	✓	✓	✓	✓

**Sources:**

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### Annex 3: Proposed Health Financing Policy Objectives and Measurements<sup>87</sup>

Policy objective	Definition and measurement
Promoting universal protection against financial risk	Protection against the risk of impoverishing health care expenditure. Indicators: percentage of households experiencing “catastrophic” health expenditures (health spending that exceeds a certain threshold percentage of total or non subsistence household spending). Another indicator measures impoverishing effect of health expenditures.
Promoting a more equitable distribution of the burden of funding the system	Relative to their capacity to pay, the poor should not pay more than the rich, the reverse should be the aim (solidarity between rich and poor). Analysis of the distributional impact should include all sources of health spending <sup>88</sup> . Indicators: out-of-pocket expenditure on health by income quintile. At the same time, non-use <sup>89</sup> of health services for financial reasons needs to be monitored to assess how equitable the health financing system would be if all had accessed health services according to need.
Promoting equitable use and provision of services relative to the need for such services	Health services and resources should be distributed according to need, not according to other factors such as people’s ability to pay for services or how money is spent by the health system. Indicators: Public per capita expenditure by geographical unit and use of different types of health services across the income distribution.
Improving transparency and accountability of the system to the population	One practical criterion to look at is if the entitlements and obligations of the population are well understood by all, reflecting a promise by the state to the citizens. Also, an issue related to transparency for many countries is the presence of informal payments for health care. Accountability arrangements for “health financing organisations” such as compulsory health insurance funds or other public agencies that manage the financial resources of the health system are essential <sup>90</sup> .
Promoting quality and efficiency in service delivery	Financing arrangements should reward good quality care and provide incentives for efficiency in the organisation and delivery of health services. These incentives need to be complemented by respective

<sup>87</sup> The following is taken and adapted from the WHO EURO publication Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

<sup>88</sup> Compulsory prepaid sources (general taxation and payroll contributions for compulsory health insurance) tend to be more equitable, voluntary prepaid sources (voluntary health insurance) are less equitable, and OOP payments are the most inequitable.

<sup>89</sup> That is the percentage of persons in a household survey that indicated they did not visit a doctor or a hospital despite the felt need because of the impossibility to pay the charges or the because of the fear to have to pay for the services, or the persons that did not buy the prescribed drugs because of lack of money.

<sup>90</sup> For example from (relatively simple) tracking and reporting on financial resources (e.g. audit), to (more complex) reporting on performance relative to some agreed measures, to (most complex) enhancing the legitimacy of the government in the eyes of the citizens. This includes therefore also the availability and accessibility of financial statements and auditing reports to the general public. Kutzin, J.: Health Financing Policy: A Guide for Decision-makers. Regional Office for Europe of the World Health Organization, 2008 ([www.euro.who.int/financing](http://www.euro.who.int/financing) accessed on 20 May 2010).

	arrangements of governance and managerial competencies of service providers (e.g. financial rewards for practices that achieve certain defined health or output targets combined with merit based hiring/firing and promoting/demoting of staff and management).
Improving efficiency in the administration of the health financing system	Promoting administrative efficiency involves focusing on minimising duplication of functional responsibility for administering the health financing system as is the case in e.g. fragmented funding of services. This does not imply a broad agenda of reducing administrative costs; indeed, many such costs are necessary and contribute to the performance of the health system.

While health financing objectives are important criteria for assessing different reform options, additional criteria might be relevant in Nepal, including sustainability (e.g. availability of fund and resources in the longer run, impact on international competitiveness of companies and on the labour market) and feasibility (resources required, time, capacity to implement and to manage).





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