



Situational Analysis of Health Financing in Nepal

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Acronyms

AAMA	Action Against Malnutrition Trough Agriculture Program
BHCP	Basic Health Care Package
CBHI	Community-Based Health Insurance
CHE	Current Health Expenditures
DFID	U.K. Department for International Development
DHS	Demographic and Health Survey
EHCS	Essential Health Care Services
EHE	External Health Expenditures
EPF	Employees Provident Fund
EPHS	Essential Package of Health Services
FDF	Federal Divisible Fund
GHED	Global Health Economic Databases
GIZ	German Agency for International Cooperation (<i>Deutsche Gesellschaft für Internationale Zusammenarbeit</i>)
HFS	Health Financing Strategy
HI	New national Health Insurance established the Health Insurance Act in October 2017.
HIB	Health Insurance Board
HIE	Health Insurance Expenditures
HMIS	Health Management Information System
IMF	International Monetary Fund
IMNCI	Integrated Management of Nutrition and Childhood Illness
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOLESS	Ministry of Labor, Employment and Social Security
NHA	National Health Accounts
NLSS	Nepal Living Standard Surveys
NPISH	Nonprofit Financing Scheme
OOP	Out-of-Pocket
PFM	Public Financial Management
PHE	Public Health Expenditures
SDG	Sustainable Development Goal
SHA	System of Health Accounts
SHI	Social Health Insurance
SHS	Social Health Security Scheme
SSF	Social Security Fund

TABUCS	Transaction Accounting and Budget Control System
THE	Total Health Expenditures
UHC	Universal Health Coverage
VAT	Value-Added Tax
WHO	World Health Organization

Executive Summary

This document is a situational analysis of Nepal’s health financing system. It discusses the key health financing issues in Nepal, raising questions about how the current mechanisms for collecting revenues, funds-pooling, and services-purchasing are structured and how aligned they are with the two main reforms that arise in the health system in Nepal—the new federal structure and the new social (national) health insurance. Understanding of these aspects is essential to formulate the country’s 2020 Health Financing Strategy (HFS). The document is focused on the opportunities and in the financial challenges that could block the path to universal health coverage (UHC), contributing with detailed insights about the rationale for and performance of the existing health financing schemes.

The Government of Nepal asked its development partners for support in preparing and implementing the HFS in Nepal. In response, an HFS task force, led by the World Bank, the World Health Organization (WHO), and the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*, GIZ), prepared this document.

The document used several databases but there are a few limitations. The main databases used in the document are the following: (a) the macroeconomic indicators from the International Monetary Fund (IMF); (b) the Global Health Economic Databases (GHED) from the World Health Organization (WHO); (c) the National Health Accounts (NHA) produced by the Ministry of Health and Population (MOHP) in Nepal; (d) household surveys, such as the Nepal Demographic and Health Survey (DHS) 2016 and the last three Nepal Living Standard Surveys (NLSS); and (e) budget data from the Red Book for more recent years. The main limitation of DHS and other household surveys are that they provide data only till 2016, lacking information for the last two years. Additionally, there are no databases and indicators for municipalities, preventing a more accurate analysis of health financing at the local level.

Determinants of Health Financing Policies

This section describes the macroeconomic determinants of health financing (economic growth and public finances) and the opportunities brought by the new federalism and social health insurance in the health financing policies in Nepal. Two comprehensive reforms are the drivers of the future health financing system in Nepal: (a) the emerging federal model of governance, shifting responsibility for health services delivery and management from a centralized structure to one shared by the federal, provincial, and municipal governments, and (b) the implementation of a national Health Insurance (HI) that is intended to reshape the previous financial schemes in an equitable and sustainable way.

On the macroeconomic side, over the next three years, Nepal is expected to have a good economic performance, creating opportunities for health prioritization by increasing tax-based funds for health in the government budget. Economic growth, according to the IMF, is expected to increase 6.3 percent in fiscal year 2019/20 and 4.5 percent to 5 percent in the following three fiscal years. Nepal’s challenge is to use the dividends of economic growth to prioritize the public tax-based funding to finance the expansion of the health system and subsidize health to the poor. However, Nepal’s health policy lacks major definitions regarding some crucial aspects of health financing: harmonizing and costing a national unified basic health care package (BHCP), consolidating efficient mechanisms for pooling funds, increasing the ability of provincial and local governments to elaborate and implement health budgets, defining policies and guidelines for efficient public financial management (PFM) and procurement mechanisms, consolidating financial protection mechanisms to avoid catastrophic spending, and creating sound health

information systems to improve monitoring and evaluation processes and ensure better health outcomes. Some of these subjects have been discussed but are in preliminary stage of formulation and need better definitions, capacity building, and financial and human resources to be implemented.

Nepal is moving in the direction of a mix of tax-based financing and health insurance premiums, but the processes to enroll beneficiaries are not yet well defined and coordinated. Both financing mechanisms need to be adjusted in the context of a federal system, because there are overlaps of beneficiaries, potential premium revenues, and subsidies. Before implementing the targeted health insurance schemes, it is crucial to make a comprehensive assessment of the existing health insurance schemes in the country to harmonize them and increase risk pooling.

Health Financing Trends

Nepal has a better health financing performance than other peer countries in the South Asia Region but, like most low-income countries, it has high proportions of out-of-pocket (OOP) spending and low proportions of public health funding in its total health expenditures. According to the NHA, in 2016, Nepal's health spending as a share of the gross domestic product (GDP) was 6.7 percent. However, 55 percent of the health spending was driven by OOP expenditures and only 19 percent corresponded to public expenditures. On rare occasions (such as 2006 and 2009), public health expenditures were higher than 20 percent of the total health expenditures (THE). Nepal is in a better position than other South Asia Region countries such as Afghanistan, Bangladesh, Pakistan, and India regarding public health expenditures (PHE) and THE as a share of the GDP. It had a faster increase in its PHE per capita than other countries in the region, but most of this increase is associated with the country's good economic performance and the increased participation of general government spending in the GDP. Considering the low increase of the health sector participation in the government total expenditures (from 4.2 percent to 5.1 percent between 2000 and 2015), reprioritization of health in total government spending has had little effect on the growth of public health spending per capita.

Nepal has been experiencing a positive correlation between increasing economic growth and increasing contribution of PHE in total health spending. In 2016, THE accounted for 6.7 percent of GDP, from a base of 5.3 percent in 2010, and PHE grew from 0.9 percent to 1.2 percent of GDP between 2013 and 2016. However, the implementation of the UHC under the new federal model could require a faster increase in PHE in the coming years. International literature¹ defines US\$90 as the minimum average per capita domestic government health spending needed to finance a basic package of health services in low- and middle-income countries. However, the 2016 PHE in Nepal was only US\$8.44, according to the GHED/WHO.

Capital health expenditures represented almost 25 percent of total health spending in 2000, but after 2010, the relative level of health investments was substantially reduced, representing around 5 percent of THE² in 2016. There is no prescription about what the adequate level of capital expenditures as a share of THE should be. However, low levels of health investment could compromise the achievement of UHC given the needs to expand, equip, and maintain health services operation with reasonable standards of efficiency and quality.

¹ World Bank (2018b).

² THE has two components: capital health expenditures, dedicated to investments in health equipment and facilities, and current health expenditures (CHE), representing spending in health goods and services.

OOP is the largest component of current health expenditures (CHE), but its participation has been reduced in the last years. Between 2013 and 2016, OOP, as a share of CHE, fell from 63 percent to 55 percent. Many government initiatives leading increase of public spending in health and in target programs for the poor such as the Safe Motherhood Program, the Basic BHCP, the Free Health Care Program, and the Impoverished Citizens' Service contributed to reduce household spending in health, and the expansion of public initiatives to reduce the burden of the health spending for the poor could be essential to achieve the Sustainable Development Goal (SDG) to reduce catastrophic health spending to zero by 2030. However, Nepal still has high levels of OOP payments, which raise the risk of catastrophic health expenditures and family impoverishment. Recent research shows that households with a higher number of children under the age of five and of elderly persons are more likely to incur catastrophic health expenditures in Nepal.

The Nepal health sector has been partially dependent on external aid, but this dependence appears to be decreasing. From 2000 to 2016, the participation of external aid in CHE fell from 21.5 percent to 11.7 percent. However, the participation of the "off-budget" funds in external health expenditures (EHE) increased from 34 percent to 64 percent between 2014 and 2016. The Government should intensify its dialogue with donors to redefine the levels of support it needs to implement UHC in the transition to federalism. A better coordination about the "off-budget" donors' health spending could help the government improve the achievement of the MOHP's goals and priorities.

From 2000 to 2016, voluntary prepaid health expenditures increased fivefold, rising from 7.2 percent to 14.3 percent of CHE—a significant share of this kind of health spending for a low-income country. These expenditures include voluntary health insurances, which represent a small fraction of the health financing in Nepal (varying at less than 0.5 percent of the CHE from 2000 to 2016), nonprofit financing schemes (NPISH), and enterprise financing health schemes. NPISH schemes, which include (voluntary) social health insurance, increased substantially between 2008 and 2016 (from 16 to 159 constant million dollars of 2016) and represent 84 percent of the voluntary prepaid health expenditures in 2016, being financed by government subsidies, external and private donations, and communities' funding. Enterprise voluntary insurance schemes increased from 2000 to 2012 (reaching US\$40 million of 2016). However, since then this scheme has been progressively reduced (spending only US\$24 million in 2016). The coordination of processes and definition of mechanisms to allow these funds to be pooled in the new mandatory health insurance are questions to be discussed in the HFS.

In 2016, the Nepal NHA series started collecting data about the nature of the health spending according to the medical and administrative kind of expenditures. The highest share of health spending in Nepal was used to purchase goods (medicines and supplies), representing 36 percent of CHE, followed by curative services (32 percent) and preventive services (18 percent). According to the data, the participation of the public sector is expressive in outpatient health services, representing 55 percent of the total expenditures in this kind of expense, but the same is inexpressive in inpatient services and medical goods.

Health Financing Arrangements

Health services delivered by the MOPH and by provinces and municipalities are mostly funded by taxes, but contributions also come from external donors (both pooled into the public budget). From 2000 to 2016, the participation of external funds in the public revenue-collecting mechanisms decreased from 50 percent to 14 percent. Given that health public services are directly delivered by health facilities, these sources are complemented by user-fee charges paid as OOP by families when the services are delivered.

For health insurance, the main revenues in Nepal are (a) contributions (premiums) collected from members with ability to pay and (b) tax funds provision, financed by the Ministry of Finance (MOF), as annual block grant directed to the health insurance fund to subsidize premiums for the poor, senior citizens and to cover the health insurance administrative expenses. Currently, the national HI scheme is in a gradual implementation process and the MOF allocated US\$5.3 million for fiscal year 2018/19 to subsidize premiums to the poor. The health insurance previewed under the Social Security Fund (SSF) is not yet implemented. However, both HI and SSF will count on tax-based subsidies and premiums paid by enterprises and enrollees, when defined by specific legislation. However, there is no effective mechanism for identifying the poor, which means that the full implementation of the national HI might face delays.

Funds-pooling mechanisms to the overall government, after the federal structure, rely on the creation of the Federal Divisible Fund (FDF), based on the income from value added tax (VAT) and excise duties collected from domestic products. The Federal (Central) Government receives 70 percent of the fund resources and 50 percent of the royalties collected from natural resources. Financing for provincial and municipal (local) governments is currently based on tax and nontax revenues from the FDF: provincial and municipal (local) governments receive, equally, 15 percent of the deposited amount. The resources are distributed as conditional grants, fiscal equalization grants, complementary grants, and special grants. Part of the FDF and related grants are used to finance the public health sector, but the amount of resources transferred to health depends on budget allocations decided by each level of government.

There are special funds-pooling mechanisms for the MOHP programs, some of which address the poor directly, which has been crucial in reducing inequality in access to health care services. These initiatives, which are aligned to the SDGs are (a) the Safe Motherhood Program, designed to cover all women in reproductive age and neonates; (b) the Free Health Care Program, designed to cover all Nepalese citizens but currently covering 72 percent of the targeted population living in the poorest areas to benefit particularly the poor, vulnerable, and unreached population; (c) the Impoverished Citizens' Service Program, dedicated to all poor citizens (currently only 8,300 citizens benefit from the program); and (d) the Bed-for-the-Poor Initiative, which makes it mandatory to allocate 10 percent of beds in private hospitals to the poor free of charge. All these programs were important to reduce the participation of OOP in health financing in the last years, as indicated previously. Initiatives such as the Safe Motherhood Program, with more than two decades of implementation, had remarkable results on reducing maternal mortality. However, recent studies (Ranabhat et al. 2019) mentioned that, despite all these efforts, "the service coverage of health care was not satisfactory. The quality of health service and financial protection were inadequate. Grass root level health workers were confused about the changing policy of government like user fee, community drug program, free health service, special health care services to minority groups, etc. and none of them ensures comprehensive package of health service with universal access."

Main arrangements in purchasing mechanisms in Nepal are based on the existence of the BHCP and little innovations on providers' payment mechanisms. Nepal has an essential BHCP but needs to estimate how affordable it is according to the current schemes of health financing. It is necessary to estimate its costs and access mechanisms to the entire population (especially the poor). In most of the public system, there are no functions that are split between purchasers and providers. Provider payments are based on inputs and paid according to line-item budgets. Public health insurances use capitation-based payment for outpatient care package; fee for services not included in the outpatient services and diagnosis; and case payments, for inpatient care. However, there are innovations in payment schemes in some public programs such as capitation-based payments (in the Safe Motherhood Program, BHCP, and free health care); cash incentives (Safe Motherhood Program); services reimbursements (voluntary

private insurances, Employees Provident Fund (EPF), SSF, and Impoverished Citizens' Service); and conditional block grants (Impoverished Citizens' Service).³

The analysis of the health financing arrangements in Nepal shows three types of overlapping which deserve the attention of the MOHP authorities to elaborate the HFS: (a) between the general coverage of the MOHP and all other Government programs; (b) among different health insurance systems, especially between the national HI and the other health insurance schemes under the SSF and EPF; and (c) between the benefits under tax-based funding and the insurance schemes. The objective of the Free Health Care Program is to provide basic health care services free of cost to every citizen, while the purpose of the national HI is to provide all essential health services beyond free health care services. Therefore, in theory, the free health care services remain free to those who are enrolled in the HI. However, with the current definition of the BHCP by the MOHP, there are many overlaps between the HI, the BHCP, and the Free Health Care Program which need to be carefully harmonized. According to the Health Insurance Act of 2017, HI is not only meant for those who are able to pay, but it is mandatory, and all Nepalese citizens must enroll. The Government will subsidize the poor to enroll and pay for eventual co-payments and registration fees, but this need to be assured by concrete procedures. As mentioned earlier, the Government is currently providing premium subsidies for health insurance for the poor and similarly other health protection schemes are provided free of cost to the poor, but the challenges are how the population will be efficiently enrolled in the HI and how this will be affordable in a UHC scale.

Social and Economic Impacts of Health Financing

Health has considerable impacts on poverty. When people close to the poverty line must pay fees or co-payments for health care, the amount can be so high in relation to income that it results in financial catastrophe for the individual or the household. Such high expenditure can mean that people must cut down on necessities such as food and clothing or are unable to pay for their children's education.⁴ In 2014, nearly 29 percent of the Nepalese population was multidimensionally poor. In some provinces, such as Karnali and Province 2, close to 50 percent of the population was multidimensionally poor. Multidimensional poverty levels could also be seen at local levels, particularly in the western parts of the country and some locations in the mountains.

Nepal has high levels of catastrophic health spending. Using total household consumption expenditures as denominator, the share of households experiencing "catastrophic" health spending could vary from 21 percent (using the 5 percent threshold) to 4 percent (using the 25 percent threshold). If only medicines expenditures are considered, these proportions fall to 19 percent and 3 percent, respectively.

In the last three decades, Nepal has increasingly put equity in health services use at the center of its health policy agenda. The distribution of free medicines to the poorest population has positively affected poverty in Nepal. However, the results produced using data from the NLSS 2010/11 indicate that

³ According Vinyals i Torres (2011), "the use of capitation in Nepal came after the abolition of user fees under the free Health Services Program. At the beginning, a fee-for-services method was introduced, under which every first outpatient department (OPD) visit was reimbursed at a pre-defined fee. After two years of implementation, due to problems related to the misreporting of the number of visits, the payment method was switched to capitation. Now every district receives a fixed amount multiplied by the number of its inhabitant."

⁴ Catastrophic health spending could lead even rich people to near the poverty line or below the poverty line. Those close to the poverty line will drop to the poverty line, and the poverty condition of the poor could worsen, dropping significantly below the poverty line.

impoverishment impact of OOP is 3.9 percent. It means that poverty increased from 25 percent to 28.9 percent due to OOP.

However, inequities persist in the physical distribution of health facilities in Nepal. In the Himal (Mountain) region, only 17 percent of the population can reach hospitals or primary health care centers within one hour, while in the Hilli and Terai regions, 42 percent and 44 percent, respectively, can do so. Levels of inequity are not so high in access to very basic services offered by health posts and primary health care outreach clinics. However, because access to more complex health units is more unequal, the proportions of live births in health facilities or attended by skilled professionals are more than twofold higher in the richest income quintile than in the poorest quintile.

Allocative and technical efficiency in health funding. Upon analyzing if the right share of the budget funds has been dedicated to the right share of the health problems (allocative efficiency), recent health budgets show that the country is underestimating the need to allocate more funding to noncommunicable diseases, which are increasing faster in the country. Regarding technical efficiency, recent studies on 32 hospitals in Nepal found that productivity increased in only 12, while it declined in the other 20 hospitals. However, more specific studies need to be carried out to address the current levels of technical efficiency in health services delivery, identifying the reasons and need to design proper solutions to improve the provision of health services.

Other problems affecting the quality of health spending. In the new federal structure, studies about potential inefficiencies in procurement processes at the local government level due to lack of economies of scale, expertise, funding, and staff need to assure a better quality of spending. In addition, it is important to avoid prioritizing expensive curative services instead of primary care services, which serve the poor best.

There are systemic gaps in transparency and accountability in many health processes related to governance, financing, service delivery, health workforce, health information systems, and medical and pharmaceutical supply. Most of health services' managers are not aware of the national health strategies, and there is some absence of clear guidelines, local support, follow-up mechanisms, and information systems at the health facilities level to align budget allocations, service delivery, and outcomes achievement. Regarding medical and pharmaceutical supply, it is important to carefully review which procurement processes will be decentralized to local levels and which must be centralized to increase efficiency and economies of scale.

Final Remarks

Challenges and opportunities on the fiscal space for health financing in Nepal. In the coming years, the fiscal space for health financing in Nepal should benefit from economic growth, increased household incomes, and Government fiscal revenues, allowing more spending for the population's health needs if priority to health is given by all three tiers of the government. Pressures to improve the country's fiscal balance could limit the possibilities to increase health spending in the coming years. However, the 2015 Constitution commitments to UHC could lead the Government to reprioritize health in the national budget system. This document shows that two big reforms—the health federalism and the new national HI—will pose some health financing opportunities.

Local and provincial governments need to plan mechanisms for collecting revenues and pooling funds, beyond the central transfers, and they need to increase their ability to elaborate and implement health

budgets. Better coordination among the three levels of government will be necessary to avoid duplication and to build common capacities and oversight mechanisms to monitor budgets and spending on health. Additionally, prioritization of health is essential in the overall budget of all three tiers of government to ensure a substantial increase in public health spending. New mechanisms and options to structure and purchase health services need to be planned, keeping in mind the issues of efficiency, economies of scale, and affordability among the three levels of government.

The 2017 Health Insurance Act has made enrollment mandatory for all citizens, posing the challenge of how to unify enrollment mechanisms to avoid duplication and how to finance a BHCP for the entire population. Nepal is moving in the direction of a mix of tax-based and prepayment contribution-based financing system. Both financing mechanisms need to be adjusted and merged in the context of the transition to the federal system, because currently there is overlap between funding strategies, such as free basic health care and health insurance subsidies. The Government needs to clarify what funds-pooling mechanisms will be in place (especially, considering the public subsidies) and what services-purchasing mechanisms the national HI will adopt.

Managing these complex structures should require new interoperable and transparent information systems, allowing the systematic production of financial and performance reporting on fiscal funds and expenditures statements. Current information systems, such as the Health Management Information System (HMIS), Health Information System (known as 'HIS') assessment tools database, and the Transaction Accounting and Budget Control System (TABUCS), as well as the health insurance management information systems, need to work in an interoperability environment to produce valuable information for analytical purposes and decision making. Structured data from interoperable health information systems will allow efficiency improvements, such as the use of payments for performance- and results-based financing mechanisms, which the new health financing strategy and its purchasing mechanisms for goods and services should foster. Costing systems need to be implemented in health facilities to improve efficiency, and rationing mechanisms need to be introduced to allow the efficient use of funds and the formulation of the budget on realistic bases.

1. Context and Objectives

This document is a situational analysis of Nepal's health financing system. It discusses Nepal's key health financing issues, raising questions about how the current mechanisms for collecting revenues, funds-pooling, and services-purchasing are structured and how aligned they are with the two main reforms that arise in the health system in Nepal: the new federal structure and the new social (national) health insurance. The understanding of these aspects is essential to formulate the country's 2020 Health Financing Strategy (HFS). The document is focused on the financial challenges that could block the path to universal health coverage (UHC), contributing detailed insights about the rationale for and performance of the existing health financing schemes.

According to the World Health Organization (WHO) and all the United Nations member states, achieving UHC brings three sets of benefits: (a) improving health outcomes and reducing health inequalities, (b) being responsive to people's expectations, and (c) ensuring fairness of financing. Achieving the third goal requires the provision of (a) financial protection for citizens through existing or new health financing schemes and (b) quality services for the overall population, positively affecting health status and ensuring coverage, equity, efficiency, transparency, and accountability in the use of public health funds.

Nepal needs to achieve UHC under recent changes in its health system: (a) the emerging federal model of governance, shifting responsibilities for health services delivery and management from a centralized structure to one in which these responsibilities are shared among the federal, provincial, and municipal levels, and (b) the implementation of the mandatory national Health Insurance (HI) that reshapes the previous pre-payment schemes in an equitable and sustainable way.

In addition to these changes, Nepal needs to address old challenges, such as raising enough resources to deliver quality health services and provide financial protection from catastrophic health care costs through explicit policies applied to the three major health financing functions: collecting revenues, pooling risks, and purchasing health goods and services.

This report addresses the overall situation of health care financing in Nepal. Section 2 analyzes the determinants of health financing policy: the macroeconomic and fiscal context, federalism, and the new Health Insurance (HI), and their impacts on financial management schemes. Section 3 provides a brief analysis of health expenditure in Nepal, situating the country in the international scenario and discussing internal trends in the health financing aggregates. Section 4 reviews existing health financing arrangements in the country and discusses their strengths and challenges. Section 5 analyzes the impact of existing health financing arrangements on financial protection, equity in health financing and service delivery, efficiency and quality, and transparency in and accountability for health spending. The last section discusses additional issues to be tackled and presents some possible future directions to be considered in the design of the HFS.

In September 2018, the Government of Nepal established a Technical Working Group and the Task Force under the Policy and Planning Division of the Ministry of Health and Population (MOHP) to prepare the HFS. The next step will be the creation of the HFS Steering Committee, which will decide on the Technical Working Committee's proposals regarding the contents and directions of the HFS.

The Government of Nepal asked its development partners for support in preparing and implementing the HFS. In response, a task team, led by the World Bank and including the WHO and the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit, GIZ*), prepared this

document. This document was based on a primary report elaborated by Dr. Shiva Adhikari (Health Economist and World Bank consultant). Other material produced by the World Bank, WHO, and GIZ⁵ was also included as a part of the information used for this document.

The preparation of this document followed the guidelines for the situational diagnosis of health financing by international organizations and specialists in health care financing. However, it was adapted to the conditions and constraints of Nepal's health system. This final version was presented and approved in the Health Financing Strategy Technical Working Group meeting of the MoHP in June 6, 2019.

⁵ The development partners group in charge of preparing this report comprised the following members: Andre Medici, Kari Hurt, and Manav Bhattarai (World Bank); Roshan Karn (WHO); and Bikesh Bajracharya and Roland Panea (GIZ). The group also involved Shiva Adhikari and Mamata Ghimire, World Bank consultants. This document is a product of the ASA P166804 - Health Financing Strategy, supported by the Policy and Human Resource Development (PHRD) funds of Japan.

2. Determinants of Health Financing Policy in Nepal

Main Messages

Two comprehensive reforms are the drivers of Nepal's future health financing system: (a) the emerging federal model of governance, shifting responsibilities for health services delivery and management from a centralized structure to one in which the responsibilities are shared by the federal, provincial, and municipal levels, and (b) the implementation of a national Health Insurance (HI) that replaces and reshapes the previous prepayment schemes in an equitable and sustainable way.

On the macroeconomic side, in the next three years, Nepal can use the dividends of economic growth to increase public tax-based funding to subsidize health premiums to the poor. Potential poverty reduction and formal labor market growth could increase domestic funding to premium payments for the new national HI.

However, Nepal's health policy lacks major definitions regarding some crucial aspects of health financing: redefining and costing a national unified health basic package; consolidating efficient mechanisms for pooling funds; increasing the ability of provincial and local governments to elaborate and implement health budgets; defining policies and guidelines for efficient public financial management (PFM) and procurement mechanisms; consolidating financial protection mechanisms to avoid catastrophic spending; and creating sound health information systems, including health financing data, to improve monitoring and evaluation processes and ensure better health outcomes. Some of these subjects has been discussed but are in the preliminary stage of formulation and need better definitions, capacity building, and financial and human resources to be implemented.

Nepal is moving in the direction of a mix of tax-based financing and prepayment mechanisms, but the processes to enroll beneficiaries are not yet well defined and coordinated. Both financing mechanisms need to be adjusted in the context of federal system because currently there are overlaps among beneficiaries, potential premium revenues, and subsidies. Before implementing the proposed new insurance mechanisms, it is crucial to make a comprehensive assessment of the existing health insurance schemes in the country.

2.1 - Macroeconomic and fiscal contexts

Since 2006, after the end of a 10-year conflict costing thousands of lives, Nepal recovered its economic growth and established a new Constitution (2015) that set-in place a federal structure and national elections in 2017 and 2018 for all levels of government. After the elections, the new Government enjoys a historic majority in Parliament, and there are great expectations of stability for the coming years.

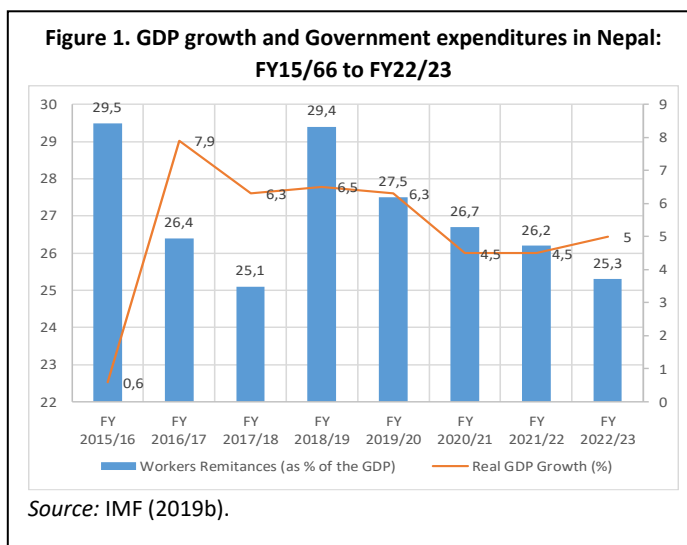
The move to federalism poses several opportunities and challenges: designing the new functions and roles of the Central Government plus seven new states and 753 local governments, delivering basic and social services, and developing infrastructure for public functions and private initiatives. Aspirations are high for the development benefits expected from the decentralization—more effective and accountable service delivery. However, the risks of jurisdictional overlap among the three tiers of government, lack of clarity

and coherence between policies and devolved powers, and duplication of efforts may remain high during the coming years.

In these circumstances, macroeconomics has a crucial role in increasing fiscal space for health. For Nepal, it should be associated with (a) the past and future perspectives for economic growth; (b) trends in poverty reduction and increase in the formal labor market, which could increase families' ability to pay for the HI premiums; and (c) trends in public finances.

Perspectives for economic growth

Over the past decade, Nepal's economy has performed reasonably well. Growth averaged 4.7 percent (at market prices) over 2008–2018, and inflation was in the single digits for most of the past decade. However, the devastating earthquakes in 2015, followed by trade disruptions, affected the entire economy, and real GDP growth in FY2015/16 was only 0.6 percent. Over FY2016/17 and FY2017/18, the economy recovered, with an average GDP growth of 7.9 percent and 6.3 percent, respectively (see Figure 1). According to the International Monetary Fund (IMF), the economy is expected to grow at 6.5 percent and 6.3 percent, respectively, for the next two fiscal years. Faster GDP growth could expand the Government's fiscal space, opening room for investments and scaled-up health interventions. However, after FY2020/21 the economic growth will be expected to slow down slightly to around 4.5 percent to 5 percent until FY2022/23.



Poverty and workers' remittances

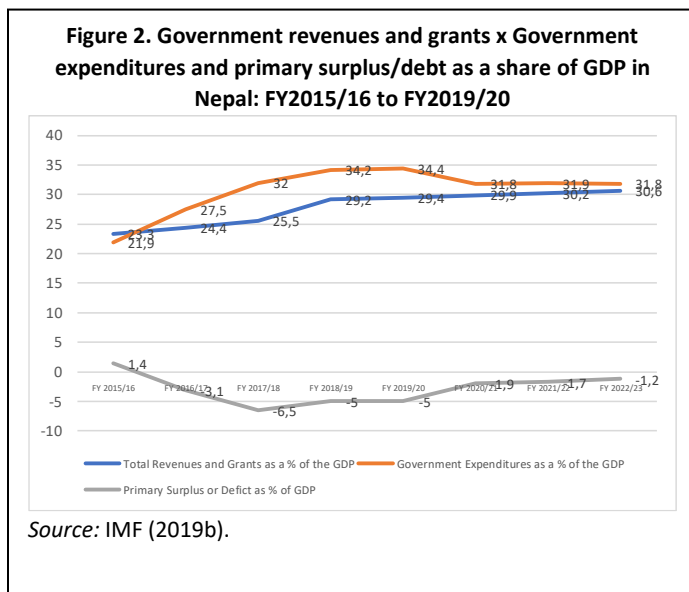
From 2011 to 2017, the poverty headcount ratio (at the international poverty line of US\$1.90 per day) is estimated to have fallen from 15 percent to 10 percent. Using a higher poverty line (US\$3.20 per day), the poverty headcount is estimated to have fallen from 51 percent in 2011 to 43 percent in 2017, indicating a reduction in vulnerability. However, these gains remain vulnerable to shocks and setbacks; indeed, according to the 2014 Multidimension Poverty Index, about 29 percent of Nepal's population is multidimensionally poor.

Workers' remittances as a share of GDP are very high in Nepal, when compared with other countries in the South Asia Region. In FY2015/16, workers' remittances represented almost 30 percent of GDP, but this percentage has declined in the last couple of years as lower oil prices have affected economic prospects in countries with large Nepalese migrant populations. The IMF projects a decrease of remittances as a share of the GDP over the next four fiscal years. The potential use of remittances to fund family expenses for the new national HI premiums is high, but this window of opportunity appears to be narrowing.

Public finances

Fiscal space depends on the size of the fiscal envelope or the size of the public space in the economy. As the size of public revenues in Nepal (government revenues and grants) increased from 23 percent to 29 percent of the GDP between FY2015/16 and FY2018/19, the country moved from a low-medium to a medium fiscal envelope situation.⁶

Fiscal balances remained sustainable because of strong revenue growth and modest spending. Both public revenues (mostly from taxes and grants) and public expenditures have increased as a share of GDP since 2015 (see Figure 2). Public finances were balanced in FY2015/16, with a small budget surplus of 1.4 percent of GDP.



However, in the last two fiscal years, public spending increased faster than public revenues because of the need to help earthquake victims and to finance investments to recover infrastructure damaged by the earthquakes. Additionally, recent reforms and the transition to federalism increased spending by 4 percentage points between FY2017/18 and FY2018/19 (when fiscal transfers to subnational governments came into effect). This has been causing an increasing public budget deficit. The IMF projects a progressive reduction of the primary public debt until FY2022/23, induced by an expected reduction in public spending and increase in public revenues.

According to the IMF's projections, revenues of subnational governments (provinces and local) will reach an average of 14.4 percent of GDP from FY2019/20 to 2020–24. Most of these revenues (8.2 percent of GDP) will be based on transfers from the Central Government. The other component (6.2 percent of GDP) is expected to be made up by the subnational governments' revenue collection.

Many countries have financed their expansion of health spending under deficit conditions, but this depends both on social preferences and on how the government has prioritized health. The expected reduction of public spending from FY2021/22 to FY2022/23 could constrain the expansion of fiscal space for health with domestic funding and grants. However, the use of international loans could be an opportunity to invest in health, supplying the need for more resources to implement the social policies required by federalism.

⁶ Fiscal envelope, or the overall level of government spending, depends on the relationship between government spending and GDP ratio. According to McIntyre and Kutzin (2016), a suggested "rule of thumb" is that a relationship lower than 15 percent reflects very low fiscal capacity; 15–20 percent is low; 20–25 percent is low to medium; 25–35 percent is medium; 35–45 percent is medium to high; and more than 45 percent is very high.

Summary

The macroeconomic conditions to increase fiscal space for health in Nepal have several positive aspects.

- (a) Even accounting for a slight slowdown to 4.5–5 percent in the coming years, there is fresh opportunity to use the dividends of economic growth—such as household income and Government fiscal revenues—to increase the domestic funding to meet health spending needs.
- (b) The results of poverty reduction efforts and formal labor market growth create domestic funds to increase family spending on health, especially by committing premium payments for the national HI, even in partially subsidized schemes.
- (c) Remittances are an additional possibility for financing health spending for families that have the ability to pay, although this source is likely to decrease in the next years. These trends—poverty reduction, formal labor market growth and a high level of remittances—could offer an opportunity to target public funding for the share of the population without the ability to pay premiums for the national HI.
- (d) Pressures to improve the fiscal balance could limit the possibilities for increasing health spending in the coming years. However, the 2015 Constitution’s commitments to UHC could lead the Government to reprioritize health as one of the top budget priorities.

2.2 - The new federalism: opportunities and impact on health governance

The new federalism

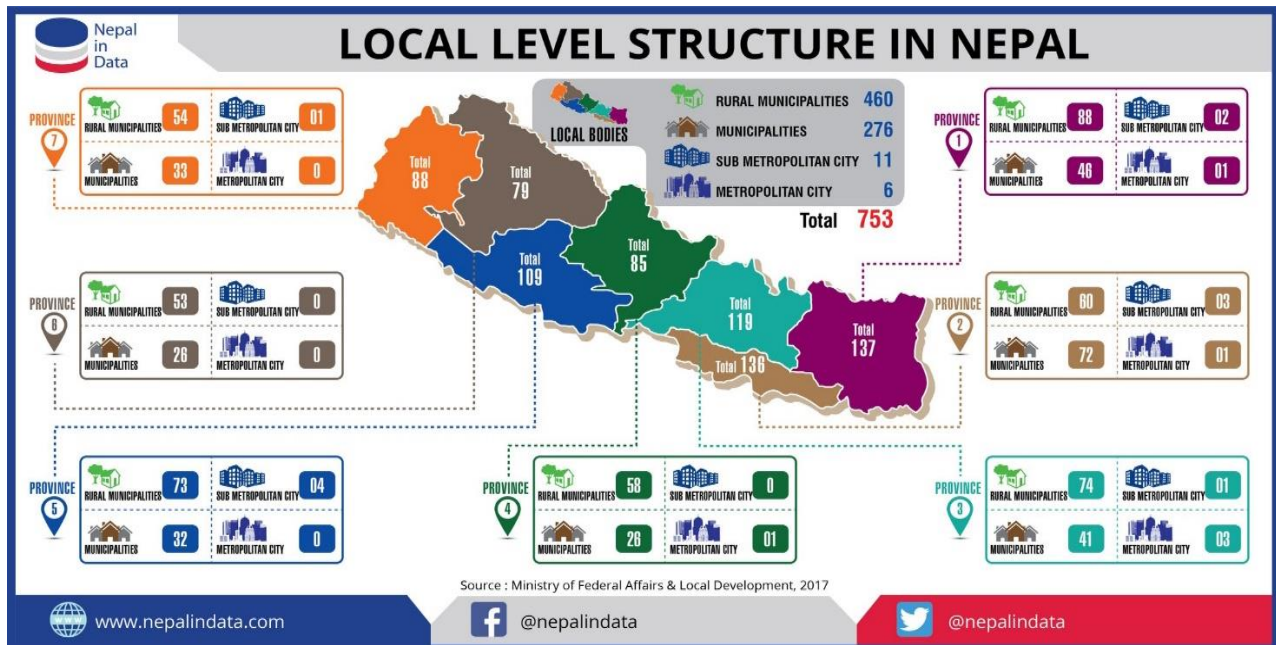
The way that the Government is organized is an important factor that influences the attainment of the UHC goals, especially the political-administrative structure, the extent of decentralization within the Government, and the decision-making authority held at different levels (McIntyre and Kutzin 2016).

In the past decade, Nepal’s Congress agreed to move the country from its unitary government system to a federal system. Accordingly, Nepal’s 2015 Constitution established a three-tier federal structure, restructuring the nation into 753 local governments (composed of 460 rural municipalities, 276 municipalities, 11 sub-metropolitan cities, and 6 metropolitan cities); 7 provincial governments; and 1 Central Government (see Figure 3).

The Constitution makes clear that these three levels of government are not hierarchically related, and their relationships should be based on the principles of coexistence, cooperation, and coordination. Before setting up the legislative and regulatory framework for these new powers, competences, and fiscal resources, the Government faced several rounds of local government elections—a process that ended in early 2018.

The main motivation for the new federal governance framework was the common sense that decentralization brings public services closer to the citizens and can increase the average person’s participation in prioritizing the way such services are delivered. This has the potential to improve overall accountability and give greater voice to the users of services, especially the poor and vulnerable.

Figure 3. Map of the new federal governance structure in Nepal



Source: Nepalindata, based on information from the Ministry of Federal Affairs and Local Development, 2017.

Impacts on the health system

Under the new federal structure, 753 local governments took over the management of the basic public health services that were previously the responsibility of 77 districts. The country's public health facilities include 123 public hospitals (75 former district hospitals), 204 rural health and community centers, 329 urban health centers, and 3,808 health posts.⁷ Because many municipalities do not have hospitals, the former district hospitals serve the population of several municipalities.

Most of the previous health sector administrative structure was at the district level, where there were some staff in charge of PFM and procurement. After the implementation of the federal structure, these functions are transferred to local governments, many of which lack the expertise to implement these functions—a deficit that may affect the procurement of drugs, the elaboration and implementation of budget allocations, and the conditions to pay health staff.

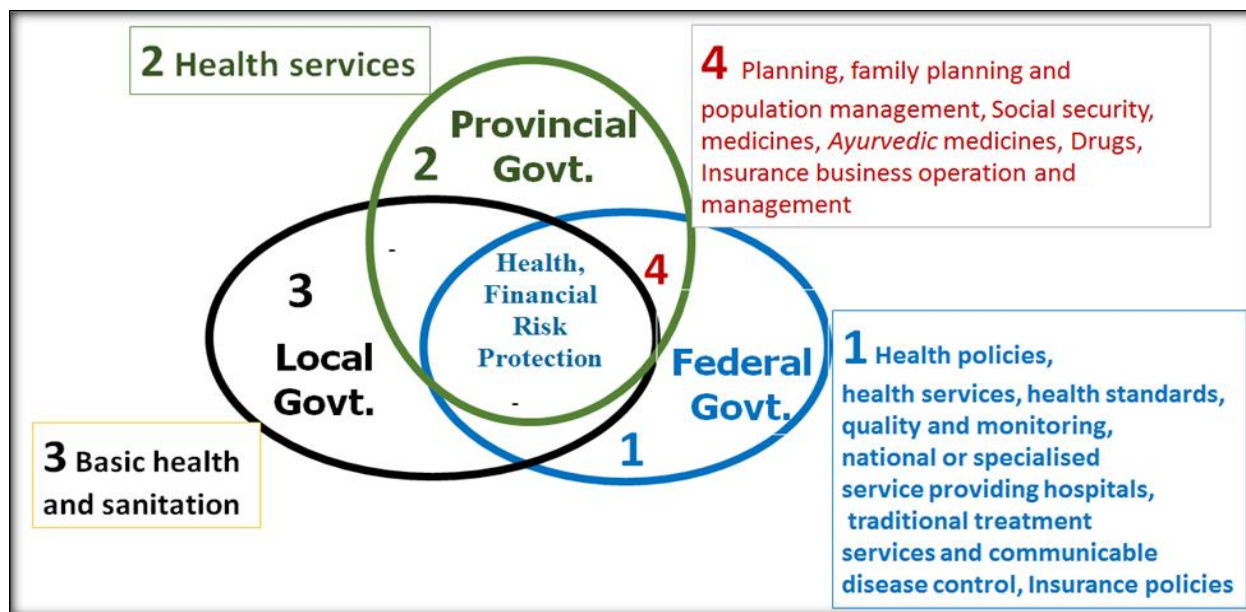
The implementation of the federal structure required new mechanisms to transfer central funds as grants to provinces and municipalities. However, these transfers are not enough to pay administrative costs and staff salaries and cover the costs of the new basic health care functions.

Figure 4 shows that, at the federal level, new roles in the health sector include the formulation and regulation of health policies (services, standards, health insurance, and quality and monitoring), provision of services at tertiary care hospitals, traditional treatments, and communicable disease control. At the

⁷ The public system also includes 12,180 primary health care outreach clinics to provide family planning, child health, and safe motherhood services closer to rural households, extending services provided by the primary health care centers and health posts. In addition, there are 16,022 immunization clinics supported by 49,000 female community health volunteers. Nepal also has 1,715 nonpublic health facilities that are contracted as providers to the public system (Adhikari 2019).

provincial level, new roles include the provision of secondary health services. The provision of basic health and sanitation was transferred to the municipalities.

Figure 4. Nepal: Health-related functions of three levels of government



Source: Adhikari 2019.

There is little assessment of the details of the functions shared among the three levels of government.⁸ The provincial and federal governments share functions such as family planning and population management, drugs supply, and health insurance enrollment and management.

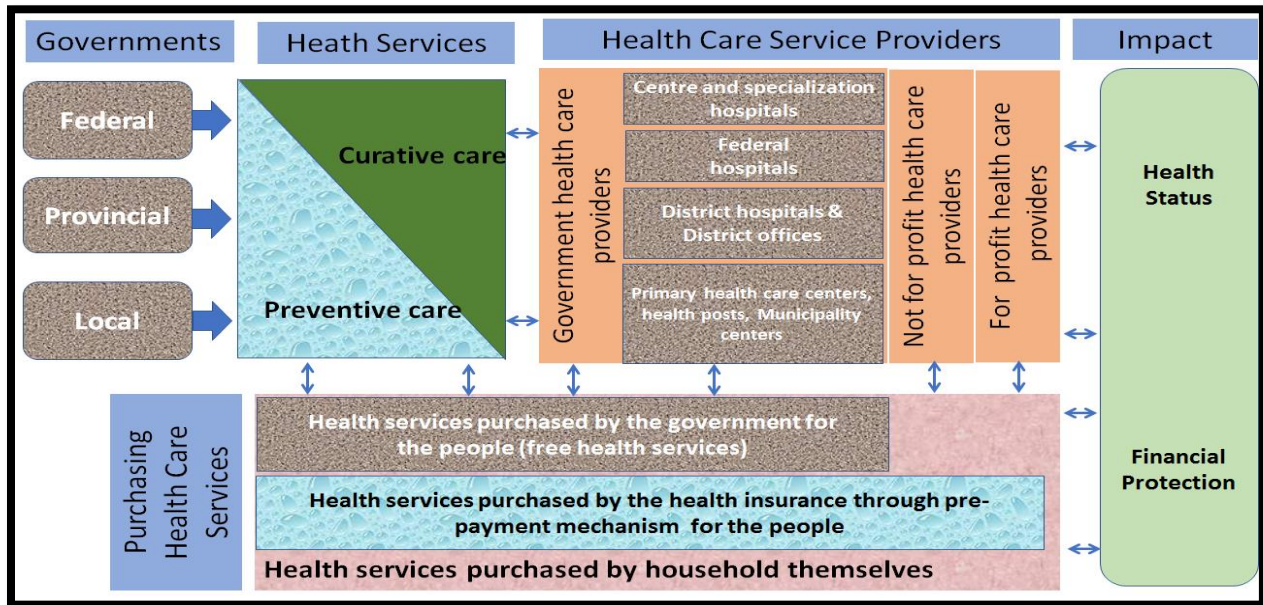
There is lack of clarity about how health functions should be shared between the local and provincial governments as much depends on the size and complexity of the specific municipality. Big municipalities such as Kathmandu can probably manage more complex health services, but small municipalities need to count on provincial governments to provide more complex services.

Before the federal system was implemented, regulations and new programs were established under which primary health care centers, health posts, and sub-health posts would provide health care services and essential medicines free of charge to all.⁹ Since 2013, a redefined basic health care package (BHCP) has formally been the foundation of an integrated health care system, including not only curative but also preventive services, such as immunization, clinical services, newborn care, maternal care, and nutrition. However, the delivery and coverage of this package are still very limited.

⁸ Appendix 1 of this document lists the distribution of functions and competences in health among the levels of government, defined by the Functional Unbundling Report, in Sharma, S.P., 2015.

⁹ These provisions include all types of services, such as health promotion, immunization, nutrition, family planning, disease prevention, and curative services with listed essential drugs for poor people at district hospitals.

Figure 5. New roles of the three levels of government in health provision



Source: Adhikari 2019.

Figure 5 shows the new roles of the three levels of governments in health provision, which will require more integrated processes for purchasing and delivering health services. Currently, there is neither a clear agreement on health services delivery between the provincial and local governments nor a clear path for integrated care among different health facilities. District hospitals and district offices will be transferred to regions or municipalities, depending on the size and complexity of local governments, according to future agreements. Such agreements, which are crucial to improve quality and efficiency in delivering health services, should include cross-payments mechanisms and compensations between these levels/facilities to make the provision of health services sustainable.

Before the federal system was introduced, the governance of the health system was defined on a top-down basis. Now, it is mostly bottom-up, agreed/co-managed among the three levels of government. Thus, coordination is the key to make the new federalism arrangements work. Because all levels lack experience with this system and clarity has not yet been reached on concurrent functions, it would be important to develop further agreements and allow for a long transitional period to study international experience, analyze the local context, and conduct policy dialogues.

Challenges to strengthening health financing

Several challenges need to be addressed to strengthen the health financing framework under the new federalism:

- (a) **Basic health packages.** The BHCP was set out in 2013 and has been implemented along the last years, but it needs to be revised and harmonized with other existing government initiatives. It also needs to be analyzed by defining how it will be costed and financed. In addition, it is necessary to create local capacity to deliver it efficiently, including referral mechanisms to tertiary and super-specialty hospitals funded by the public sector.

- (b) **Pooling funds.** Subnational (local and provincial) governments need to structure their sources and mechanisms for pooling funds. It is necessary to have instruments to include other resources beyond the central transfers, such as local taxes, services revenues, grants and donations, and eventually lending resources, in integrated funding mechanisms that will be easy to match with local and regional needs.
- (c) **Budget allocation and implementation.** Local and provincial governments need greater ability to efficiently elaborate and implement health budgets according to their needs. This implies the creation of financial management and procurement arrangements that could expedite the use of funds and avoid having unspent resources left at the end of the fiscal year.
- (d) **Integrated health financing plans.** New integrated planning tools are needed at the three levels of government to define resource needs, improve the use of grants and local revenues, and build local capacity to monitor budgets and health spending.¹⁰
- (e) **Purchasing goods and services.** It is necessary to define and identify the options to provide and purchase health services and provider payment mechanisms, considering the issues of efficiency, economy of scale, and affordability.
- (f) **Equity and financial protection.** Nepal should develop a health financing road map for expanding financial protection to the poor and other vulnerable groups and improving access to health services so that citizens will not suffer from regional/local/financial inequities.
- (g) **Health information systems.** Nepal needs to create interoperable data systems for strengthening information management, governance, and accountability in the use of public funds.

Besides all these challenges, the transition to federalism is still ongoing, and the rules that govern the processes of public sector budget formation, distribution, financial control, and expenditure reporting are still not completed or implemented. The definition of these PFM rules, as well as the roles, responsibilities, and relative power of different actors in the budget decision-making process at all three levels of government, could have important implications for UHC.

2.3 - The new national Health Insurance and other insurance schemes

Nepal has a history of implementing health insurance, but never has more than a small portion of the population participated in these schemes. Some two decades ago, community-based health insurance (CBHI) was provided in the informal sector on a voluntary basis. These schemes provided health insurance to farmers, agricultural workers, people from low-income groups, and wage earners.¹¹ Some medical institutions such as BP Koirala Health Science, Patan Hospital, and Model Hospital also implemented insurance schemes in some rural areas.

Government-funded CBHI schemes were implemented through primary health care centers in six locations: Mangalbare (Morang District), Dumkauli (Nawal Parashi District), Tikapur (Kailali District),

¹⁰ Development partners, such as U.K. Department for International Development (DFID), are helping the MOHP define instruments for medium-term planning in the health sector. In 2019, the MOHP, with the contribution of DFID, prepared a draft document about Guidelines for Preparation of Business Plan for Health Sector.

¹¹ An interesting analysis comparing the public and private CBHI existing before 2013 in Nepal can be found in Ranabhat et al. (2017).

Lamahi (Dang District), Chadranigahapur (Rautahat District), and Katari (Udayapur District). The premium rates were determined by the living standards and the frequency of illness in these locations. The Government subsidized the premiums for poor people. The CBHI covered 28 village development committees throughout the country and almost 6 percent of households in Nepal. After the introduction of universal free health programs below the district level, the CBHI is close to being discontinued. The CBHI is still running in five primary health care centers (PHCC), but in Tikapur, it has been merged into the new national HI scheme.¹²

In 2013, the Government of Nepal developed the National Health Insurance Policy, a key document to guide health insurance in the country. In 2015, the Government found that important details—such as the roles of providers and purchasers—were missing from the Social Health Security Scheme (SHS) strategy and regulations and corrections were made. Based on these guidelines, in February 2015, a Social Health Security Development Committee, an autonomous body outside the MOHP, was formed as a legal cabinet to start implementing the SHS. The SHS contributed to UHC by increasing access to, and utilization of, quality health services. The first phase of the SHS scheme was implemented in three districts—Kailali (2016), Baglung (2015), and Ilam (2016)—as a program of the MOHP.

The SHS was gradually scaled up to other districts. In FY2016/17, the system reached 15 districts as a voluntary insurance based on family contributions. Families of up to five members may contribute NPR 2,500 per year and NPR 425 per additional member. Benefits of up to NPR 50,000 per year were available for families of up to five members, with an additional NPR 10,000 coverage for each additional member and with a maximum benefit of NPR 100,000.¹³

The new National Health Insurance

In 2017, the SHS was renamed national Health Insurance (HI) as a unified scheme covering all families (formal and informal workers, including the poorest families). The Health Insurance Act of October 10, 2017, approved by the President of Nepal made it mandatory for all Nepalese citizens. Families of civil servants, formal enterprises, and employees already enrolled under the prevailing laws, and persons going abroad for foreign employment (those that send remittances) must be enrolled in the national HI. The HI contribution is prepaid by employers and employees, but a full waiver is given to poor households. The insurance covers preventive, promotive, curative, diagnostic, and ambulance services. An average of 5 percent of the total population of Nepal and 17 percent of total population of the districts that implemented health insurance are currently covered by the HI.

There is quite a difference between the rules established by the discontinued Social Health Security Development Committee about the previous SHS and the new rules proposed by the Health Insurance Board (HIB) overseeing the HI, in terms of provisions, approaches, and institutional set-up. However, the HIB continued the previous approach of expanding the coverage of health insurance, focusing particularly on expanding the number of covered districts (see Table 1).

¹² The Government is still providing (in FY2018/19) NPR 1 million to each PHCC, channeled by the Health Insurance Board (HIB) to finance the CBHI in these health units.

¹³ This kind of voluntary health insurance, partially sponsored by the tax-based funding, donors, and families, could be included in the System of Health Accounts (SHA) classification under the concept of “nonprofit institutions serving households” (NPIS), and it was until 2016 the major health insurance or prepaid scheme existing in Nepal.

The Government aims to cover 60 of the former districts by July 2019 and all 77 former districts by July 2020, although the mechanisms to register citizens in health insurance are not clearly defined.¹⁴ The country still faces other related problems, such as the low registration to get a national identity or civil registration number, which requires logistics and dissemination of information technology equipment and skills in all municipalities.

Table 1. Geographic coverage of health insurance¹⁵

Fiscal years	Former districts covered additionally in each year	Number
2016–2017	Kailali, Baglung and Ilam, Baitadi, Achham, Palpa, Kaski, Myagdi	8
2017–2018	Bhaktapur, Chitwan, Tanahun, Jumla, Gorkha, Makwanpur, Jajarkot, Bardiya, Surkhet, Sindhulim Rolpa, Jhapa, Sunsari, Solukhambhu, Bhojpur, Khotang, Ramechhap	17
2018–2019	Mahottari, Pyuthan, Arghakhanchi, East Rukum, West Rukum, Rautahat, Bajura, Kapilvastu, Bajhang, Parsa, Kalikot, Mugu, Humla, Dolpa, Siraha, Syangja, Sankhuwasabha, Darhcula, Kanchanpur, Banke	17
Total	42 out of 77 former districts in Nepal	

Source: HIB Database, March 2019.

As of mid-March 2019, a total of 1,665,276 individuals (301,475 households)¹⁶ have been enrolled in HI, and as of December 2018, the service had been utilized 418,518 times. According to the HIB, the HI is covering 12.83 percent of Nepalese households; however, going by total population estimations for 2018,¹⁷ the HI reached only 5.6 percent of the Nepalese population in 2018. In the initial efforts in implementing the HI, the HIB did not cover all the formal sector. HI rules and regulations—although they were finalized on the basis of the Health Insurance Act of 2017—were published only at the end of March 2019.

Contributions for the HI were defined and approved by the Nepalese Parliament in 2017 and must be deposited in the HIB’s Health Insurance Fund. This fund is also financed from general taxes transferred by the MOF in the form of annual block grants to subsidize poor householders’ premiums. The HIB will purchase services from public and private providers (contracted) on behalf of enrolled members, and public providers are the first point of contact. Most payments are on a fee-for-service basis, but there are some other schemes such as case-based payments and capitation. For example, capitation is used for outpatient services’ package as NPR 200 for primary health care centers and NPR 400 for referral hospitals. Fee-for-services are not included in the outpatient services’ package. Case-based payments are used for inpatient services.

Other health insurances

The HI is the main Government initiative to create a unified health insurance policy for the Nepalese population. However, there are at least two other public health insurance schemes that could challenge this effort toward a unified health insurance in Nepal—health insurance by the Social Security Fund (SSF)

¹⁴ Current regulation defines that the citizens enrollment in the HI should be done by three mechanisms: (a) by enrollment assistants, (b) and (c) by visiting enrollment assistant once in a week at the municipal level.

¹⁵ Despite the fact that the HI was still implemented in 42 of the 77 former districts, only 36 of these former districts offered services provision to the enrolled beneficiaries.

¹⁶ Some of these individuals are registered but are not active members. This figure also includes those members who did not renew the HI policy as well.

¹⁷ Nepal’s population in 2017 was estimated at 29,504,663 inhabitants.

under the Ministry of Labor, Employment and Social Security (MOLESS),¹⁸ and health insurance by the Employees Provident Fund (EPF), under the MOF.¹⁹

The SSF—not yet implemented—was created under the Social Security Act 2017 and its contributions were defined by the Social Security Regulations and Operational Guidelines issued in 2018. The SSF finances several social security policies to the formal and informal sectors, including medical and health protection, maternity protection, accident protection, old-age protection, dependent family protection, and unemployment protection.

The SSF resources come mostly from employers' and employees' contributions.²⁰ Subsidies for the provident fund and financial incentives for the poor employees are deposited in the National Level Welfare Fund from resources collected as a social security tax and from donations and grants from local or foreign governments and loans, among other sources.

Although the SSF's provisions have not yet taken effect, its medical and health protection could overlap the health coverage offered by the HI. This overlap needs to be addressed as a matter of coordination. It is not clear whether the SSF will take over the financing of the HI, its funding mechanisms, and the arrangements for purchasing health services, or whether the HI will be responsible for these functions and the SSF will erase health and medical insurance from its functions.

The other health insurance scheme in Nepal that risks duplication with the HI is the health insurance by the EPF. This is a 'private-like' insurance scheme owned by a government agency called Rastriya Beema Company Limited, based on the Contributors Social Security Program 2018. The beneficiaries are employees and families from both public and private sector enterprises that contribute to the EPF (about 525,000 insured persons²¹). The EPF is financed by premiums paid by employees (for the public sector) and by employers (for companies with 10 or more employees).

The EPF pays a negotiated amount of the premium to Rastriya Beema Company Limited on behalf of its members/contributors for pooling and purchasing the services of public and private hospitals for specific benefits and diseases (up to NPR 100,000) or high-cost interventions (up to NPR 1,000,000) required by specific medical conditions, such as heart attack, kidney failure, cancer, Alzheimer's disease, Parkinson's disease, head injury, spinal injury, sickle cell anemia, and liver damage. The existence of this kind of insurance is not incompatible with the national HI, but some coordination is needed to avoid duplication

¹⁸ The SSF was established in June 2011, but it has not been able to exercise all its functions because of weak coordination among agencies, poor information management systems, and a lack of institutional capacity.

¹⁹ In addition to these two schemes, some of the national banks have introduced health insurance schemes for their clients (depositors and borrowers) without additional charge. It seems that such health insurance schemes are introduced very aggressively in the market, targeting the high-income groups of the formal sector.

²⁰ According to a study in which the International Labour Organization analyzed the payroll of 50,000 workers and employees in Nepal, the total payroll contributions were on average 8.2 percent in 2015, divided among maternity care facilities (0.4 percent), illness facilities (0.4 percent), workplace accident (1.3 percent), medical care (3.6 percent), and unemployment facilities (2.4 percent).

²¹ Information from the EPF website last updated on October 2018: <http://web.epfnepal.com.np/>.

and ensure integration and continuity of care. Patients pay fees to partially complement the values paid by Rastriya Beema to cover the full cost of the services provided.²²

Enterprises also contribute to the health protection of their workers, paying health benefits, most of the times on a noninsurance basis. Sometimes these contributions are paid only by the companies or shared with the workers as a payroll payment.

Table 2 presents some of the characteristics of the existing medical insurances. Overlaps are everywhere. The payroll is the base for all existing and proposed voluntary and mandatory health insurances, and the beneficiaries of the proposed health insurance under the SSF are the same as some of the beneficiaries of the national HI. Nepal needs to make a comprehensive assessment of all the current health insurance mechanisms in the country to avoid overlap in the design and implementation of the new HI.

Table 2. Characteristics of health insurance schemes in Nepal and levels of overlap

Characteristics	National HI	Voluntary Private Insurance	EPF	Enterprises Private Insurance	SSF
Legal framework	Mandatory	Voluntary	Voluntary	Voluntary	Mandatory
Target population	All Nepalese citizens	Enrolled population	Formal labor market	Formal labor market	All formal and informal Nepalese workers and families
Coverage	1.7 million persons (301,500 households), 5.6 percent of Nepalese population (March 2009)	Less than 1 percent of Nepal's population	About 525,000 enrollees, according to 2018 estimations	70 percent of all employees of private enterprises in Nepal receive some health benefit, but some of them are enrolled in EPF.	No coverage (because the insurance is not implemented yet)
Sources of funds	Tax-funded from the MOHP and MOF in annual block grants and premiums collected from members	Individual premiums paid out-of-pocket (OOP)	Employees' premiums (for the public sector) and employers' and employees' premiums (for private companies with more than 10 employees)	Premiums paid by companies and employees mostly through payroll. Premiums' values and percentages vary by enterprise.	Health is part of an SSF payroll contribution of 11 percent for employees and 20 percent for employers in the formal sector. Rules for the informal sector are not defined.
Subsidies	Premiums are paid by the Government for disadvantaged	No defined subsidies	No defined subsidies	No defined subsidies	The poor will receive subsidies, but the

²² Most of experiences of health reform seeking to achieve UHC search for the integration of health insurance schemes. In Ghana, coverage was nil in 1995 but reached almost 50 percent 15 years later, owing to the National Health Insurance Act of 2003, and the publicly financed National Health Insurance Scheme, whose coverage began to grow in earnest in 2005. Health insurance coverage also grew in an important way in Vietnam through Vietnam Social Security, from just over 13 percent in 1995 to 59 percent in 2010. In the Philippines, official coverage by PhilHealth doubled during the period, to reach over two-thirds of the population by 2009. Colombia's Law 100, which in 1994 mandated SHI coverage for all citizens, helped increase coverage from about 50 percent when it was passed to virtually universal coverage by 2009. These are examples that could be searched by Nepal on the implementation of the national health insurance and its harmonization with other public insurances.

Characteristics	National HI	Voluntary Private Insurance	EPF	Enterprises Private Insurance	SSF
	<p>groups. Some expenses (such as free ambulance services and drugs) are paid for ultra-poor identified groups.</p> <p>Currently 3,538,000 ultra-poor are enrolled in 26 former districts</p>				mechanism is not yet specified.
Benefits or entitlements	All services enlisted under the health insurance benefit package under NPR 100,000 contracted by public and private providers	Benefit packages vary by private insurance provider.	Reimbursement inpatient care for 9 chronic diseases under NPR 100,000 and up to NPR 1 million to 9 chronic diseases	Reimbursement of lump-sum and cash advances with different limits according to the enterprise	Wide coverage, including outpatient and inpatient for surgical and medical emergencies, including maternity and drugs in public and private providers

Challenges to health financing

The main challenges associated with the current implementation of the HI are the following:

- (a) **Lack of sound mechanisms to beneficiaries' registration:** Although enrollment is mandatory under the Health Insurance Act 2017, in practice, HI affiliation is still voluntary for most of the population due to lack of incentives and processes to register the informal sector. So far, few poor people are enrolled, and the health insurance regulation was approved only in March 2019.
- (b) **Fragmented social health protection schemes within the MOHP and among other different ministries.** The existence of other public (or public-induced) health insurance mechanisms, implemented or not, has created a lot of uncertainty and risks of miscoordination in the implementation of the national HI. The main stakeholders need to negotiate and agree about unifying the public health insurance mechanisms or regulating existing health insurances to avoid duplication, inefficiencies, and problems of coverage and quality.
- (c) **Lack of a health financing strategy and unclarity of the health financing functions, responsibilities and attributions among government partners,** which implies inappropriate budget allocations and pooling mechanisms inside the health sector and between the health sector and other government sectors.
- (d) **Lack of clarity and negotiation capacity of the HIB with the MOF, donors, and the insurance population** to raise priority to the HI, weakening the capacity to get resources to finance the HI expansion.

- (e) **Lack of mechanisms to attribute responsibilities.** It is necessary to separate functions of regulation, purchasing, and services provision under the HI structure to avoid conflict of interests in the management of the system.
- (f) **Lack of mechanisms to integrate and avoid overlapping of the HI health package** with the BHCP with other packages, such as the proposed by the EPF schemes? What is the cost of the health package and how affordable is it, given the HI contributions and public subsidies for the population without ability to pay?
- (g) **Insufficiency of funding.** The contribution defined on the Social Security Act 2017 made the Government of Nepal liable for assuring the continued provision of health insurance if resources are insufficient for providing the benefits to the participants. However, actuarial risk tables are not available to determine the size of the Government liability associated with the HI.
- (h) **Lack of clarity on funds-pooling mechanisms.** There is no clarity about the funds-pooling mechanisms to be used (especially considering the public subsidies) and the service-purchasing mechanisms the HI will adopt in different circumstances.

Nepal is moving in the direction of a mix of tax-based financing and prepayment mechanisms. Both financing mechanisms need to be adjusted in the context of the federal system because of overlapping subsidies, such as free basic health care and the health insurance subsidy. Currently, programs such as the BHCP, the Action Against Malnutrition Trough Agriculture (AAMA) Program, and vertical programs run by different divisions of the MOHP.

3. Brief Analysis of Health Financing Trends in Nepal

Main Messages

Like most low-income countries, Nepal has high proportions of OOP and low proportions of public health funding in its total health expenditures although it is in a better position than other South Asia Region countries such as Afghanistan, Bangladesh, India, and Pakistan. In Nepal, the public health expenditures (PHE) per capita have increased more rapidly than in other countries in the region, but most of this increase is associated with good economic performance and the increased participation of general Government spending in the GDP. Reprioritization of health in the total Government spending had little impact on the growth in public health spending per capita.

There is a positive correlation between Nepal's increasing economic growth and the increasing share of PHE in THE. In 2016, THE accounted for 6.7 percent of GDP, from a base of 5.3 percent in 2010, and PHE grew from 0.9 percent to 1.2 percent of GDP between 2013 and 2016. However, the implementation of the UHC under the new federal system could require a faster increase in the PHE in the coming years. Low-income countries, such as Liberia and Sierra Leone, increase the PHE as a share of the GDP by 31 percent and 67 percent per year in 2013–2016, respectively.

Capital health expenditures represented almost 25 percent of total health spending in 2006, but after 2010, the relative level of health investments was substantially reduced, representing around 5 percent of THE during 2014–2016. This low level of investment could compromise the achievement of UHC.

In 2016, OOP represented 55 percent of current health expenditures (CHE), followed by PHE (19 percent), health insurance (14 percent), and external expenditures (12 percent). High OOP payments bring the risk of catastrophic health expenditures and families' impoverishment. Recent research shows that households with a higher number of children under age five and of elderly persons are more likely to incur catastrophic health expenditures in Nepal.

The Nepal health sector has been partially dependent on external aid, but this dependence appears to be declining. From 2000 to 2016, the participation of external aid in CHE fell from 21.5 percent to 11.7 percent. However, the Government should intensify its dialogue with donors to agree on how external aid could improve the support to the implementation of the UHC in the transition to federalism.

From 2000 to 2016, HIEs increased fivefold, from 7.2 percent to 14.3 percent of CHE—a significant share of this kind of health spending for a low-income country.

In 2016, the highest share of health spending in Nepal was used to purchase goods (medicines and supplies), representing 36 percent of CHE, followed by curative services (32 percent) and preventive services (18 percent).

3.1 - International comparisons

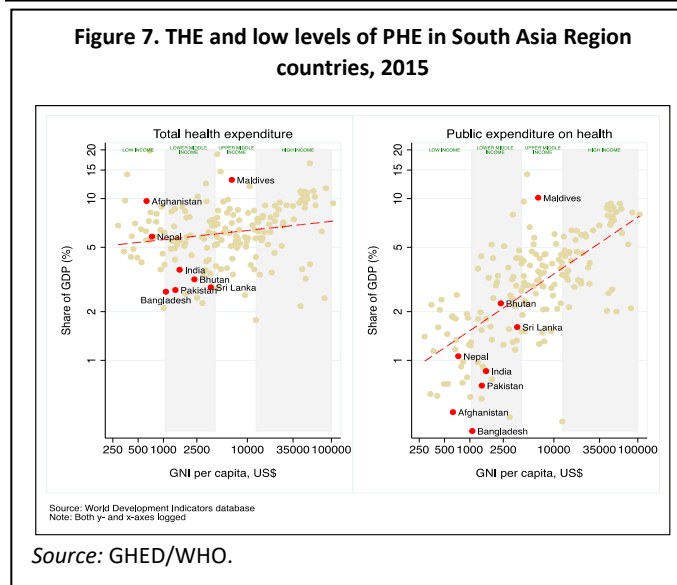
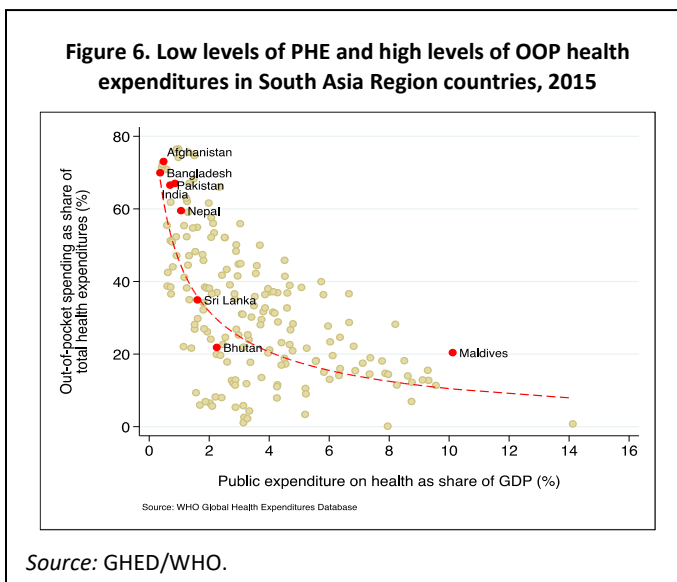
This section analyzes some variables of the national health accounts (NHA) in Nepal and other South Asia Region countries, using the Global Health Expenditures Database (GHED) of the World Health Organization (WHO). THE in any country can be defined by four components: PHE, external health expenditures (EHE), Health Insurance Expenditures (HIE), and OOP.

The international consensus is that increasing public health spending is one of the main contributors to achieving UHC, along with reducing OOP to avoid risks of catastrophic health payments and household impoverishment. Many South Asia Region countries tend to have larger proportions of OOP and low proportions of PHE as a share of GDP. As Figure 6 shows, Nepal presented this kind of profile (high OOP and low PHE) but was in a better situation than other South Asia Region countries.

Compared with other South Asia Region countries, Nepal is in an intermediate position in terms of the size of health spending. Total health spending as a share of GDP (Figure 7) is high in comparison to other South Asia Region countries with higher per capita income—Sri Lanka, Pakistan, India, and Bangladesh. Only in Afghanistan and Maldives does total health spending represent a higher share of GDP.

Nepal’s PHE is also higher than that of India, Afghanistan, Pakistan, and Bangladesh, even though some of these countries have a higher gross national income. However, PHE in Nepal represents less than 2 percent of GDP, probably because of the low priority of health in the budget allocations over the past years.

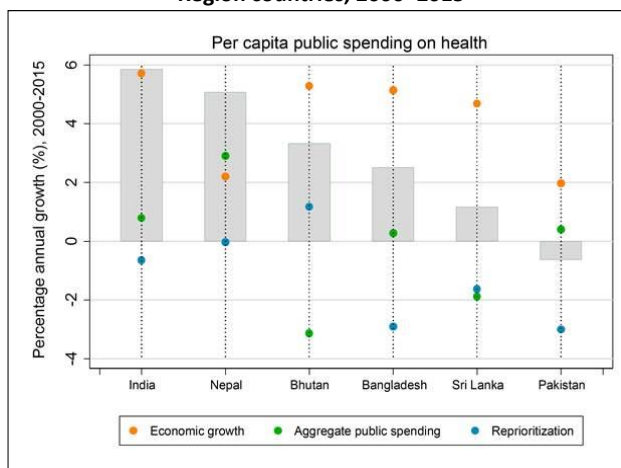
Compared with other South Asia Region countries, only Pakistan and Bangladesh have lower per capita health spending than Nepal, but this has been partially compensated for by Nepal’s rapid increase in per capita health spending, driven by the participation of the public sector in health financing. As Figure 8 shows, most of the increase in Nepal’s public health spending was due to economic growth and to increases in aggregate Government spending.



Reprioritizing health as a share of the public budget had zero effect on increasing public health spending between 2000 and 2015. However, Nepal is not alone: most South Asia Region countries (except Bhutan) also gave low priority to health spending as a share of the public budget.

Including health as a top priority in public budget allocations is one of the big challenges to be faced by health authorities and the Nepalese population to achieve UHC as promised in the 2015 Constitution and in the current health strategy. The transition to federalism makes health prioritization more complex because the sector must compete with other priority sectors disputing the public budget allocations.

Figure 8. Growth of per capita health expenditures compared with the growth of GDP per capita, public expenditures per capita, and health reprioritization in the budget in South Asia Region countries, 2000–2015

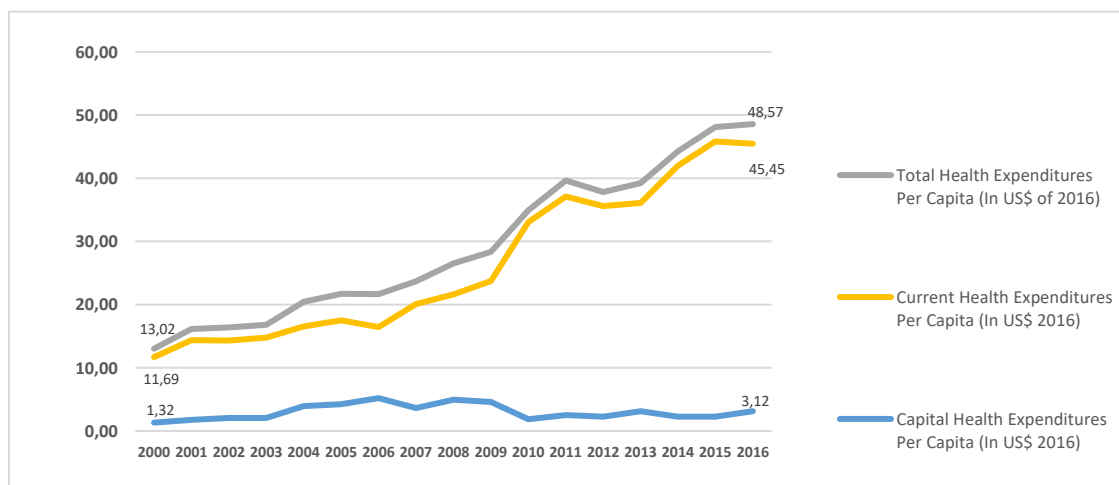


Source: GHED/WHO.

3.2 - The national context

To understand the national context of health financing, it is necessary to analyze the long-term trends of the main financing schemes for the health sector in Nepal: families (OOP); Government (public budget); health insurance (premiums paid by public, community, voluntary, and private insurances); and external funds (donors and private, bilateral, and multilateral institutions). As Figure 9 shows, since the early 2000s Nepal’s per capita THE increased almost fourfold, followed closely by the CHE. Per capita health spending grew faster after 2006, fostered by the development bonus brought by the end of the internal conflict, democratization, and economic and social reforms.

Figure 9. Total current and capital health expenditures in Nepal, 2000–2016



Source: GHED/WHO.

Capital expenditures were very important to building health facilities and equipping health units after the conflict (see Figure 10). In 2006, capital expenditures represented almost 25 percent of total health spending, but after 2010, the relative level of health investments declined substantially, representing around 5 percent of total health spending in 2014–2016.

Nepal’s implementation of health federalism will require the return of acceptable levels of health investment in both the public and private sectors, not only to refurbish and recuperate health units depreciated by use or damaged by the 2015 earthquakes but also to support the expansion of the national HI and to achieve UHC, especially in the poorest and most remote provinces and municipalities.

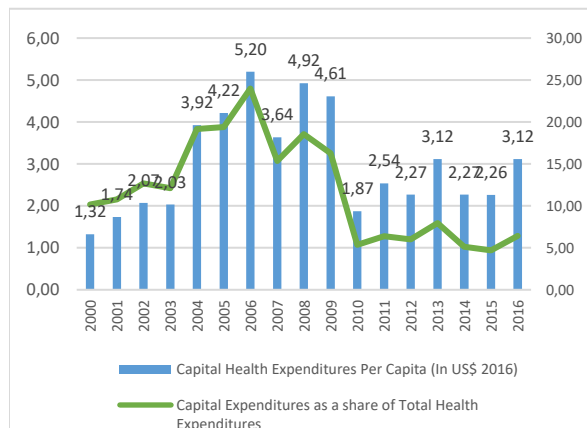
After a period of relative stagnation, Nepal’s THE as a share of GDP has grown systematically since 2010 (see Figure 11). In 2016, health expenditures represented 6.7 percent of GDP in Nepal, from a base of 5.3 percent in 2010. Deducting capital expenditures, CHE represented 6.3 percent of GDP in 2016 (equivalent to US\$1,317 million in constant 2016 dollars).

Figure 12 shows the 2016 distribution of the CHE by component: OOP, PHE, health insurance, and EHE. A complete understanding of Nepal’s health financing issues requires a detailed analysis of each of these components.

Public health expenditure

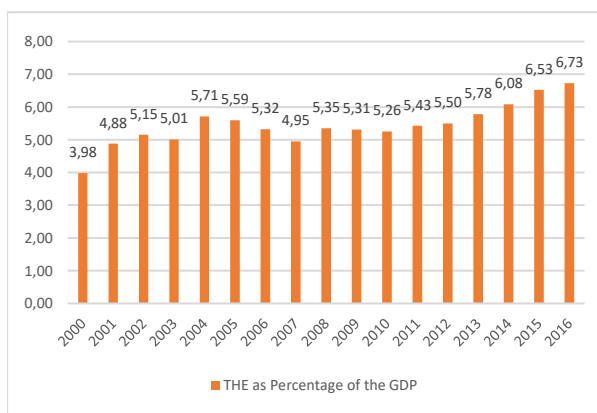
The increase in PHE in Nepal is one of the positive signals that fiscal space for health is expanding. From 2000 to 2016, PHE increased both as a share of GDP (from 0.6 percent to 1.2 percent) and as a share of general Government expenditures (from 4.2 percent to 5.3 percent) (see Figure 13).

Figure 10. Capital expenditures in health in Nepal, 2000–2016



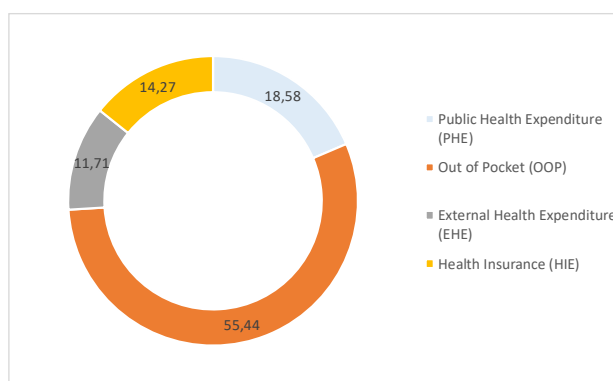
Source: GHED/WHO.

Figure 11. THE as percentage of GDP in Nepal, 2000–2016



Source: GHED/WHO.

Figure 12. Percentage distribution of THE in Nepal, by component, 2016

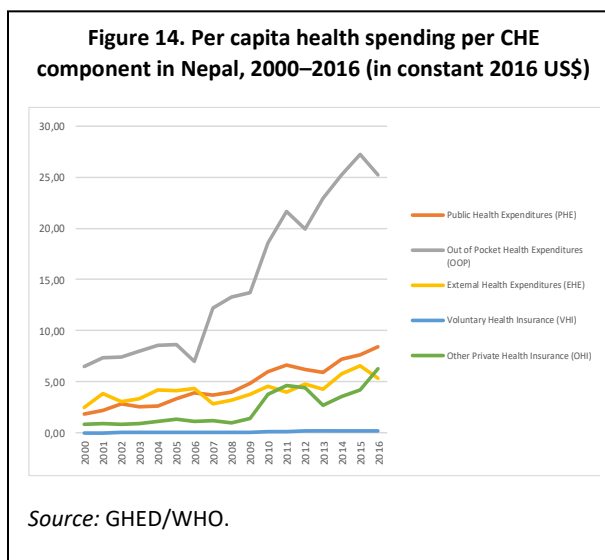
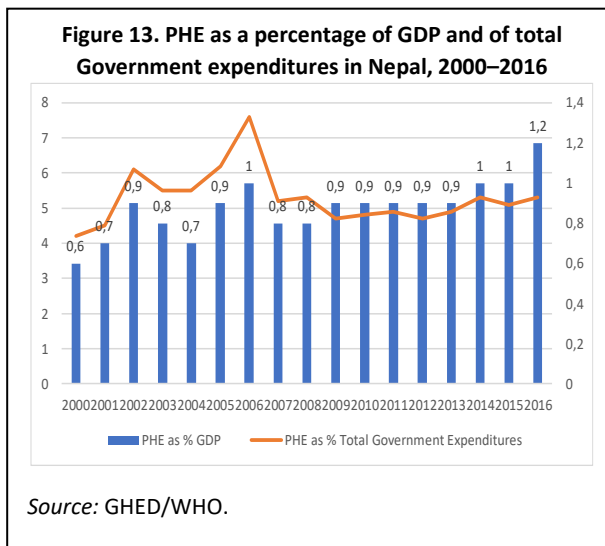


Source: GHED/WHO.

Between 2013 and 2016, PHE increased as a share of GDP (from 0.9 percent to 1.2 percent) and as a share of Government spending (from 4.9 percent to 5.3 percent). Economic growth slowed in 2015 because of the economic and social consequences of the earthquake, but in all other years—including 2016, 2017, and 2018—the economy was characterized by sparkling economic growth. In the last couple of fiscal years, public health spending also increased as a share of Government spending at all three levels of government, pushed by the local budgets and the new federal structure.

The IMF predicts good economic perspectives for Nepal over the next two years despite an expected slight reduction in economic growth from 6.3 percent (2019) to 4.5 percent (2021). There has been a positive correlation between Nepal’s economic growth and the increasing share of public health spending. However, achieving UHC under the new federal system could require a faster increase in the PHE.²³ International literature defines US\$90 as the minimum average per capita domestic government health spending needed to finance a basic package of health services in low- and middle-income countries. However, in 2016, PHE in Nepal was only US\$8.44, according the GHED data. Considering the minimum average public health spending of US\$90 to attend basic health needs in a middle- and- low income country, Nepal needs to increase PHE yearly at 18.4 percent to achieve the health SDG goals in 2030.²⁴

PHE could be the most powerful driver of positive impacts on the equity and organization of Nepal’s health systems. In Nepal, PHE per capita is progressively increasing (Figure 14), but it fluctuates as a share of CHE, indicating a faster increase of other components of health spending. In absolute terms, from 2000 to 2016, PHE per capita increased fivefold (from US\$1.81 to US\$8.44 in constant 2016 dollars), but the participation of PHE was always below 20 percent of CHE, except in 2006 (see Figure 15). However, lack of proper planning and budgeting in the past years makes it difficult to find a link between health policy

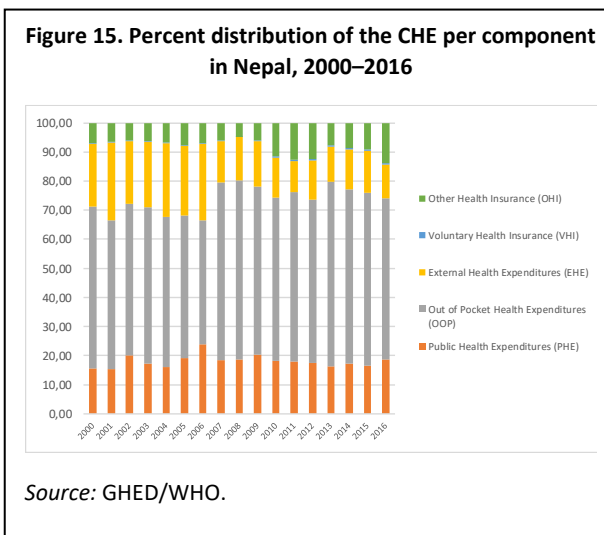


²³ According to the WHO, some African countries committed to health reforms to implement UHC, such as Liberia and Sierra Leone, increased the participation of PHE on GDP (despite still low levels) faster: from 0.8 percent and 0.3 percent to 1.8 percent and 1.4 percent of the GDP, between 2013 and 2016, respectively, which represents yearly growth levels in the PHE participation in the GDP of 31 percent and 67 percent, respectively.

²⁴ According to the World Bank (2018b), 3.7 billion persons live in 69 countries where the government spent less than US\$90 per capita year in health; 2.6 billion live in 46 countries where government spent less than US\$25; and 0.7 billion live in 25 countries where government spent less than US\$10 per capita.

and annual budget growth. Most health budgets in Nepal are prepared from a one-year perspective, carrying historic spending trends forward.

There is no multiyear budgeting process in the country, narrowing the possibility of a systematic approach to planning long-term public health investments and corresponding recurrent costs. Most health programs have been designed without sound budgetary planning, and in some of them no links between programs and activities proposed in the annual budget can be found. Annual budgets need to be developed with a multiyear perspective or a medium-term expenditure framework. From FY2014/15 to FY2017/18, health as a share of the total Government budget fell from 6.1 percent to 4.4 percent, recovering slightly to 5.5 percent in FY2018/19.



OOP health expenditures

OOP is the principal source of health financing in Nepal, contributing more than 55 percent of CHE in 2016 (see Figure 12). From 2012 to 2015, OOP in Nepal increased from 3.4 percent to 3.7 percent of GDP and then declined to 3.5 percent in 2016. As Figures 13 and 14 show, OOP per capita grew faster than other components of the CHE: from US\$5.52 (2000) to US\$25.20 (2016). However, the participation of OOP in CHE declined from 64 percent to 55 percent between 2013 and 2016, while the participation of PHE increased moderately from 16 percent to 19 percent in the same period. This is a good signal that health financing patterns in Nepal are aligning more functionally to the achievement of UHC.

Families use OOP to purchase medicines (about one-third of OOP is dedicated to this), curative services, and diagnostics at tertiary and secondary care facilities although services are available at subsidized rates at the public hospitals. Curative care, which accounted for one-fourth of total OOP expenditure in FY2015/16 is the second biggest component of OOP spending. A considerable amount of OOP (10.6 percent) goes to ancillary services, such as medical laboratory and imaging services used for diagnostics. Patient transportation is also a relevant part of OOP spending.

High OOP payments put families at risk of catastrophic health expenditures and impoverishment. Recent research by Adhikari and Sapkota (2018) shows that households with a higher number of children under age five and of elderly persons are more likely to incur catastrophic health expenditures. Some ethnic groups, such as Dalits, are significantly at risk of incurring catastrophic expenditures, and some poor regions, such as Terai, are also disproportionately affected by catastrophic health payments.

External health expenditures

Nepal’s health sector has been partially dependent on external aid, but this dependence appears to be reducing, which is a positive sign. Even though per capita EHE increased twofold between 2000 and 2016 (from US\$2.52 to US\$5.32 in constant 2016 U.S. dollars), the participation of EHE in the CHE declined from 21.5 percent to 11.7 percent in the same period.

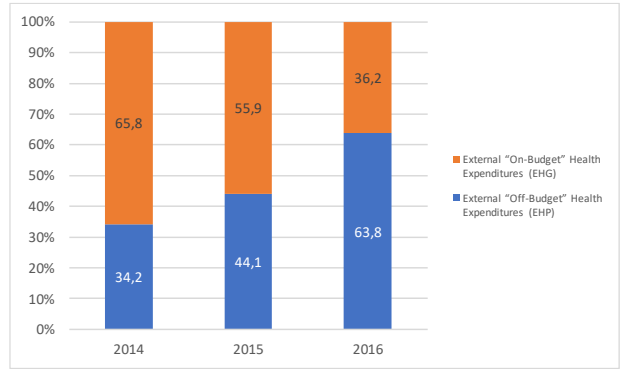
The WHO's GHED provides additional information from Nepal's NHA to assess the share of EHE that has been transferred to be spent by the MOHP's health financing schemes (on-budget external funds) and the share that is administered directly by the external agencies, NGOs, or the private sector (off-budget external funds).²⁵ It is important to highlight the recent increase in off-budget funds as a share of the total EHE (see Figure 16).

Fostering greater integration between external financing and Government priorities in the health sector could require joint efforts with donors to plan and coordinate funds, programs, and projects and to pool external funds with domestic financing to match the priorities and actions defined by the MOHP and other levels of Government.

Another important benefit of the use of EHE in on-budget funding is to increase the amount of funds under Government coordination, avoiding the duplication of efforts and inefficiencies that can occur when multiple donors' efforts are not coordinated. Figure 17 shows that, despite the reduction in per capita on-budget external funding since the early 2000s, the health spending managed by the Government increased significantly by including these external funds, reaching almost US\$10 per capita in 2016. However, the participation of external funds accounted for more than 50 percent of the total health funds managed by the Government in 2000–2001 and only 14 percent in 2016.

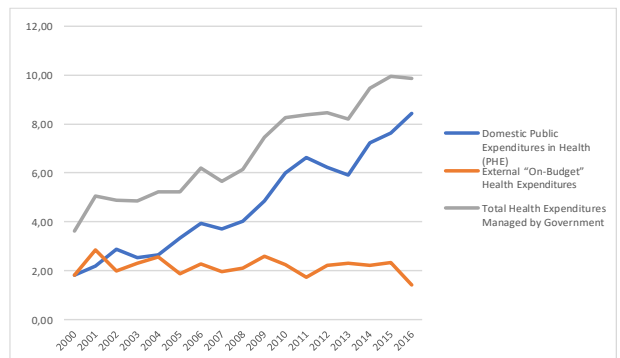
Summarizing, external health funds are progressively losing relevance as a component of health financing in Nepal. In terms of future strategy, the Government of Nepal needs to decide if is necessary (and feasible) to have more intense dialogues with donors to increase the “on budget” part of the EHE, not only to increase the amount of foreign transfers of funds to finance health projects during the transition to federalism, but also to align funding coordination to achieve UHC as promised in the current health strategy and in the 2015 Constitution.

Figure 16. Percent distribution of the EHE in 'on-budget' and 'off-budget' managed resources in Nepal, 2000–2016



Source: GHED/WHO.

Figure 17. Per capita THE managed by the Government, 2000–2016 (n constant 2016 US\$)



Source: GHED/WHO.

²⁵ Considering the total GHED series, we found some inconsistency in the estimates from previous years, but there is apparently more consistency in the data collected in 2014–2016. It would be necessary to improve national registers, maybe improving the MOF's Aid Management Platform database, to evaluate the distribution of external funds for health in on-budget and off-budget funds.

Health insurance expenditures

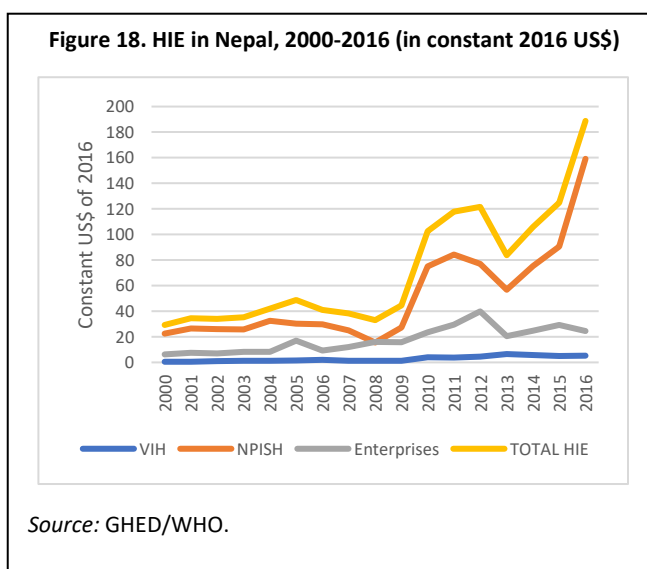
Health insurance or prepaid health schemes, especially those managed by the private sector, communities, or local governments, have been present in Nepal for the last two decades. In 2000, they represented 7.2 percent of the CHE in the country, and they began to grow rapidly after 2009 (see Figures 14 and 15), with fluctuations in some years. In 2016, they accounted for 14 percent of the CHE (see Figure 11), and as the new national HI is implemented, the HIE is likely to be a major player in the financing of health care in the country.

The GHED analyzes prepaid health schemes in three categories:

- (a) Voluntary health insurance—generally related to the remaining community-based health insurance schemes but also to voluntary private insurance to the more affluent segments of the society—represents a very small number of affiliates and revenues of less than 1 percent of CHE. In 2016, such schemes spent only US\$5 million in the country. Since they are voluntary, they probably will remain as a complementary health insurance for the rich after the expansion of the new national HI.
- (b) NPISH²⁶ are nonmarket prepaid mechanisms managed by institutions that are separate legal entities—for example, religious societies, sport clubs, trade unions, and political parties. What they provide is not a proper insurance scheme, given that it could be financed by prepayments but also by fees and sales for services delivered to the community, external aid, voluntary contributions in cash or in kind from households in their capacity as consumers, payments made by general governments, and property income. There has been a huge increase in the NPISH schemes since 2009. This could offer a good way to expand the new national HI: the affiliation and beneficiary registration mechanisms for these kinds of institutions could be used as a base to expand the affiliation of beneficiaries under the HI.
- (c) Enterprise financing schemes are financed directly by big formal companies and are often partially paid for by employees.

Figure 18 shows the evolution of the expenditures of these three kinds of schemes from 2000 to 2016.

From 2008 to 2016, the HIE increased fivefold in Nepal—a pattern that is mainly associated with



²⁶ According to OECD/Eurostat/World Health Organization (2017), NPISH, initially defined as “non-profit institutions serving households,” are financing arrangements or financing programs defined by the following characteristics: (a) the participation or enrollment is voluntary; (b) benefit entitlement is noncontributory and/or discretionary; (c) funded by donations, public or government budgets, foreign aid, or corporations; and (d) the mechanisms and extend of pooling funds vary across different programs but in general are associated to the program level.

the increase in NPISH schemes, which do not necessarily involve prepayment mechanisms. In Nepal, NPISH initiatives are associated with several Government programs combining public, private, and community solutions. One solution, the AAMA Program, created in 2005, combines both consumer-led demand-side payments and provider payments, covering costs for transportation and other facilities and incentivizing consumers to pay for the services. In 2009, this program removed user fees for all types of delivery in national-level public health facilities. After this, other demand-side financing schemes were created in Nepal and are still operating.

3.3 - Health spending by health functions

Another question explored by this health financing diagnosis is how different financing schemes are contributing to provide the main health functions the population needs. Table 3 shows this information for CHE, PHE, and other financing schemes in 2016. The highest share of health spending in Nepal is used to purchase goods (medicines and supplies), followed by curative services and preventive services. These three items combined represent about 86 percent of the CHE. Administrative expenses, which are only 5 percent of the country's total current health spending, are almost three times bigger in PHE.

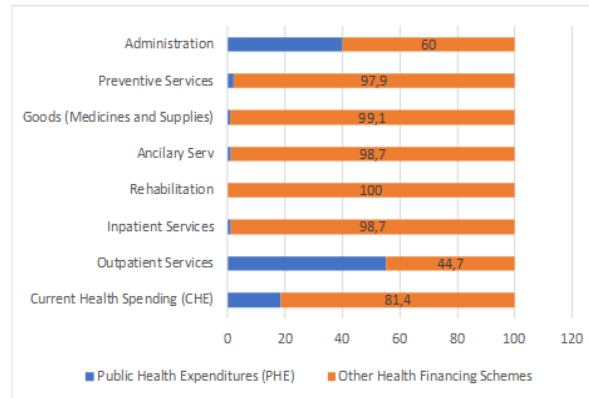
Table 3. Distribution of CHE by public and other health financing schemes in Nepal, 2016 (in constant 2016 US\$)

Main Health Functions	Current Health Expenditures (CHE)		Public Domestic Health Expenditures (PHE)		Other Health Financing Schemes	
	US\$, millions	Percentage	US\$, millions	Percentage	US\$, millions	Percentage
Curative services	422	32.0	172	70.2	250	23.3
• Inpatient care	151	11.5	2	0.8	149	13.9
• Outpatient care	208	15.8	115	46.9	93	8.7
• Others/unspecified	63	4.7	55	22.4	8	0.7
Rehabilitation	3	0.2	0	0	3	0.3
Ancillary services	78	5.9	1	0.4	77	7.2
Goods (medicines and supplies)	467	35.6	4	1.6	463	43.2
Preventive services	237	18.0	5	2.1	232	21.7
Administration	65	4.9	26	10.6	39	3.6
Not classified	45	3.4	37	15.1	8	0.8
Total expenditures	1,317	100.0	245	100.0	1,072	100.0

Source: GHED/WHO.

Figure 19 shows how health spending in Nepal is distributed between PHE and other health schemes for specific medical and administrative items. PHE represents only 18.6 percent of the CHE but represents almost 55.0 percent of outpatient services health spending. It also has high administrative expenses when compared with other schemes, especially because it covers the functions of planning and coordinating the country's health system. However, it is apparently not relevant to the financing of several health services (inpatient care, ancillary, rehabilitation services, goods such as medicines and supplies, and preventive services).

Figure 19 – Health Expenditures in selected medical and administrative items by public and other health expenditures schemes: Nepal 2016



Source: GHED/WHO

The comparative analysis of the composition of CHE and PHE health spending generates some concerns in terms of how complementary public and other financing health systems are and how coordination and integration among them could be improved. Many questions arise, for example, why have preventive expenses not counted as relevant in Nepal's public health spending? What is prevention spending in other health financing schemes buying, and for whom? Given that most secondary and tertiary hospitals in Nepal are public, why are inpatient expenditures not relevant in the public health financing schemes? Why are other health financing schemes directing money to secondary and tertiary care, and how are equity principles influenced (or not) by this?

4. Review of Existing Health Financing Arrangements: Strengths and Challenges

Main Messages

Revenues collected for health services delivered by the federal MOHP, provinces, and municipalities come mostly from taxes, but contributions also come from external donors (both pooled in the public budget). These funds are complemented by user-fee charges paid as OOP by families when the services are delivered. On the health insurance side, the main revenues in Nepal are (a) contributions (premiums) collected from members with the ability to pay and (b) tax funds, financed by the MOHP and MOF, provided as annual block grants to the national HI fund to subsidize premiums for disadvantaged groups and to cover its administrative expenses.

Fund-pooling mechanisms, after the federal structure, rely on the creation of the Federal Divisible Fund (FDF) which finances the expenditures of the overall government, based on the income from VAT and excise duties collected on domestic products. The Central Government receives 70 percent of the fund resources and 50 percent of the royalties collected from natural resources. Provincial and municipal (local) governments' financing is currently based on tax and nontax revenues from the FDF: they receive 15 percent of the deposited amount. The resources are distributed as conditional grants, fiscal equalization grants, complementary grants, and special grants. Part of the FDF is used to finance the public health sector but the amount of resources transferred to health depends of budget allocations decided by each level of government.

There are funds-pooling mechanisms for special MOHP programs, some addressing directly the poor, which have been crucial to reducing inequality in access to health care services and are aligned to the Sustainable Development Goals (SDGs): The Safe Motherhood Program, the Free Health Care Program, the Impoverished Citizens' Service Program, and the Bed-for-the-Poor Initiative.

Regarding purchasing mechanisms, Nepal has an essential health basic package but needs to estimate its costs and its affordability to the entire population (especially the poor). In most of the public system, there are no functions split between purchasers and providers. Provider payments are based on inputs and paid according to line-item budgets. However, some public programs have introduced innovative payment schemes, such as capitation-based payments, cash incentives to providers, and service reimbursements.

The analysis of the health financing arrangements in Nepal shows that the three areas of overlap require the attention of the MOHP authorities: between the general coverage of the MOHP and all other Government programs; among different insurance systems, especially between the national HI and the health insurance under the SSF; and between the benefits under the tax-based funding for the MOPH and the benefits under the social insurance schemes.

Nepal's health system is characterized by fragmentation among different health-sector-financed programs and health insurance schemes. Appendix 2 of this document shows the disease programs, free-care packages and health insurance schemes currently existing in Nepal, along with their coverage, eligibility, financing, and managerial mechanisms. There is a great deal of overlap and duplication among all these programs and financial mechanisms. One of the urgent tasks for the MOPH is to undertake a careful process of integration, coordination, and pooling of the revenues from these different schemes to create a more efficient organization of the system.

4.1 - Revenue-collecting mechanisms

Revenue collecting, according to McIntyre and Kutzin (2016), comprises four kinds of sources: (a) compulsory and mandatory prepayments; (b) voluntary prepayments; (c) household OOP spending; and (d) foreign resources, such as development assistance.

Most of the short-term challenges in Nepal are associated with compulsory or mandatory prepayments because they are at the center of the two big reforms in the health system: the federal structure and the new national HI. Such prepayments comprise the following mechanisms:

- (a) General revenues of the central and local governments, which include direct taxes levied on individuals and firms, indirect taxes levied on consumption or trade, and revenues from government-owned assets or enterprises. These are important sources for health sector financing in Nepal and will be explored in more detail in this section.
- (b) Earmarked revenues of central or local government, such as taxes on tobacco and alcohol, are potential resources that may need to be revisited. According to Belay and Tandon (2015), Nepal introduced earmarked taxes on cigarettes and alcohol in the early 1990s, with revenues going to establish the Health Tax Fund. These funds—which financed spending to the tune of NPR 214 million in 2005/2006—have been managed by the BP Koirala Cancer Hospital, directing resources to finance cancer treatment and community mobilization activities promoting health lifestyles. In addition, Nepal levies an excise tax and a 10 percent value added tax (VAT) on cigarettes. Nepal needs to reevaluate and update its information on the use of these funds, looking at their potential to raise revenues for the health sector.
- (c) HI contributions, also called payroll taxes, are a kind of direct or earmarked tax commonly used as a source of funds for mandatory/social health insurance. In 2017, Nepal created a mandatory national HI, but as has been discussed, its implementation has been challenging because Nepal still has a large informal labor market, which makes it difficult to establish compulsory mechanisms to collect premiums.

Under the revenue-collecting mechanisms, Appendix 2 shows that there are many institutional health initiatives in Nepal that could be classified as mostly tax-based (public system, the Safe Motherhood Program, the Free Health Care Program, the BHCP service, and the Impoverished Citizens' Service Program). In addition, other institutional initiatives rely on premiums under the health insurance framework (the HI, voluntary private insurance, enterprises' private insurance, and the SSF).

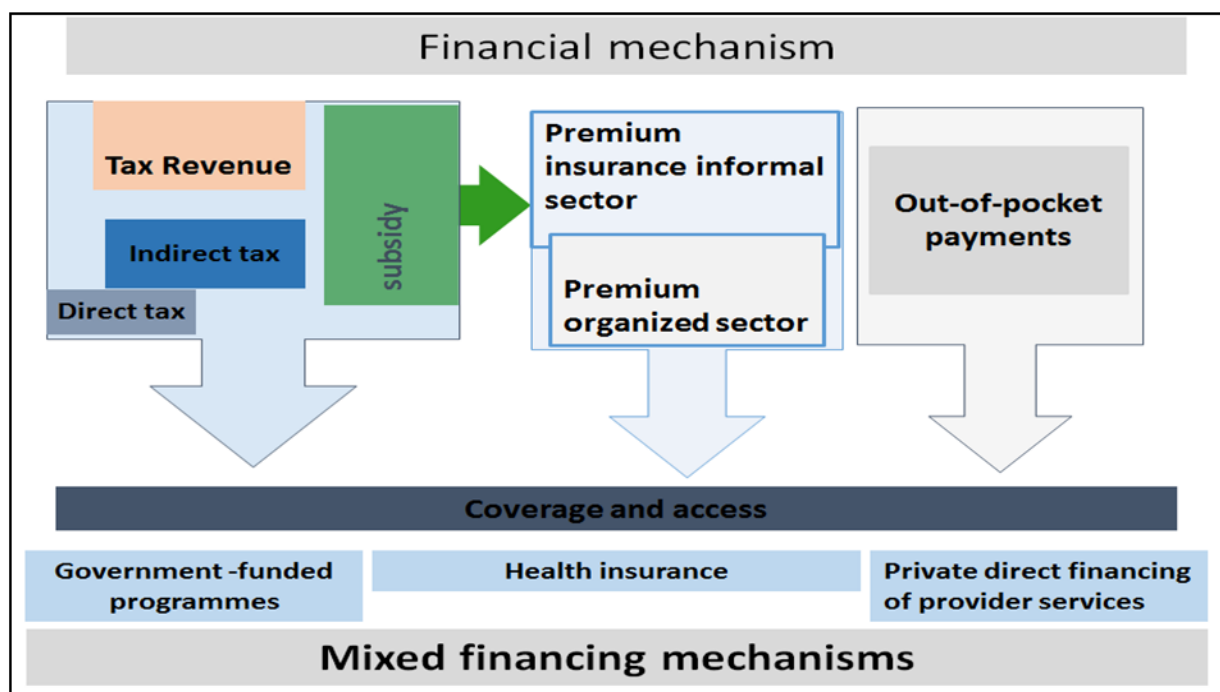
Despite the existence of all these institutional initiatives, Nepal relies mostly on household OOP spending, which finances a large share of health care services and health goods (including co-payments for public

services delivered by the Government).²⁷ Given the high risk of family impoverishment due to catastrophic health expenditures, the Government is committed to reducing the dimension of OOP by targeting poor and vulnerable groups with free-of-charge health services or subsidies.

Foreign sources have also been important in financing health care spending in Nepal, but they are losing relevance in recent years: their participation in Nepal’s CHE fell from 21.5 percent to 11.7 percent between 2000 and 2016. However, the Government has the possibility of enhancing efficiency in the use of foreign health resources by improving coordination with donors and persuading them to convert off-budget to on-budget funds.

To evaluate the revenue-collecting processes under the health federalism and the national HI created in 2017, this document explores two funding mechanisms: tax-based financing and HI contributions. Both need reforms to improve the revenue-collecting process under the federal health system. Figure 20 illustrates mixed tax-based/health insurance revenue-collecting mechanisms in the current health system in Nepal.

Figure 20. Revenue-collecting mechanisms in Nepal’s mixed health financing system



Source: Adhikari 2019.

The tax-based financing for universal public health is internationally known as the Beveridgean system,²⁸ under which health services are provided by a network of public and sometimes contracted private

²⁷ As Figure 12 showed, 55.4 percent of the CHE in Nepal is financed by OOP funds in 2016.

²⁸ Lord William Beveridge, a liberal British economist, published in 1942 an important report commissioned by the Government to find ways that Britain should be rebuilt after World War II. The report recommended that the Government should find ways of fighting the five “Giant Evils” of “Want, Disease, Ignorance, Squalor and Idleness.” After the Labor Party defeated Winston Churchill in the 1945 general election, the new prime minister, Clement Attlee, announced the introduction of the welfare state

providers that make up a national health service. Health insurance, known as the Bismarckian system,²⁹ is based on compulsory membership among workers and their families or, by extension, among the overall population. The base for workers' and enterprises' contributions is usually the payroll for salaried workers, or the estimated income of informal/self-employed workers, small employers, and so on. The Government may provide contributions for those who are not be able to pay, such as the poorest groups.

Tax-funded revenues

Health services delivered by the MOPH, provinces, and municipalities (including general health services and others such as the Safe Motherhood Program,³⁰ the Free Health Care Program, the BHCP service, and the Impoverished Citizens' Service Program) are mostly tax funded but also receive contributions from external donors (both pooled in the public budget). These funds are complemented by user fees paid as OOP by families when the services are delivered.³¹

The proportion of the funding from each of these sources in the financing of each of these programs is currently unknown, because there are no data on where the OOP funds go. But there are probably overlaps in the financing—for example, between the Free Health Care Program and the BHCP services program. Therefore, it is important to analyze the funding composition and the size of overlaps in each program to measure the levels of efficiency in the funds' allocation.

Health insurance funding mechanisms

On the health insurance side, the main government scheme since 2017, when the Health Insurance Act was approved by the President of Nepal, is the national HI. Funding for this insurance is based on (a) contributions (premiums) collected from members with the ability to pay; and (b) tax funds, provided by the MOHP and MOF as annual block grants to the national HI fund to subsidize premiums for disadvantaged groups and to cover its administrative expenses.

Other health insurance schemes in Nepal are voluntary health insurance, enterprise health schemes, the EPF, and health insurance under the SSF.

- (a) Voluntary prepayment mechanisms, financed by premiums collected from enrollees, are not significant as mechanisms to raise revenues for the whole system because of the small size of the population that is enrolled and is willing to pay for this kind of insurance (less than 1 percent of the population).
- (b) Enterprises and employees may have their own schemes for health insurance, financing premiums, or health benefits for their workforce and families. These premiums may also be financed through employees' payroll contributions. As a mechanism to raise revenues, this is not an important source of funding, given the small size of the formal labor market in Nepal.

outlined in the 1942 Beveridge Report, which included the establishment of a National Health Service in 1948 with free medical treatment for all, financed by general taxes instead of workers' payroll contributions.

²⁹ In 1883, Prussia's Chancellor, Otto von Bismarck, proposed a health care model for universal health insurance as an effective tactic in his design for German unification. Under this model, employers and employees jointly fund insurance through premiums (monthly payments) that are pooled by an insurance (public or not) fund, managed by an institution with responsibilities for financing, providing, and purchasing health services under a defined health package.

³⁰ The Safe Motherhood Program is currently the Government's own activity, financed integrally by tax-based funds and independent of donor financing.

³¹ Except for the Free Health Care Program and the Impoverished Citizens' Service Program.

- (c) The MOF contracted a Government agency (Rastriya Beema Company Limited) to manage the EPF social security benefits for workers, such as pensions and health insurance. The contributions are funded by a payroll deduction equal to 20 percent of the payroll (10 percent from employees and 10 percent from employers) for all benefits, including health insurance. The program is managed by the MOF and includes public and private companies.
- (d) Another health insurance mechanism is the SSF, which also defined health insurance based on the payroll contributions of employers and employees. However, this health insurance has not yet been implemented.

As can be seen, there is a huge overlap in the revenue-collecting mechanisms among the different health insurances. Except for voluntary health insurance schemes, which could be complementary (as they are in many countries), the revenue-collecting mechanisms of all other health insurances overlap with those of the national HI. The status of the national HI as universal health insurance will be complete when it is able to be merged with all other mandatory health insurance schemes.

4.2 - Funds-pooling mechanisms

Funds-pooling mechanisms aim to maximize the redistributive capacity of the prepaid funds such as general revenues and premium contributions for the national HI. The main benefits of the pools are associated with (a) their size, given that greater funds have the capacity to provide cross-subsidies to the poor; (b) their diversity, given that the funds must have a mix of people as contributors and beneficiaries with different socioeconomic characteristics; (c) compulsory participation, which avoids adverse selection of the sicker and the poorer as beneficiaries of the fund; and (d) the unitary character of the fund, which avoids fragmenting the fund for earmarked or other uses based on privilege, preventing the use of cross-subsidies for equity purposes.

Pooling mechanisms in Nepal should be understood according to the two major health financing schemes: the tax-based schemes and the health insurance schemes.

Tax-based pooling mechanisms

Nepal's federalism introduces new fiscal responsibilities, such as the assignment of expenditures, taxes, and revenues to different levels of government, intergovernmental fiscal transfers, subsidies, and possibilities to borrow funds shared among the central, provincial, and local governments.

Major sources of financing for the Central Government include tax and nontax revenues, foreign on-budget grants, and external and internal loans, and these resources are mostly pooled to finance central Government programs and priorities. An FDF receives the income from the VAT tax and excise duties collected on domestic products. The Central Government receives 70 percent of the fund resources and 50 percent of the royalties collected from natural resources.

Provincial and municipal (local) governments' financing is based on tax and nontax revenues from the FDF: they receive 15 percent of the deposited amount. The resources are distributed as conditional grants, fiscal equalization grants, complementary grants, and special grants. Table 4 shows the criteria for distributing the FDF grants to provinces (states) and municipalities (local governments).

Table 4. Sources, methods, and criteria for distribution of the FDF in Nepal

Sources	Methods	Criteria
Conditional grants	Distributed according to terms and conditions for projects implemented at the provincial and local levels	Grant holders (provincial or local municipal governments) report to the Central Government on the physical and financial progress associated with the funds according to agreed project goals.
Fiscal equalization grants	Distributed according to the provincial and local needs and revenue-generation capacity	Criteria-based formula developed by the National Natural Resources and Fiscal Commission
Complementary grants	Distributed to complementary needs of infrastructure investments	The Central Government provides ceilings for complementary grants. Provincial and local governments submit proposals for complementary grants along with the MTEF in December to get resources for the next fiscal year. A committee at the MOF informs the approval of complementary grants.
Special grants	Distributed specifically for health and education service delivery, balanced development, and community development	The Central Government provides ceilings for special grants. The provincial and local governments submit proposals for special grants along with the MTEF in December to get resources for the next fiscal year. A committee at the MOF informs the approval of special grants.

Source: Adhikari 2019.

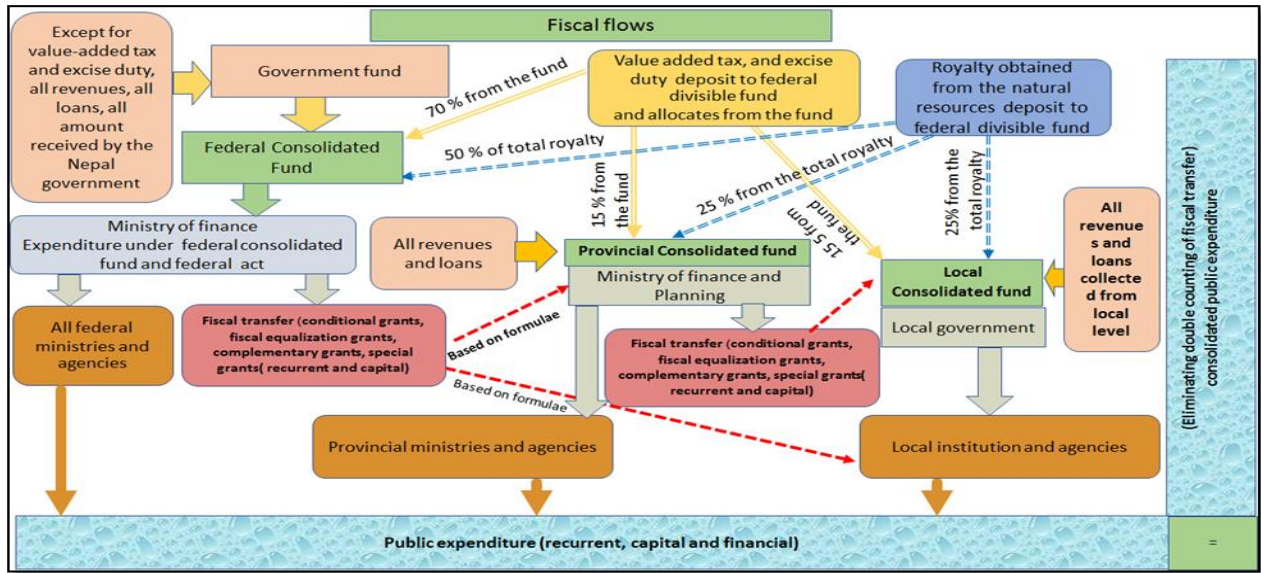
Thirty percent of the FDF, deposited in equal parts in the Provincial Divisible Funds and Local Divisible Funds, is distributed to the provinces and municipalities according to the criteria and framework determined by the National Natural Resources and Fiscal Commission (NNRFC). For FY2018/19, the NNRFC weighted the distribution of these funds according to the following criteria: 70 percent was based on population size; 15 percent on the kind of geographical area (mountain, plains, and so on); 10 percent on the provincial development index (a specific metric developed by the NNRFC); and 5 percent on the human development index.

For FY2018/19, these criteria directed the highest amount of revenue to Province 3 and the lowest amount to Province 6 (renamed Karnali Province by popular vote), with Province 1, Province 4 (renamed Gandaki by popular vote), Province 5, Province 2, and Province 7 (renamed 'Sudur Pashchhim' by popular vote) between (in order, higher to lower).

Fiscal equalization grants are distributed to the provincial and local levels on the basis of their needs for funds and their revenue-generation capacity. These grants are distributed according to the following criteria: 60 percent for development programs and service delivery, 15 percent according to the multidimensional poverty index, 10 percent according to the infrastructure development index, and 15 percent for special needs and capacities to be met through the equalization grants. Using these criteria, the distribution of the equalization grants in FY2018/19 had the following order (higher to lower amounts): Karnali Province, Sudur Pashchhim Province, Province 2, Province 5, Gandaki Province, Province 1, and Province 3. The criteria for equalization grants for local governments were recently changed: the weighting for development programs and service delivery increased from 60 percent to 70 percent, and that for special needs and capacity decreased from 15 percent to 5 percent; the weighting of the other two criteria remained the same.

Figure 21 summarizes the fiscal federalism and financial flows according to information from the intergovernmental fiscal council.

Figure 21. Fiscal federalism in Nepal: Resources and financial flows



Source: Adhikari 2019.

Additionally, with the consent of the MOF, the central, provincial, and municipal governments may obtain internal loans, within the limits recommended by the Government. The provincial and local governments submit a proposal to the MOF, along with details of the plan for which the loan is sought, specifying outputs and outcomes likely to be achieved, the loan payment plan, and the conditions for and institution extending the loan.

Table 5. National, provincial, and local government budget and health budget (in NPR billion), Nepal FY2017/18 and FY2018/19

Budget by Level of Government	FY2017/18	FY2018/19
Government budget		
Central	1,279.0	1,315.2
Provincial	7.0	113.4
Local	225.1	195.1
Health budget		
MOHP budget	46.9	65.4
Provincial health budget	—	4.1
Local health budget	15.1	18.2

Source: MOHP 2018.

Although some funds had been already decentralized in FY2017/18, the provincial and local governments were not yet fully established. In fact, FY2018/19 is the first year of implementing the federal system. Table 5 shows the allocation of budgets among the three levels of government, based on the MOF's Red Book. In FY2018/19, the Government has provided NPR 65.4 billion (US\$593.1 million) to the health sector, of which NPR 4.1 billion (US\$37.2 million) is allocated to the provincial governments and NPR 18.2 billion (US\$165.1 million) to local governments, while 66 percent of the funds (NPR 43.1 billion, or

US\$390.9 million)³² remain at the MOHP. The Central Government’s health budget includes the budget for the MOHP’s operation and conditional grants to be transferred to the provincial and local governments to fund projects to be prepared at these levels of government; however, the subnational governments’ weak capacity to prepare and implement health projects may mean that these resources will not be totally used. The MOHP needs to create mechanisms to assist local governments in properly using these transferred funds.

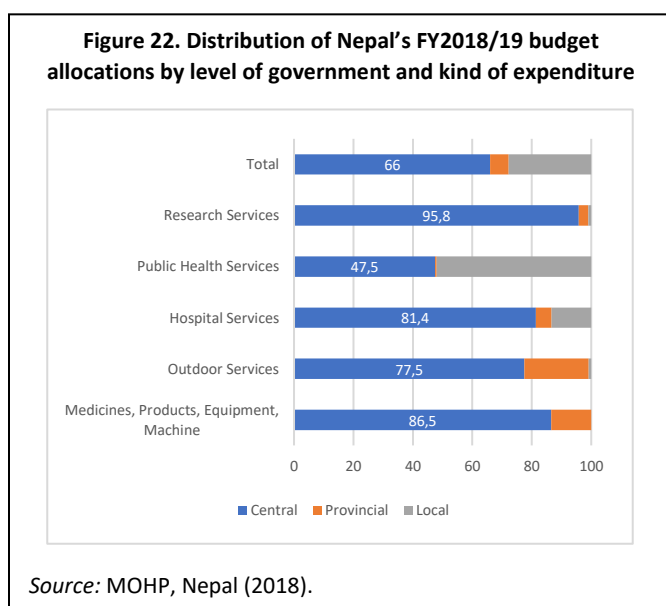
Table 6. Allocation of budget by services and by level of government - Nepal, FY2018/19 (in NPR millions)

Kind of Expenditure	Central	%	Provincial	%	Local	%	Total	%
Medicine production, equipment, and machines	482	1.1	75	1.8	0	0.0	557	0.9
Outdoor services	4,011	9.3	1,116	27.4	45	0.2	5,172	7.9
Hospital services	15,308	35.5	1,004	24.7	2,506	13.8	18,817	28.8
Public health services	15,491	35.9	1,613	39.6	15,520	85.5	32,624	49.9
Research services	7,829	18.2	263	6.5	82	0.4	8,173	12.5
Total	43,121	100.0	4,070	100.0	18,153	100.0	65,343	100.0

Source: MOHP 2018.

Table 6 shows the proposed health budget allocations at the three levels of government by kind of expenditure for FY2018/19. While hospital services expenditures remain concentrated at the central and provincial levels, public health services are being funded in higher proportions at the local levels, although the Central Government still has considerable participation in these kinds of services.

Another way to view the FY2018/19 health budget allocations is to observe how the different kinds of expenditures are distributed among the three levels of government (see Figure 22). The central level kept more than half of the fund allocations during the first year of the shared health budget under the federal system—except for public health services, for which most of the funds (52 percent) were transferred to local levels.



An analysis of the tax-based pooled funds according to the kind of expenses found that salaries are determined and paid centrally to the MOHP staff at all levels of government, but some processes to transfer staff to the provincial and local levels will probably happen in the future following the decentralization process. For locally hired staff, salaries are determined and paid locally, and this could create some problems about what arrangements should be made to avoid big discrepancies in the salaries

³² The exchange rate of June 2018 is used: NPR 110.265 per US\$1.

paid to workers performing the same tasks at local levels. Currently, grants transferred to the provinces and local levels (conditional, equalization, matching, and so on) cover only non-salary inputs.

External resources are centrally managed by the MOF under a pooled donor-assistance fund, managed directly by the Government central treasury. When the budget is formulated, the Central Government distributes the donors' pooled fund to the ministries according to their sectoral budget proposals.

Pooling funds for the poor

Appendix 2 shows the specific pooling mechanisms related to different programs. Some of these programs were designed or restructured to increase access by poor people to basic health services and are aligned with the 2014 Health Policy, the Nepal Health Sector Strategy (2015–2020), and the Sustainable Development Goals. These programs have been crucial to reducing inequality in access to health care services in Nepal: The Safe Motherhood Program, the Free Health Care Program, the Impoverished Citizens' Service Program, and the Bed-for-the-Poor Initiative.

The Safe Motherhood Program, designed to cover the needs of all women in reproductive age and neonates, pays public and private health facilities to provide free birth delivery, and has been found to be effective in increasing the use of skilled attendants and reducing the probability that a woman would deliver at home (Lagarde et al. 2010). The program started in 1997, but several improvements have been introduced along its existence. Service coverage has grown along with the development of policies, programs, and protocols. The policy on skilled birth attendants endorsed in 2006 by the MOHP specifically highlights the importance of skilled birth attendance at every birth. A national blood transfusion policy issued in 2006 was also a significant step toward ensuring the availability of safe blood supplies in the event of a birth emergency. To ensure focused and coordinated efforts, the National Safe Motherhood Plan (2006–2017) has been revised, with wide participation of development partners.

The Safe Motherhood Program has a demand-side financing approach where the mothers are provided free delivery care at health facility with provision of transport funds. A transportation allowance of NPR 1,000 in the lowland area (Terai), NPR 1,500 in the hills, and NPR 2,500 in the mountains is provided to all pregnant women to visit health facilities for child delivery. The MOHP central budget directly reimburses the facilities after the service delivery. Because of challenges to its long-term sustainability, the program (initially financed in part by donor funding) is currently financed totally by domestic funds as part of the MOHP budget. The program has contributed, since its creation in 1997, to a stellar reduction of the maternal mortality in Nepal from 548 to 258 per 100,000 children born alive, from 2000 to 2015, according to the World Bank Indicators.

The Free Health Care Program, launched in its first phase in 2006 and refurbished in 2009 was designed to cover all citizens, providing free-of-cost health services to all citizens in sub-health posts, health posts, primary health care centers, and district hospitals of up to 25 beds. It also provides about 70 types of basic drugs free of cost in all health facilities across the country. The sub-health posts have been upgraded to health posts, and a policy on health personnel retention in rural areas has been adopted to minimize absenteeism among health personnel in health facilities. In terms of pooling arrangements, the Central Government pools and distributes the funds for the facilities at the three levels of government.

Under the Impoverished Citizens' Service Program,³³ poor and marginalized people receive free treatment for eight hard-to-treat/acute chronic diseases: heart attack, kidney failure, cancer, Alzheimer's disease,

³³ Currently only 8,300 citizens are enrolled in this program.

Parkinson's disease, head/spinal injury, sickle cell anaemia, and liver damage. For this program, the funds are pooled at the MOHP central budget.

Additionally, the Government mandates that private sector hospitals allocate 10 percent of their beds to poor and marginalized people (the Bed-for-the-Poor Initiative). However, this initiative has not been consistently evaluated and assessed by the MOHP.³⁴

Recent studies (Ranabhat et al. 2019) mentioned that, despite all these efforts “the service coverage of health care was not satisfactory. The quality of health service and financial protection were inadequate. Grass root level health workers were confused about the changing policy of government like user fee, community drug program, free health service, special health care services to minority groups, etc. and none of them ensures comprehensive package of health service with universal access.”

Given all these innovations, it is recommended that Nepal assesses how the pooling mechanisms and grant programs are improving equity and benefiting the poorest provinces and municipalities, and whether the poorest and sickest families have increased access to health care. Since FY2018/19 is the first year in which the grants mechanisms are in place, it is necessary to investigate some questions. Are these funds used equitably? Are the criteria for allocating these funds the best, or could they be allocated more effectively to optimize execution rates? How could the link between the local level of use/implementation of these funds and the national priorities in health be improved?

Health insurance pooling mechanisms

Funds pooling under health insurance schemes tends to perform according to classical mechanisms of social security. For example, the funds for the new HI compose a single pool at the national level managed by the HIB, while the governance of the proposed health insurance under the SSF will be based on a single national pool managed by the SSF. Although the SSF pool has not yet been created, the question is whether (and when) the two funds will be pooled under a single governance.

Voluntary health insurance funds are pooled separately, according to the different health insurance providers, and managed individually. Given the small size of these funds, the conditions for their governance and solvency need to be carefully evaluated.³⁵

Enterprise funds are managed individually for the health protection schemes for their workers, and they generally are not pooled. EPF funds are pooled at the MOF and transferred to a government agency (Rastriya Beema Company Limited) that is responsible for managing the resources.

Clearly, funds for health insurance in Nepal are very fragmented; to increase efficiency, the pooling mechanisms need to include all mandatory schemes. Some voluntary schemes, such as the EPF, which is

³⁴ This is essential because according to Citrin et al. (2018), two-thirds of all hospital beds in the country are private, and 60 percent of Nepalese doctors are employed in the private sector. The private sector is large and important in Nepal, but there are many complaints that it is poorly monitored and regulated. There is scant evidence about the scale, scope, and quality of the private sector.

³⁵ To ensure sustainability, health insurance regulations need to evaluate risks associated with the following aspects: solvency ratio (admitted assets over liabilities); liquidity ratio (cash over short-term payables); net income ratio (net income over earned premium); incurred expense ratio (incurred expenses over earned premium); and incurred claims ratio (incurred claims over earned premium).

related to government schemes through the MOF, could also be part of the pooled funds, but this will require calculating which part of the premium should be transferred to the new HI.

4.3 - Services-purchasing mechanisms

Purchasing mechanisms are ways to transfer pooled funds to health services providers. The analysis of the purchasing function examines the following aspects: (a) the existence of benefit entitlement policies, describing the package of services to be purchased from the pooled funds and the means by which these entitlements will be rationed; (b) the existence of mechanisms to pay providers and the incentives created as a result; (c) the organizational structure and governance of the purchaser, to ensure its ability to provide the health package to the beneficiary in the conditions assured by the benefit entitlement policy; and (d) the existence of monitoring and evaluation systems to measure the beneficiary health outcomes achieved with the purchased services.

Packages of health services

As section 2.2. of this document discussed, Nepal has a benefit package but needs to redefine it to ensure UHC requirements under federalism. According to Wright (2015), Nepal's first experience of defining a health basic package was in 1999 (the Essential Health Care Services package) as part of the second Long-Term Health Plan, which included 20 broad health specialties, but it was poorly implemented. In 2004, the Government's Health Sector Strategy concluded that this package was not affordable and proposed a new one focused on delivering four main specialties of essential care across all districts—safe motherhood and family planning, child health, control of communicable diseases, and strengthened outpatient care—as part of the Nepal Health Sector Program Implementation Plan 2004–2009. This new package was called Essential Package of Health Services (EPHS).

The subsequent Nepal Health Sector Program Implementation Plan 2010–2015 updated and expanded the EPHS to include new services under the reproductive health and child health specialties, new programs on mental health, oral health, environmental health, community-based newborn care, and a community-based nutrition care, and support program. In addition, the new EPHS added a noncommunicable disease control component to address changes in demographics and disease burden and provide free access to medicines. At this time, the Government considered the EPHS as a tool to be used in achieving UHC, and the package was to be delivered to the poor as part of the Free Health Care Program.

However, despite the positive achievements of the EPHS reflected in improvements in health output and outcome indicators according to the last Demographic and Health Survey (DHS 2016), for the sustainability of the EPHS, the Government needs to focus on the health financing side by

- Estimating the cost of the EPHS, given that part of the constraints to expanding services is the lack of cost information to understand the full impact of EPHS coverage in the public budget;
- If EPHS costs are not affordable, discussing how to adjust its provisions by limiting services or looking for additional financing; and
- Given that the EPHS is also financed by OOP, determining what the OOP contribution is and how it affects the poor to decide what amount of public subsidy the EPHS financing needs (this will be discussed in the coming parts of this document).

Payment mechanisms

Provider payment mechanisms are essential to foster efficiency, fairness, and accountability in health services provision. The purchase function exists in every health system, whether as budget line items, fee-for-services, or sophisticated performance-based payment methods. To understand payment mechanisms, it is essential to know what the purchasing agencies are, what the institutional/legal framework is for both purchasers and providers, and what the incentives are to deliver quality health services.

In most of Nepal's public health system, no functions are split between purchasers and providers. The MOHP is responsible for the provision of services at the national and specialized hospitals, and provincial and local governments are both owners and purchasers of health services at the subnational levels. Provider payments are based on inputs paid according to line-item budgets.

However, some specific public initiatives, such as the Safe Motherhood Program, use capitation-based payments from the MOHP, as well as cash incentives to providers (including personnel), according to the ease of access and the complexity of the services to be delivered. Other public initiatives, such as the Basic Health Care Package Service Program (which delivers the EPHS), use capitation for outpatient department services by local governments. The Impoverished Citizens' Service (financed by the conditional grants transferred to the local level) uses services reimbursement as its payment mechanism.

Some specific public projects, such as AAMA, innovated in payment mechanisms by having a policy of free delivery of services to patients and stimulating the demand side by costing patient items, such as transportation, as well as by reimbursing health units for all costs and paying extra incentives for health personnel. This program was evaluated as efficient on covering the main costs of services, creating some surplus that the health units can invest in improving services and staff (Witter et al. 2011).

On the health insurance side, the main government initiative—HI—uses fee-for-service to pay for outpatient services and case-based payments for inpatient health services. For ancillary services such as diagnoses, the use of fee-for-service payment is common, except for diagnoses included in the inpatient services, which are part of the case-based schemes. Other health insurance schemes (enterprises, EPF, and SSF) pay for services by conditional reimbursements.

Organizational structure and governance for purchasing

The public health system purchase services (mostly transferring budget) for all public health facilities and pays some private facilities for specific services, such as hemodialysis and cancer or other specific treatments associated with noncommunicable diseases. For public facilities, the services are “implicitly” purchased—that is, no explicit contracting takes place with these facilities. However, some contracts are prepared to cover specialized services from private providers.

One innovation in the public purchasing environment was the contracts under the Safe Motherhood Program, which were signed for selected public and private providers on the basis of the capitation payment system. This process was not used with the two other public programs described in Appendix 2.

For the national HI, the HIB contracts both public and providers for the services delivered.³⁶ Other health insurances (voluntary health insurances, enterprises, and EPF) do not have purchasing contracts with providers since the payment for services delivered is a cash reimbursement to the beneficiary.

4.4 - Challenges of the existing health financing arrangements

Overlapping of the current health financing arrangements

The analysis of the health financing arrangements in Nepal shows that there are three types of overlap that require the attention of the MOHP and local and regional authorities on the design of the HFS.

Overlap between the general coverage of the MOHP and all other Government programs. In terms of entitlement to benefits, the public system covers immunization; nutrition; integrated management of nutrition and childhood illness (IMNCI); family planning, safe motherhood, and newborn health; primary health care; and surveillance and disease control vertical programs for such diseases as HIV/AIDS, tuberculosis, malaria, leprosy, and polio. However, other public programs have also created entitlement to part of these benefits. For example, the Safe Motherhood Program is part of the general MOHP coverage in areas such as antenatal care, institutional delivery (normal, assisted, and surgical), postnatal care, and perinatal care. On the financial side, the difference is the use of cash transfers—for example, transportation costs—to service users. The Free Health Care Program covers all costs of outpatient services at health posts, primary health care centers, and public hospitals of up to 25 beds, as well as for 70 drug items. The Impoverished Citizens' Service Program covers treatment of chronic diseases, such as heart and kidney (renal failure) diseases, Alzheimer's and Parkinson's, cancer, and head and spinal injuries, subsidizing costs up to NPR 100,000. All these programs could be integrated in just one basic health package to which the economic subsidies would be allocated according to the economic status of the users.

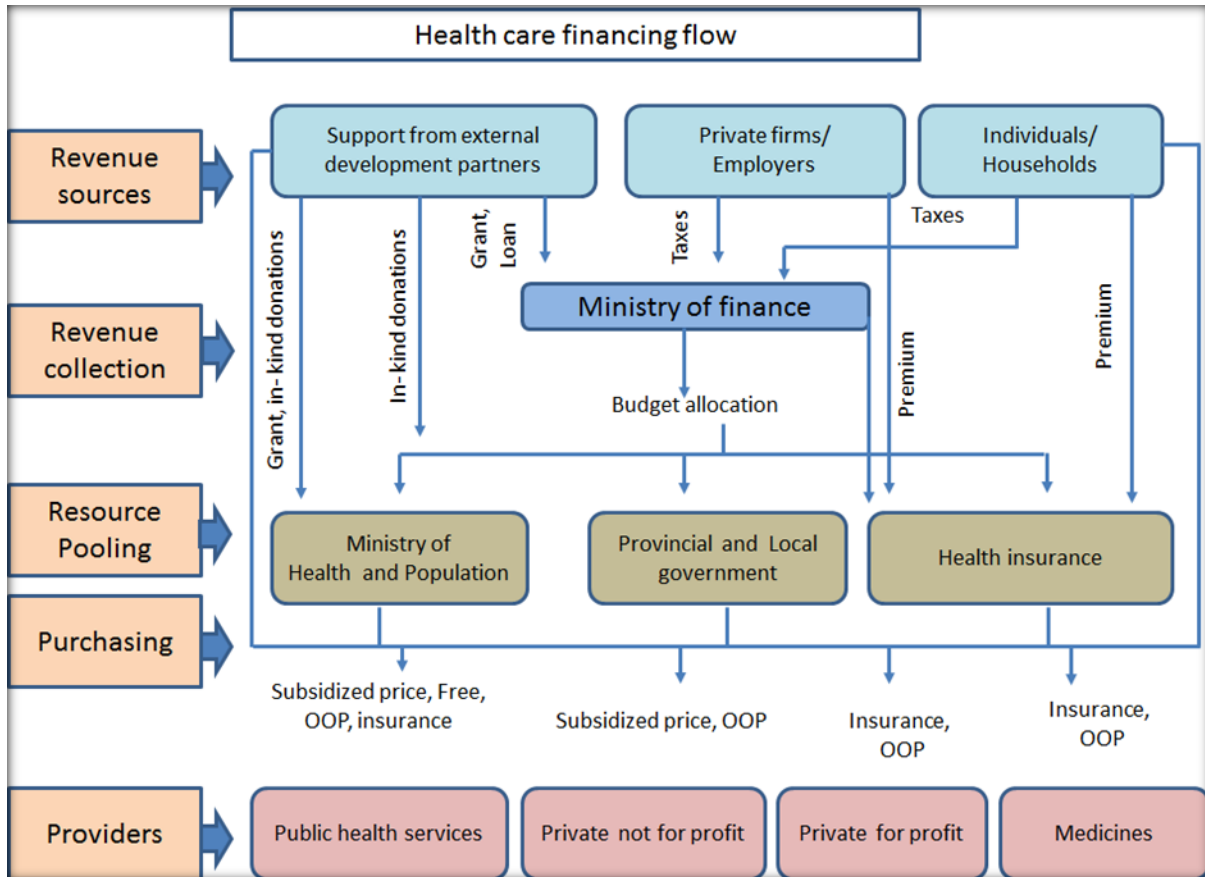
Overlap among different insurance systems, especially between the HI, the health insurance under the SSF, and the health insurance under EPF for formal sector employees. Since the SSF health insurance has not yet been implemented, there is a good chance to define policy decisions integrating both systems under the HIB, pooling these two funds in just one financing scheme.³⁷ (Table 6 shows the levels of overlap in the current health insurance schemes.)

Overlap between the benefits under the tax-based funding for the MOPH and the benefits under the social insurance schemes. In this case, Nepal needs to choose whether its population wants to achieve UHC using a Beveridgian system or a Bismarckian system or a combination of both systems y. If the choice is to have both systems, it is crucial to eliminate all overlaps among beneficiaries and financial funding to increase the efficiency and the full complementarity of both systems in the path to achieve UHC.

³⁶ There is no information on the SSF health insurance payment mechanisms because this insurance has not yet been implemented.

³⁷ In this sense, the existing voluntary insurance mechanisms should keep existing since they would offer different services than those included in the national HI. However, one overlap between the EPF and the SSF health insurance could, perhaps, be avoided regarding the formal sector payers/beneficiaries who could also be part of the nonsubsidized part of the national HI.

Figure 23. Financial flows and overlapping in Nepal's mixed health financing system



Source: Adhikari 2019.

Figure 23 shows that the current financial mechanisms overlap the finance of Government-funded programs, health insurance, and private direct financing of service providers without coordination, creating risk of duplication of efforts, and inefficiency in the use of the funds. Health financing reforms should be introduced to increase the coordination of the financial mechanisms and avoid overlaps in coverage, benefits, and financial flows.

Governance

Federalism transferred from the MOHP to the provincial and local governments the responsibility for collecting revenues and for establishing pooling and purchasing mechanisms without (a) creating proper local governance, skills, and competencies to manage health financing and (b) transferring all funding required for efficient service delivery.

Governance at both the central and local levels needs to be enhanced in the new federal structure. The role of the MOHP is expected to change by strengthening its stewardship functions, such as policy analysis, monitoring and oversight, quality assurance, standard setting, licensing and accreditation, regulation and supervision systems, sector performance assurance, health surveillance, and the use of financing mechanisms to support health sector policy.

On the implementation side, specialized health functions need to be established at the local level to carry out such tasks as budget and planning, service delivery, and health financing arrangements. Specialties requiring more investment, such as disease prevention and disaster preparedness, may be more at risk.

While local governments are responsible for local service purchase and delivery, their systems are not yet in place. The fragmentation of purchasing functions and structures at the central, provincial, and local levels could limit the extent to which strategies used by one level could influence the providers' behavior. Currently, the central and especially the local levels lack adequate mechanisms to review providers' performance (particularly in terms of quality of care) to identify frauds, implement audits, and process beneficiaries' claims and ensure that expenditure does not exceed the available resources.

In FY2018/19, almost 70 percent of all public budget allocations for health were still under the domain of the Central Government (Figure 22) for all essential health functions, except public health services, in which local levels share almost the same funding proportions as the federal level. Apparently, there is a disproportionality between the funding and the responsibilities for services delivery received by the local governments, and this could compromise the coverage and quality of health services provision.

Health information systems and arrangements for evaluation and monitoring systems need to be established or strengthened to identify where service delivery disruptions are occurring and to fix them on time. For example, data on or estimates of the coverage and socioeconomic composition of the beneficiaries by existing health packages is crucial to avoid loopholes on coverage, unfair distribution of funds, and future adverse risk selection. It is also important to have estimates of the level of cross-subsidies in the pooling schemes and to gauge the needs for future resources to improve the allocation and equalization mechanisms.

For the procurement of pharmaceuticals and medical supplies, the Government is considering full decentralization. This poses risks in terms of the capacity and ability of local governments to ensure good pricing through economies of scale and good quality through sound procurement and supply strategies. It will be important to consider different purchasing models that are responsive to local needs and local purchasing but have the benefits of pooled purchasing (economies of scale and quality).

Exploring future scenarios

If policy choices in Nepal lead the health system structure to be shaped as health insurance, in a Bismarckian way, probably the federal, provincial, and municipal health budgets would be used to buy subsidized premiums for the poor, and these premiums would be pooled with the health insurance premiums paid by individuals, enterprises, and other agents with ability to pay and used to manage the health governance structure and to purchase health services. In other words, tax revenues and premiums should be used to finance subsidies to pay for informal sector premiums (or only for poor and neglected groups under the informal sector) delivering the same health services package as that financed by payroll contributions for the formal health sector.

However, it is important to consider that, probably at the early stages of implementing the federal system, all these pooled funds may not be enough to finance all coverage of and access to the health package. In this case, OOP payments should be expected from those with ability to pay, to complement the funds paid from the purchasing agencies, under local government regulation and oversight.

OOP should be paid directly to the health facilities, financing the cost of some health services, drugs, supplies, and ancillary services in the form of registration fees, copayments, or other means. Before

establishing fees and copayments, the beneficiaries' need for subsidies should be carefully measured to avoid catastrophic payments, especially from the poorest families and those that are at risk of poverty.

Purchasing agencies should be created or restructured (as directly or indirectly managed by the Government), applying principles of economies of scale to manage purchasing services associated with the delivery process, based on a national unified health package to meet the needs of all citizens.

The federalism process and the creation of the national HI offers an excellent opportunity to ensure the UHC financing. The following suggestions would help increase the governance of health financing mechanisms.

Tax-based financing. The Federal Government, the provinces, and the local level should prepare and agree on an estimated PHE plan with a medium-term perspective (such as three years), organized to contain the following: (a) objectives; (b) expenditures allocation for the proposed plan, addressing feasibility; (c) outputs and outcomes to be achieved in the current and the next two fiscal years; (d) detailed expenditures required for the plan's implementation and the sources of financing in each fiscal year; (e) a chronogram for the plan's implementation and detailed activities, with expected physical and financial goals to be achieved; and (f) provision for an external ex post evaluation of the annual budget plans to be contracted at the end of each plan's implementation.

Health insurance. Achieving UHC needs to be understood as a long-term objective. To reach this goal, the national HI needs to be based in an independent or quasi-independent institution with the ability to technically raise revenues, mixing payroll contributions and subsidies; run actuarial analyses, ensuring that funding is financially adequate and stable; and negotiate and purchase health services from both public and nonpublic providers. Although the HIB currently lacks the autonomy to perform these functions, it could be given increased political and technical autonomy to take independent decisions.

Substantive aspects of the national HI regulation also require more detailed discussion—for example, defining (a) the typology of beneficiaries of the national HI and the assessment mechanisms for each group of beneficiary; (b) what premiums, benefits, and subsidies would guarantee equity and sustainability; (c) purchasing and provider payment mechanisms; (d) the institutional profile of the health services (primary care networks, hospitals, doctors and other professionals participating in the service delivery) and the mechanisms to guarantee quality and adequacy; (e) mechanisms to guarantee balanced funding and sustainability; and (f) the strategic expansion of coverage in a sustainable timeframe in coordination with the expansion of the health services and skilled health human resources.

5. Social and Economic Impacts of Existing Health Financing Arrangements

Main Messages

Health has considerable impacts on poverty in Nepal. In 2014, nearly 29 percent of the Nepalese population was multidimensionally poor, and in some provinces, such as Karnali and Province 2, close to 50 percent of the population was multidimensionally poor. In general, the poorest people live in the western parts of the country and at some locations in the mountains.

Considering the total household consumption expenditures as denominator, the percentage of households in “catastrophic” health spending could vary from 21 percent (using the 5 percent threshold) to 4 percent (using the 25 percent threshold). If only medical expenditures are considered, these proportions fall to 19 percent and 3 percent, using the same thresholds.

In the last three decades, Nepal has increasingly put equity in health services utilization at the center of the health policy agenda. The distribution of free medicines to the poorest people affected the dimension of poverty in Nepal, reducing the proportion of poor from 29 percent to 25 percent, according to data from the NLSS 2010/11.

Inequities persist in the physical distribution of health facilities in Nepal. In the Mountain (Himal) region, only 17 percent of the population can reach hospitals or primary health care centers within one hour or less, while in the Hilli and Terai regions 42 percent and 44 percent, respectively, can do so.

Levels of inequity are not so high in access to health posts and primary health care outreach clinics. However, because access to more complex health units is more unequal, the shares of live births in health facilities or attended by skilled professionals are more than twofold higher in the richest income quintile than in the poorest quintile.

Analysis of the allocative efficiency of health budgets shows that the country is underestimating the need to allocate more funding to noncommunicable diseases, which are rising faster in the burden of diseases. Regarding technical efficiency, recent studies on 32 hospitals in Nepal found that productivity increased in only 12 and declined in the remaining 20 hospitals.

In the new federal structure, recent studies show potential inefficiencies in procurement processes at the local government level due to lack of expertise, funding, and staff, along with prioritization of expensive curative services instead of primary care services, which best serve the poor.

There are systemic gaps in transparency and accountability in many health processes related to governance, financing, service delivery, health workforce, health information systems, and medical and pharmaceutical supply.

5.1 - Financial protection for health

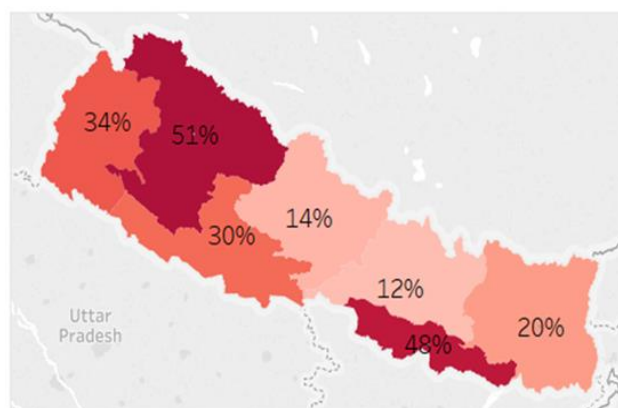
Financial protection is one of the key goals of UHC. To ensure financial protection, it is necessary to know how equitable health services are and how they have been financed. It is also important to know the proportion of households that incur catastrophic health spending and how many are impoverished as a result of health care expenditures. To better understand the situation in Nepal, some of the poverty trends need to be explained.

Poverty trends

An analysis of the poverty dynamics in Nepal³⁸ between FY2003/04 and FY2010/11, based on the NLSS, shows that almost 21 percent of the population remained in poverty in both periods and 58 percent stayed in non-poor status. However, while 14 percent of the population moved from poor to non-poor status, only 7 percent moved from non-poor to poor status, demonstrating a positive balance in the country's poverty dynamics during both periods (Adhikari 2016).

Other recent analysis shows the figures of multidimensional poverty in Nepal,³⁹ which is directly related to health status and health services access/coverage. In 2014, nearly 29 percent of the Nepalese population was multidimensionally poor, but in some provinces, such as Karnali (51 percent) and Province 2 (48 percent), the proportions were much higher (see Figure 24). The poorest people live in the western parts of the country and in some locations in the mountains (see Figure 25).

Figure 24. Multidimensional poverty in Nepal by provinces, 2014

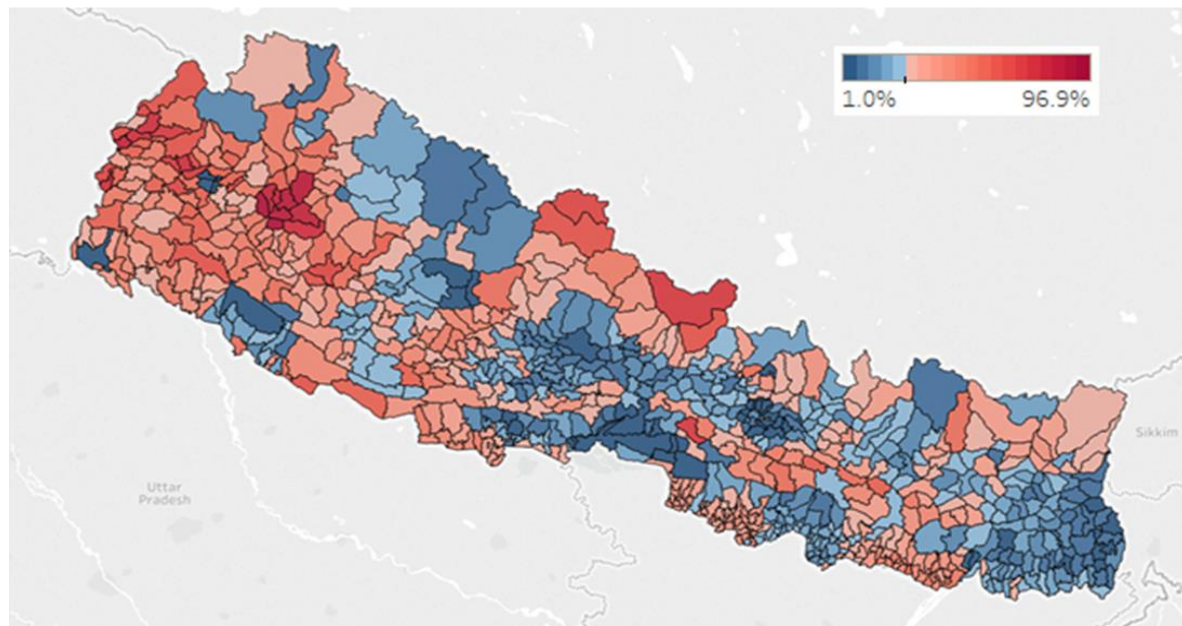


Source: Nepal National Planning Commission 2018.
Multidimensional Poverty Index: Analysis Towards Action.

³⁸ According to Adhikari (2019), poverty dynamics discusses the length of time a share of the population experiences poverty and explains movements in and out of poverty during certain period. Evidence on poverty dynamics is important for policymakers to design appropriate antipoverty and health care financing policies.

³⁹ The Oxford Poverty and Human Development Initiative states that "Multidimensional poverty is analyzed according to several factors that constitute poor people's experience of deprivation - such as poor health, lack of education, inadequate living standard, lack of income, disempowerment, poor quality of work and threat from violence. A multidimensional measure can incorporate a range of indicators to capture the complexity of poverty and better inform policies to relieve it. Different indicators can be chosen appropriate to the society and situation." More information can be found at <https://ophi.org.uk/policy/multidimensional-poverty-index/>.

Figure 25. Multidimensional poverty levels in Nepal by local levels (Palikas), 2014



Source: Nepal National Planning Commission (2018), Multidimensional Poverty Index: Analysis Toward Action.

Catastrophic health expenditures

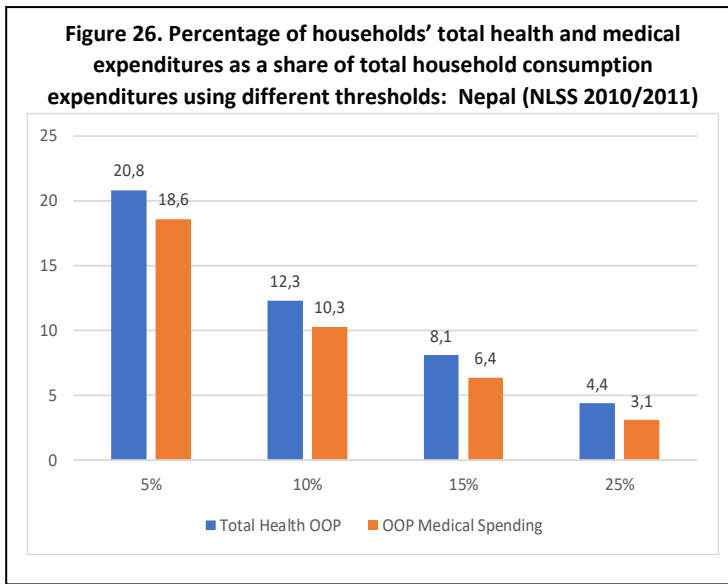
According to Xu et al. (2005), “when people have to pay fees or copayments for health care, the amount can be so high in relation to income that it results in financial catastrophe for the individual or the household. Such high expenditure can mean that people must cut down on necessities such as food and clothing or are unable to pay for their children's education.”

The indicator used to measure a catastrophic OOP expenditure is a household's health spending as a percentage of its total income, total consumption expenditure, or non-subsistence expenditure (such as spending on basic food items). However, there is no consensus in the literature about what threshold defines a catastrophic health expenditure in this indicator. For this reason, the choice of a threshold for OOP spending in health is arbitrary, and most of the existing analyses use different thresholds, in general from 5 percent to 40 percent (which is consensually considered critical).

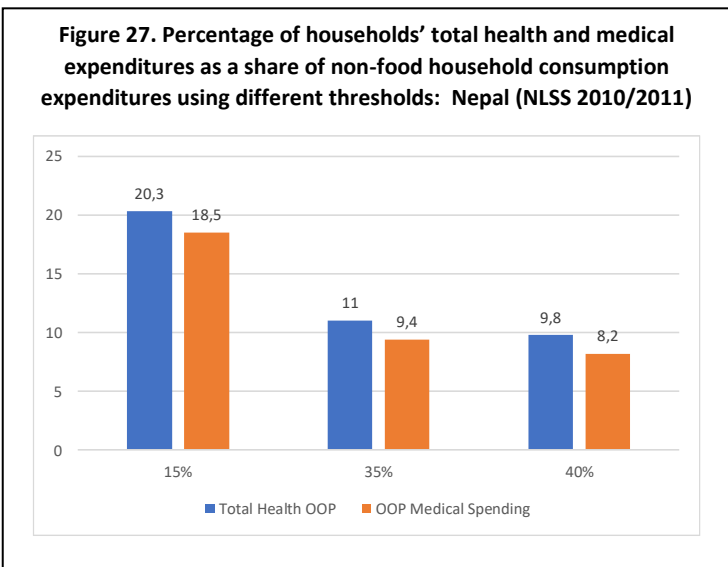
The data from the NLSS 2010/11 (the last available) allow an analysis of catastrophic health spending in Nepal. With the total household consumption expenditures as denominator, the percentage of households with “catastrophic” health spending could vary from 21 percent (using the 5 percent

threshold) to 4 percent (using the 25percent threshold) (see Figure 26). If only medical expenditures are considered, these percentages fall to 19 percent and 3 percent, using the same thresholds.

However, considering non-food consumption expenditures instead of total consumption expenditures and using higher thresholds (Figure 27), the proportion of households with catastrophic health spending reaches higher levels—varying from 20 percent (using the threshold of 15 percent) to 10 percent (using the threshold of 40 percent) for total health expenditures, and from 18 percent to 8 percent for medical expenditures, using the same thresholds.



Detailed analysis using the NLSS 2010/11 (Adhikari and Sapkota 2018) highlights some factors that could influence catastrophic health expenditures: (a) households with a greater number of children under age five and of elderly people are more likely to incur catastrophic payments; (b) Dalit households⁴⁰ are significantly more likely to incur catastrophic expenditures; (c) residents of Terai⁴¹ are more likely to incur catastrophic payments in terms of OOP and medical expenditure; (d) increased household size is found to be associated with catastrophic expenditure for OOPs and medical expenses; (e) households in the three poorest income quintiles are more likely to incur catastrophic payments; and (f) greater educational attainment of the head of a household makes the household less likely to incur catastrophic expenditure.



⁴⁰ Dalits is the lowest socioeconomic group under the caste system in Nepal, estimated at 13 percent of the country's total population.

⁴¹ Nepal's territory is geographically divided into three areas. Himal (or Parbat) is a mountainous and snowy region, where high ridges rise substantially above 3,000 meters. Hilli is a mountainous region, more densely populated, that does not generally contain snow; it is situated south of the Himal and mostly has a medium altitude. Terai is a lowland region containing some hill ranges, which begins at the Indian border and includes the southernmost part of the flat and intensively farmed Gangetic Plain.

Impoverishment led by health expenditures

There has been some criticism about the arbitrary adoption of different thresholds to define catastrophic health expenditures. Impoverishment led by health expenditures is considered a straighter measure, as it considers whether spending on health care pushes families or households below the poverty line. There is international statistical evidence from middle- and low-income countries that the larger the health spending is as a share of the total household expenditures, the higher the proportion of households below the poverty line.

Common poverty estimation methods follow the “cost of basic needs” approach to estimate the poverty line, but they do not include health care as a basic need in Nepal and many other. The failure to include OOP health payments in poverty estimations could give a misleading and biased picture of trends in poverty over time.

Therefore, Adhikari and Sapkota (2018) revised the Nepal poverty statistics by including basic health care needs in the basket with other basic needs, such as food, clothing, and shelter to calculate the percentage of the poor in the population. As result, the national poverty line for per capita household consumption, calculated at 25.2 percent using the NLSS 2010/11, should be recalculated to 28.6 percent if drugs were not provided freely by the Government in Nepal. In other words, the cost of medicine that is subsidized by the Government would put 3.4 percent of the non-poor population below the poverty line. This study also estimated that 4 percent of the poverty in Nepal is caused by OOP health expenditures.

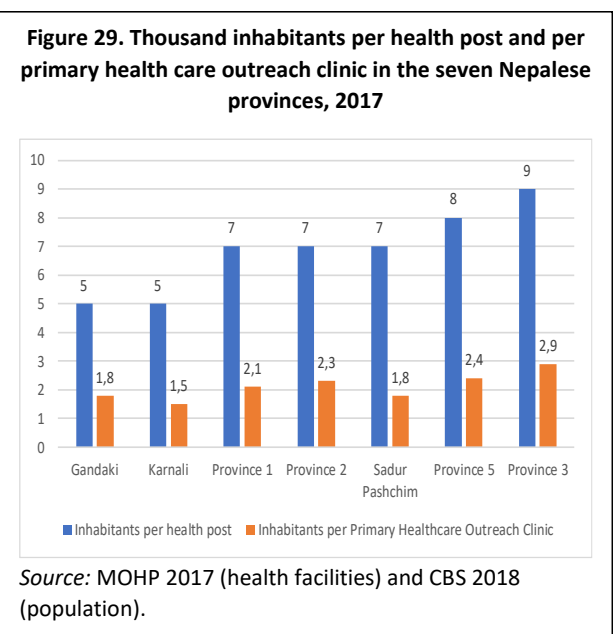
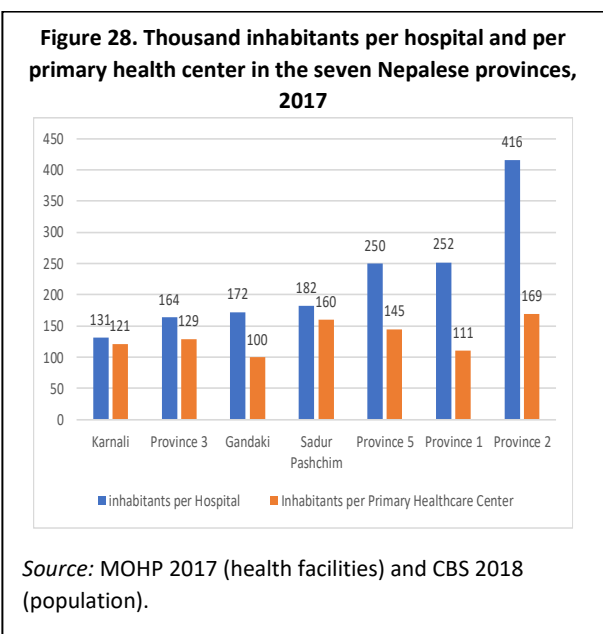
5.2 - Equity in services utilization and medical spending

Equity is a fundamental pillar for building the path to UHC. However, most health systems are practically configured on a basis of inequity, with strong differences in utilization levels and discrepancies in access to and quality of health services across socioeconomic groups. Over the last three decades, Nepal has increasingly put equity in health services utilization at the center of the health policy agenda.

- In 1991, the country proclaimed a National Health Policy with the objective of providing modern medical facilities to the rural population.
- In 1997, the Government formulated the Second Long-Term Health Plan, focused on ensuring equity in gender, socioeconomic inclusion, and access to quality health care services, based on an essential health care services package (EHCS) to be provided to the districts.
- In 2004, this plan was retargeted to prioritize family planning, safer motherhood, neonatal health, child health, communicable disease control, and outpatient care.
- In 2005, the AAMA Program (still in place) was launched to remove financial barriers and improve access to services.
- In 2007, the Government declared all health services at health posts and subposts to be free of charge, removing financial barriers to increase utilization of basic health services for all. In the same year, a program was introduced to provide free services at district hospitals and to reduce the impact of OOP payments for the poor.

- In 2011, the Government created the Medical Treatment of Deprived Citizens Fund (Bipanna Nagarik Kosh) to provide some financial relief to people facing financial shocks due to noncommunicable diseases such as cardiovascular disease and cancer.
- In 2014, the Government revoked the previous policy and created a new National Health Policy to ensure health care as citizens' fundamental human right, with the objectives to (a) make available free basic health services; (b) establish an effective and accountable health system with required medicines, equipment, technologies, and qualified health professionals; and (c) promote people's participation in extending health services.⁴²
- In 2015, the new Constitution of Nepal 2015 proclaimed free basic health services for all citizens.

How is this effort affecting real access to health services? Are health facilities proportionally well distributed according to the provincial population?



A comparison of the distribution of high-complexity (hospitals) and medium-complexity (primary health centers) health facilities by region (Figure 28) shows that hospitals are apparently more unequally distributed than primary health centers. Karnali has fewer inhabitants per hospital than any other province, but Nepal's capital city (Kathmandu) is in Province 3, and most of the general and specialized hospitals are in this city. Inequalities in hospital distribution is an issue that should be evaluated in Nepal. However, better transportation and referral systems could have more impact on increasing access to specialized care than the construction of new hospitals in provinces where economies of scale are low and recurrent costs are unaffordable.

⁴² This new National Health Policy would be explicitly financed by Government revenues, foreign loans and donors' assistance, and investments by the private sector.

Even when some services provided by hospitals and primary health care centers overlap, in general, they have been complementary in Nepal. Figure 28 shows, for example, that Province 2 has a higher population per hospital, but this tends to be compensated for by a lower population per primary health care center.

However, data about physical access to facilities from the NLSS 2010/11 show that in Himal region, only 17 percent of the population can reach hospitals or primary health care centers within one hour, while in the Hilli and Terai regions, 42 percent and 44 percent of the population, respectively, can do so.

Low-complexity health facilities (health posts and primary health care outreach clinics) are also unequally distributed by region (see Figure 29), but these kinds of facilities are better designed to meet the health needs of the rural population. Therefore, Province 3 has higher population size per health facility because of its higher urbanization rates. In this region, the scale and density of service utilization require more complex health units.

Table 7. Concentration indexes (Gini) of health facilities according to population per province: Nepal, 2017

Kind of Health Facility	Gini Concentration Index ^a
Hospitals	0.3937
Primary health care centers	0.3725
Health posts	0.3823
Primary health care outreach clinics	0.3849

Source: MOHP 2017 (health facilities) and CBS 2018 (population).

a. Gini concentration indexes vary from 0 (maximum equality) to 1 (maximum inequality).

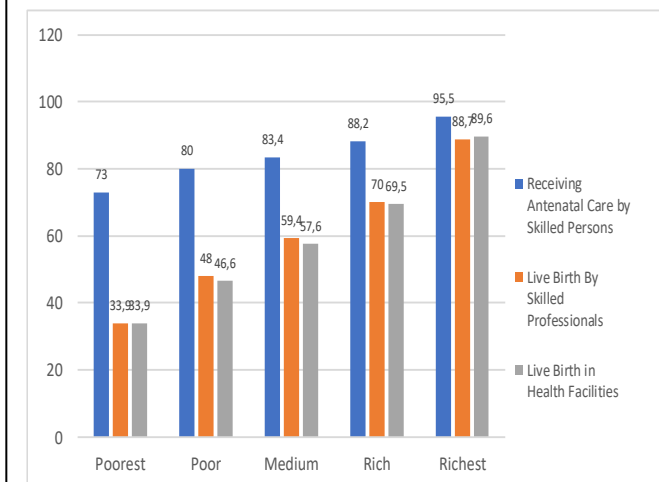
Table 7 presents the Gini concentration indexes for different kinds of health facilities for the Nepalese population in seven provinces, showing that, despite the relative low levels and homogeneity of concentration indexes in different kinds of facilities, inequality is higher for access to hospitals and lower for access to primary health centers.

Inequality in access to health services is also expressed by income levels. Data from the Nepal DHS 2016 show that the poor have the greatest difficulty in accessing reproductive health services (see Figure 30).

Levels of inequity are not so high for antenatal care provided by skilled persons because there is more equitable access to health posts and primary health care outreach clinics. However, because access to more complex health units is more unequal by income levels, the shares of live births in health facilities or attended by skilled professionals are more than twofold higher in the richest income quintile than in the poorest quintile.

Improving equity in service utilization is one of the final goals of any health system in the path to UHC. Nepal has improved equity in access to health services over the last two decades, but it still has a long way to go to achieve UHC. The implementation

Figure 30. Percentage of Nepal's population with access to main reproductive health services by income quintiles, 2016

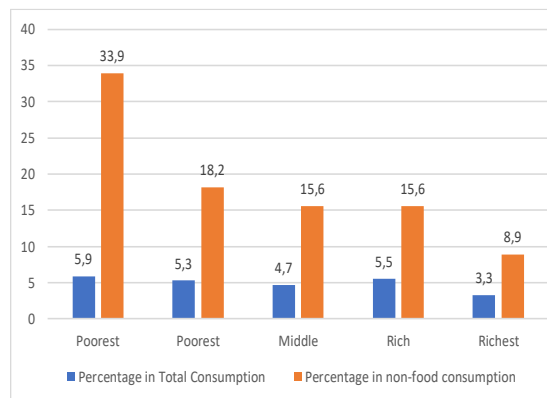


Source: Nepal DHS, 2016.

of the federal structure could be a good opportunity to identify the regional and income discrepancies and make investments in infrastructure and skills to improve access to and quality of health care.

The NLSS 2015/16 provides information about medical expenses by income levels considering the total consumption spending and the non-food consumption spending. As can be seen in Figure 31, the differences on the percentage of medical expenditures among income quintiles is not so high as the poorest quintile spend 5.9 percent compared with 3.3 percent in the richest quintile. However, given that health expenditures tend to be relatively inelastic because of essential needs, the poorest quintile spent more than one-third of its non-food expenditures in medical goods and services, compared with only 9 percent in the richest quintile. If medical services are free of cost to the poor, one-third of the poorest quintile population non-food budget could be used to spend on children’s education, housing improvements, or other essential needs and, as seen before, some of the population in this quintile could be out of the risk of going below the poverty line.

Figure 31. Percentage of medical spending as a share of total and non-food consumption of the Nepal’s population by income quintiles, 2016



Source: Nepal NLSS 2015/16.

5.3 - Efficiency and quality of health spending

Because most low-income countries’ health systems suffer from limited funds, technical resources, and professional skills, the efficient use of financial, technical, and human resources is key to better results in the path to UHC. If most services are provided efficiently, producing the maximum outcomes with the minimal amount of financial resources without compromising quality, more people can benefit. Efficiency and quality need to be seen as two faces of the same coin; there is no efficiency in health care when quality is compromised.

There are two important concepts of efficiency in health care financing: allocative efficiency, or “doing the right thing,” and technical efficiency, or “doing it the right way.” Since Nepal has limited fiscal space to increase its health budgets, improving the efficiency of health spending is key to increasing the fiscal space in the health sector.

Scarce evidence of efficiency in Nepal

Evidence of both allocative and technical efficiency in Nepal’s health sector is scarce. A systematic Government approach to improving technical and allocative efficiency in health services delivery is an urgent task to be carried out in partnership with academic institutions, consulting firms, and international donors.

Regarding allocative efficiency, a recent article published by Sharma et al. (2018) considers that one of the sources of inefficiency in health spending in Nepal is linked to the Government’s budgetary practices. The categories for spending are remnants of disease-centric vertical programs, with scant resources

earmarked for addressing the rising burden of noncommunicable diseases, mental health, and other emerging conditions. Given the fast processes of demographic transition and urbanization in the country, the health system should be centered in people outcomes. This requires moving beyond the programmatic proclivities of yesteryear and making judicious choices toward a strategy that drives necessary quality improvements and responsiveness in the health system.

In terms of technical efficiency, recent studies on the productivity of 32 hospitals in Nepal between 2011/12 and 2013/14 (Silwal and Ashton 2017) found that productivity increased in only 12 (37.5 percent) and declined in the remaining 20. The total factor productivity loss was influenced by a decline in technology change, but the authors mentioned that detailed and consistent measures of hospital inputs and outputs is a major challenge for this type of analysis in the country.

Regarding the efficiency and quality of health care management and provision at district levels, a study by Devkota (2008), mixing technical and allocative aspects, raised several issues that need to be checked and revalidated in the actual context.

- Most health services managers and personnel are not aware of the country's health sector strategies, a situation that prevents good coordination between resources and outcomes.
- Even considering the increased coverage of primary health services, quality continues to be a problem, especially in mountain areas and among neglected populations such as the Dalits.
- There is an absence of clear policies, guidelines, support, and follow-up mechanisms at the health facilities that have been handed over to poor communities, so they are unable to improve the quality of services.
- Health posts and primary health care outreach clinics seem less willing than hospitals and primary health care centers to charge user fees, limiting their incentives to improve quality.
- Support of the private sector, such as nongovernmental organizations, is important but irregular and not clearly defined. It is necessary to identify areas of potential partnership with the private sector, including in health promotion activities.
- The budget absorption capacity of the district health systems (in 2008) seems above 95 percent, and their administrative costs are below 15 percent and declining. However, further studies are necessary to ascertain the cost-effectiveness of the essential health care services delivered at the local level.
- Acute shortages of service providers (particularly medical personnel) in district hospitals and primary health care centers have been reported; the main reasons are the lack of proper supervision and of periodic and timely review of positions in these areas. Therefore, Devkota suggested a functional supervision, decentralized to local bodies where possible, and timely review of the health workforce. It is probable that these problems persist in the transition to federalism, and even with autonomy, local governments will need the MOPH supervision to identify and correct them.
- Regarding the physical conditions of the health facilities, Devkota said that in the absence of staff with proper knowledge of handling and maintenance, important equipment seemed to be

nonfunctioning in many health facilities. Training staff on handling and equipment maintenance and ensuring proper storage of medicines and supplies seems to be crucial.

- Health sector services still need to be made more inclusive, considering local needs, and should be linked with doable safety nets.

Many other problems with the efficiency and quality of health care in Nepal need to be tackled when more evidence becomes available. One urgent problem associated with changes in responsibilities in the decentralization context is to organize the processes of procuring medical goods (pharmaceuticals, other supplies and equipment) that were transferred to the local governments.

Efficiency risks in procurement at local governments

A recent health procurement assessment of the local governments in Nepal, sponsored by the DFID (Crown Agents 2019), summarized the main problems that currently compromise the efficiency of the procurement processes at the local governments: (a) a lack of public financial and procurement management expertise; (b) conditional grants that are insufficient for paying staff salaries, purchasing drugs, and covering the costs of other basic health care functions; (c) delayed and inefficient procurement of drugs; (d) resistance among district health office staff to be transferred to local governments; and (e) over-politicization of local spending, prioritizing expensive curative care over basic preventive care, and spending on ward-level projects rather than sectorwide municipal-level services.

In the transition to federalism, efficiency issues could be raised by the lack of qualification of the local government contracting authorities, especially in the functions of purchasing services and procuring supplies. During the transition, it is critical to build local-level capacity to harness the benefits of decentralization, with increased transparency and procurement based on local needs (Thapa et al. 2019).

The efficiency-side benefits of centralized procurement

According to international studies (Dubois et al. 2019), there is increasing evidence that centralized procurement systems allow public buyers to obtain significantly lower prices and increase efficiency in the procurement processes because (a) demand-side concentration may enhance public buyers' bargaining power, allowing them to negotiate lower prices; and (b) centralized procurers are likely to buy larger quantities, securing price discounts on larger orders. Therefore, it is important to review carefully which procurement processes will be decentralized to local levels and which must be centralized to increase efficiency and economies of scale.

There are many sources of inefficiencies in health financing, and many of them are related to pharmaceuticals:

- **Underuse of generics and higher-than-necessary prices of medicines.** It is necessary to prepare and require the use of essential drug lists linked with standard treatment guidelines (especially in public sector facilities). Retail pharmacies and doctors also need to be monitored to avoid the substitution of generics by brand name prescribed medicines.
- **Use of substandard and counterfeit medicines.** Adequate standards and tests to ensure the quality of pharmaceuticals need to be mandatory and implemented.

- **Inappropriate and ineffective use of pharmaceuticals.** Medicines should be prescribed and dispensed separately, by different health care providers.

Inefficiency can also be related to under or overuse or supply of equipment, exams, and procedures; the issuance, implementation, and oversight of health protocols, guidelines, and clinical pathways are essential to improve the use and allocation of the resources. Overall, in economic terms, each disease or medical condition requires a production function to be treated and cured, and for each production function, there is an optimal allocation of its production factors.

Another source of inefficiency is related to human resources, especially an inappropriate staff mix or undermotivated health workers. Protocols and clinical pathways are also relevant to define the staff mix to be used in each clinical condition, and many high-cost medical interventions (such as the use of doctors to administer vaccines, as happens in countries like Cuba that have an oversupply of doctors) could be avoided if technical protocols and guidelines are followed.

5.4 - Transparency and accountability

To achieve UHC, it is necessary to communicate accurately with all health system stakeholders (managers, providers, payers, beneficiaries, patients, and so on) about their roles, entitlements, and responsibilities. Many health systems have failed because stakeholders do not understand their roles and have overly low or high expectations about benefits, responsibilities, financial flows, and so on. In the area of health financing, information about funding flows, payments and copayments, premiums, and all other financial data need to be very well communicated.

Transparency and accountability are not only a matter of behavior and consciousness but also a matter of clarity about processes, data, and information. During Nepal's transition to the federal system, lack of clarity has created significant issues of understanding how the health sector is moving, particularly regarding the responsibilities and roles of the central, provincial, and local levels.

Lack of clarity on roles and responsibilities

Many issues about roles and responsibilities are not yet agreed. Moving from a unitary structure to a federal one creates technically complex organizational challenges, so that more evidence needs to be produced on the following questions:

- What are the likely health system gaps and challenges in the emerging federal system across the six health building blocks—governance, financing, service delivery, health workforce, health information, and medical and pharmaceutical supply?
- How will the new health federal structure organize the basic functions of health care financing, such as collecting revenues, pooling, purchasing, and providing services?
- How will the national health policy and the health annual budgets be linked? This problem will be widening in the transitional period of implementing the federal system.
- How will these changes be reflected in the budget formulation process of the three levels of government, in the benchmarking cost of the basic health package, in the prioritized health programs (if a vertical approach prevails), in the design of health system outputs and outcomes,

and so on? The current budget approach does not provide a good basis for federalism and for the unbundling of functions.

- How will provincial and local governments be prepared (in terms of human resources training and functional structures) to support the new health planning and budgeting processes?
- How will the three levels of government be able to build an interoperable health management information system, integrating all flows of medical, epidemiological, managerial, and financial information and including automatic links between budget allocation, budget implementation, health outputs, and population health outcomes?

Transparency and accountability processes will be ready and functional, not only when these questions are answered, but especially when they are well communicated, understood, and commonly implemented by all stakeholders, ensuring a space for adjustments and changes when politically, economically, and socially necessary.

6. Final Remarks

Main Messages

Over the next three years, fiscal space for health financing in Nepal should be benefited by economic growth, increasing household incomes and Government fiscal revenues and allowing more spending to meet the population's health needs. The success of poverty reduction measures and could increase domestic health revenues from those who are able to pay health insurance premiums and could help to define the size of the population that needs public subsidies and free health care. Pressures to improve the country's fiscal balance could limit the possibilities to increase health spending in the coming years. However, the 2015 Constitution commitments to UHC could lead the Government to reprioritize health in the national budget system. This document shows that two big reforms—health federalism and the new national HI—will pose some health financing challenges.

Local and provincial governments need to plan mechanisms for collecting revenues and pooling funds beyond the central transfers and need to increase their ability to efficiently elaborate and implement health budgets to meet their needs. Better coordination among the three levels of government will be necessary to avoid duplication and to build common capacities and oversight mechanisms to monitor budgets and spending on health. New mechanisms and options to structure and purchase health services need to be planned, considering the issues of efficiency, economy of scale, and affordability among the three levels of government.

The HI, as the single mandatory health insurance, needs to define unified enrollment mechanisms to avoid duplication, and to adopt the basic health package defined by the MOHP for both receiving subsidies and paying contributive premiums.

Nepal is moving in the direction of a mixed tax-based and prepayment financing system. Both financing mechanisms need to be adjusted and merged in the context of the transition to the federal system to avoid overlapping funding strategies such as free basic health care and health insurance subsidies. The Government needs to clarify what funds-pooling mechanisms will be in place (especially considering the public subsidies) and what service-purchasing mechanisms the national HI will adopt.

Managing these complex structures should require interoperable and transparent health information systems, allowing the systematic production of financial and performance reporting on fiscal funds and expenditures statements. Current information systems, such as the HMIS, Health Information System assessment tools database, and the TABUCS, as well as the health insurance management information systems, need to work in an interoperability environment producing valuable information for analytical purposes and decision making. Structured data from interoperable health information systems will allow efficiency improvements, such as the use of payments for performance and results-based financing mechanisms, which the new health financing strategy and its purchasing mechanisms for goods and services should foster. Costing systems need to be implemented in health facilities to improve efficiency, and rationing mechanisms need to be introduced to allow the efficient use of funds and the formulation of the budget on realistic bases.

Since 2015, Nepal has increased its commitment to UHC, as is reflected in its Health Strategy and the 2015 Constitution. The transition to federalism (started in 2015) and the creation of the new national HI (started in 2017) create a challenging but positive environment to implement this commitment but raise some financial challenges that need to be faced in the country's first HFS.

Over the next three years, fiscal space for health financing in Nepal should benefit from an economic growth of 4.5 percent to 5 percent, increasing household incomes and government fiscal revenues and allowing more spending to meet the population's health needs. The results of poverty reduction measures and remittances could increase domestic health revenues for those who are able to pay health insurance premiums and could help define the size of the population in need of public subsidies and free health care. Pressures to improve the country's fiscal balance could limit the possibilities to increase health spending in the coming years. However, the 2015 Constitution commitments to UHC could lead the Government to reprioritize health in the national budget system. This document shows that two big reforms—health federalism and the new HI—will pose some health financing challenges.

Local and provincial governments need to plan mechanisms for collecting revenues and pooling funds, beyond the central transfers and need to increase their ability to efficiently elaborate and implement health budgets according to their needs. Better coordination among the three levels of government finances will be necessary to avoid duplication and to build common capacities and oversight mechanisms to monitor budgets and spending on health. New mechanisms and options to organize and purchase health services need to be planned, considering the issues of efficiency, economy of scale, and affordability among the three levels of government.

On the health insurance side, the Government needs to coordinate the existing health insurances with the national HI and unify the mandatory enrollment mechanisms to avoid duplication. The national HI basic health package must be the same adjusted package for those subsidized by public funding. Since in recent years, only 6 percent of the population has been enrolled in health insurance, the national HI enrollment should be universal and most of its finance will come from tax-based funds targeted to the poor.

However, there is no clarity about what funds-pooling mechanisms will be in place (especially considering the public subsidies) and what service-purchasing mechanisms the national HI will adopt, but what is certain is that these mechanisms must be progressively merged to be the same as those used by the public system. Nepal is moving in the direction of a mixed tax-based and prepayment financing system. Both financing mechanisms need to be adjusted and merged in the context of the transition to the federal system to avoid overlapping funding strategies such as free basic health care and health insurance subsidies.

Some of these challenges could be addressed by building capacities. Local and provincial governments must be able, on a bottom-up basis, to decide on the categories and on the quantity and quality of services that they intend to offer and to elaborate budgets reflecting these needs, which would be adjusted according to the availability of funding. However, to avoid discontinuity and to provide predictable financing for local needs, all levels of government need to coordinate the funding process, mixing federal transfers, external resources, HI premiums, and OOP resources. The proportions of this mix will vary according to regions, priority diseases, socioeconomic/income groups, and levels of government, and it needs to be carefully designed in conjunction with the revenue-collecting, resource-pooling, and purchasing processes mechanisms.

Managing these complex structures requires a new HMIS that needs to be interoperable and transparent, allowing the systematic production of financial and performance reporting on fiscal funds and expenditures statements. Efficiency needs to be improved by using payments for performance- and results-based financing mechanisms, which should be fostered in the new health strategic purchasing mechanisms for goods and services. Costing systems need to be implemented in health facilities to improve efficiency, and rationing mechanisms need to be introduced to allow the efficient use of funds and the formulation of realistic budgets.

The health sector in Nepal needs to create a Master Plan, built on dialogue with and the expectations of the main stakeholders and based on a careful analysis of the sector's strengths, weaknesses, opportunities, and threats. This plan should encourage the development of multiyear plans on which the sector's annual budgets would be based. The multiyear plans should reflect the mission, vision, values, and long-term goals of the MOPH, which is responsible for the sector's stewardship and for coordinating all stakeholders' expectations. At the same time, multiyear plans allow managing long-term priorities, planning a more predictable environment, and negotiating long-term commitments in health financing with the economic authorities, donors, and the broader society.

Despite the small size of Nepal's private sector, public-private partnerships to fill gaps and address health system needs should be enhanced—from upgrading primary care capacity to developing centers of excellence at the local and provincial levels, including for research and specialty care.

Other challenges that are external to the health sector need to be considered as the MOPH formulates its strategy of collecting revenues for health services. Compared with other countries in South Asia Region, the share of health in Government spending has been relatively high, but it has been declining since 2011, indicating that the Central Government is giving lower priority to the health sector. Therefore, federalism is affecting not only health but also other economic and social policies in the country, limiting the fiscal space to address health needs because of competing Government priorities in other sectors.

However, the Government cannot give up the current perspectives to increase revenues to the health sector in the short term, because some fiscal space could be opened by advocacy to reprioritize health among other Government policies, based on the commitment to UHC and the implementation of the new health federal structure. For this, it is crucial to increase transparency, information, and perspectives and to improve efficiency in health spending.

Without a carefully designed health strategy, the transition to federalism could increase the risk of disruption in service delivery, given that budget allocations to the municipalities would be at risk of not being spent or of being spent with low efficiency and management performance. This situation could lead to lack of health services, pharmaceuticals, medical supplies, and human resources, putting the poorest population at risk. Therefore, part of the HFS should be preparing the local and provincial levels to implement the new health financing functions brought by the new federal structure, such as procurement and financial management, which were previously performed by the central or district governments. This will require enabling new regulatory mechanisms to ensure a minimum quality of care in all public and private providers.

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Appendix

Appendix 1 - Health in Federal Nepal: Distribution of Functions and Functionaries

(Source: Functional Unbundling Report)

Federal Competence (exclusive)	Provincial Competence (exclusive)	Local Competence (exclusive)	Concurrent – Needs to be clarified
<p>Section 16: Health policies, health services, health standards, quality and monitoring, national or specialized service providing hospitals, traditional treatment services, and communicable disease control</p> <ul style="list-style-type: none"> • Development and promotion of promotional, preventive, curative, rehabilitative, and palliative health services in the national level • Formulation of standards and regulation of academic, occupational, and professional institutions relating to health • Establishment, operation, and regulation of health institutions • Accreditation of hospital and health institutions • Registration, operation, permission, physical infrastructures, management, and regulation of national or specialized service providing hospitals • Quality standardization and regulation relating to medicine health equipment and health technology production and development, storage, sales, and distribution and final disposal • International health regulation, health relating treaty and agreement and relation, 	<p>Health services</p> <ul style="list-style-type: none"> • Provincial policy, law, quality standards, planning, implementation, and regulation relating to health service and nutrition • Promotional, preventive, counter acting, curative, rehabilitative, and palliative health service management as needed in the state level • Registration, operation, permission, and regulation of state-level academic, professional, and occupational organizations relating to health services • Quality assurance, registration, permission for operation, management, and regulation of state-level treatment centers and services • Quality standards, registration, permission for operation and registration relating to production of medicinal and health technology materials, storage, maximum retail price, final disposal according to the national standards • Agency-wise cooperation and coordination 	<p>Basic health and sanitation</p> <ul style="list-style-type: none"> • Policy, law, standards, planning, implementation, and regulation relating to basic health and sanitation • Operation and promotion of basic health services • Establishment and operation of hospitals and other health institutions • Physical infrastructures development and management relating to health services • Management of sanitation awareness program and health-related waste • Collection, reuse, processing, disposal, determination of service fee, and regulation of health-related solid waste • Matters relating to blood circulation service, local, and urban health service • Matters relating to medical shop operation and regulation 	<p>Planning, family planning, and population management (including from schedule 5(5)) (p.70)</p> <p>Legal profession, auditing, engineering, medicines, Ayurved medicines, veterinary, Amchi and other professions</p> <p>Local government - Schedule 8(8)</p>

Federal Competence (exclusive)	Provincial Competence (exclusive)	Local Competence (exclusive)	Concurrent – Needs to be clarified
coordination and cooperation with development partners <ul style="list-style-type: none"> • Policy and standardization of traditional health treatment service including ayurvedic, yunani, amchi, homeopathy, and naturopathy • Policy and standardization relating to communicable and noncommunicable disease control 			
From Schedule 9(3) <ul style="list-style-type: none"> • Policy, law, standards, and regulation relating to health (treatment) tourism • Policy, law, standards, and regulation relating to social security including health insurance • Human resource development and management of health sector • National standardization, implementation, and regulation relating to health services and material fee • Pharmacovigilance and regulation • Standard and regulation of medicine procurement and supply management • Study, research, and regulation relating to health science • Medicinal research of herbs and mineral • Management of health information system and health audit system • Public health surveillance of national and international concern • Standardization of basic health service • Formulation of national protocol of health service necessary at different levels 	From Schedule 9(3) <ul style="list-style-type: none"> • Registration, permission for operation, and regulation of hospital and nursing house, Nidan (Curing) center, and other health institutions according to national standards • Quality monitoring and analysis model of drinking water, food material, sound and air and standard of quality and implementation • Implementation, surveillance, and monitoring of provincial programs • Management and regulation of health insurance including health security programs according to national standards • State-level health sector human resource development and management • Matters relating to pharmacovigilance, appropriate use of medicine, and antimicrobial resistance reduction • Procurement and supply management of immunization and family planning including quality sensitive medicine and health materials • Determination of priority of research, study, and research and information delivery at the state level 	From Schedule 9(3) <ul style="list-style-type: none"> • Target and quality determination of local level according to the nation and provincial target and standards • Clinic registration, operation, permission, and regulation of general hospitals, nursing homes, observation center, and other health institutions • Production, processing, and distribution of medicine-related vegetation, herbs, and other medicine-related materials • Social security program management including health insurance • Minimum price determination and regulation of medicine and other medical products at the local level • Appropriate use of medicine and antimicrobial resistance reduction at the local level • Procurement, storage, and distribution of medicine and health equipment at the local level • Health system management at the local level • Public health surveillance at the local level • Operation of promotional, preventive, curative, rehabilitative 	

Federal Competence (exclusive)	Provincial Competence (exclusive)	Local Competence (exclusive)	Concurrent – Needs to be clarified
<ul style="list-style-type: none"> • Establishment of operation of national reference laboratory and testing center • Development of national referral system • Quality monitoring and analysis, model/pattern and quality standardization of drinking water, food stuffs and air • Model/scheme formulation, implementation coordination and regulation of health sector climate change adoption • Public health emergency situation, disaster in health and epidemic management • Buffer stock management of medicine and medical equipment for emergency situation • Determination of scope of basic health services • Emergency health service delivery 	<ul style="list-style-type: none"> • Institutional management of health information system and health audit system at the state level • State level public health surveillance management • State level standard and management relating to ayurvedic and other vogue health services • Standards, control and regulation of tobacco, alcohol and intoxicant matters • Permission, operation and expansion of cure centers and laboratory services • Public health emergency situation, disaster in health sector and epidemic management • Communicable and noncommunicable disease control and prevention • Physical infrastructures development and management relating to health service according to national standards • Standardization, implementation and regulation relating to health-related solid waste management • Provincial buffer stock management of medicine and medicine related materials for emergency situation • Matters relating to ayurvedic, unani, amchi, homeopathic, naturopathy including traditional and health services management • Emergency health services delivery 	<p>and palliative health services at the local level</p> <ul style="list-style-type: none"> • Promotion of public health including healthy lifestyle, nutrition, physical exercise, yoga, adoption of health circle, panchakarma • Control and management of zoonotic and insects related diseases • Control in use and awareness promotion of tobacco, alcohol, and drugs-related substances • Management of traditional health treatment services including ayurvedic, unani, amchi, homeopathy, and naturopathy • Control plan and implementation of public emergency health, epidemic control at the local level • Control and prevention of communicable and noncommunicable disease at the local level • Matters relating to emergency health services delivery 	

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Chapter 3: Function, duties and rights of rural municipality and municipality	
<p>Exclusive:</p> <p>11. Function, duties and rights of rural municipality and municipality:</p> <p>(1) The exclusive rights of the rural municipality and municipality shall be as mentioned in Schedule-8 of the Constitution.</p> <p>(2) The function, duties and rights of the rural municipality and municipality, without adversely affecting the universality of Sub-clause (1), are as follows.</p>	<p>Basic health and sanitation</p> <ol style="list-style-type: none"> (1) Formulation, implementation, monitoring, evaluation, and regulation of policies, laws, standards and plans related to basic health, sanitation and nutrition, (2) Operation and promotion of basic health, reproductive health, and nutrition services, (3) Establishment and operation of hospitals and other health institutions, (4) Physical infrastructure development and management for health services, (5) Setting of standards for clean drinking water and food, control and regulation of air and noise pollution, (6) Awareness raising on sanitation and management of health-related wastes, (7) Collection, recycling, processing and disposal of health-related wastes, and determination and regulation of its service fee, (8) Operation of blood transfusion service, and local and urban health services, (9) Permission, monitoring and regulation of pharmacies/drug stores operation, (10) Coordination, collaboration and partnerships with private and non-governmental sectors for management of waste produced from sanitation and health sectors (11) Services, permits, monitoring, and regulation related to family-planning and mother-child welfare services, (12) Reduction, prevention, control and management of malnutrition in women and children.
<p>Concurrent:</p> <p>(3) The concurrent rights to be exercised by the rural municipality and municipality jointly with the federation and province shall be as mentioned in Schedule-9 of the Constitution.</p> <p>(4) The function, duties and rights of the rural municipality and municipality shall be as follows under the purview of the federal and provincial law on the following subjects without having adverse impact on the universality of Sub-clause (3):</p>	<p>b. Health</p> <ol style="list-style-type: none"> (1) Determination of local level health target and standards as per the federal and provincial target and standards, (2) Clinic registration, operation license and regulation of general hospital, nursing home, diagnosis center and other health institutes, (3) Production, processing and distribution of medical plants, herbs and other medical goods at the local level (4) Health insurance and other social security program management, (5) Determination and regulation of minimum price of medicines and other medical products at the local level (6) Proper use of medicines at the local level and micro-organism resilience minimization (7) Purchase, storage and distribution of medical and medical equipment at the local level, (8) Management of local level health information system (9) Public health surveillance at the local level (10) Operation of promotional, defensive, curative, rehabilitative and palliative health service at the local level (11) Promotion of health lifestyle, nutrition, physical exercise, yoga, following health circle, panchakarma and other public health service,

Chapter 3: Function, duties and rights of rural municipality and municipality	
	(12) Control and management of pests and diseases, (13) Control of the use of tobacco, alcohol and drugs and awareness raising, (14) <i>Ayurvedic, Yunani, Amchi</i> , homeopathic, natural medicine and other traditional medical treatment service management (15) Public health, emergency health and epidemic control plan and enforcement (16) Disease control and prevention (17) Emergency health service supply and local service management
12. Function, duties and rights of ward committee: (1) The function, duties and rights of the ward committee shall be as prescribed by the executive. (2) The executive shall prescribe the function, duties and rights of the ward committee as per Sub-clause (1) to include at least the following:	(4) Manage ward-level health center and sub-health center, (5) Operate, manage and coordinate vaccination service program, (6) Operate and coordination nutrition program, (7) Operate health awareness development and health information program at the ward level, (8) Operate, cause to run urban and rural health clinics, (34) Take the unclaimed and helpless sick people to the nearby hospital or health center for medical treatment, e. Recommendation and certification (10) Recommendation for free or paid health treatment,

Appendix 2 - Health Programs and Health Insurance Schemes in Nepal: Coverage, Eligibility, Financing, and Managerial Mechanisms

CRITERIA	Public System	National Health Insurance	Voluntary Private Insurance	Safe Motherhood Program	Basic Health Care Package Service	Free Health Care	Enterprises Private Insurance by the Employers	SSF	Impoverished Citizens' Service	Health Insurance by Employee Provident Fund
TARGET POPULATION	All Nepalese citizens	All Nepalese citizens	Targeted Population	Women in reproductive age and neonates	All Nepalese citizens	All Nepalese citizens particularly poor, vulnerable, and unreached population	Salaried workers associated to EPF scheme or workers of the enterprises	All formal and informal workers	All poor citizens	Target formal workers
POPULATION COVERED OR ENROLLED	Automatic	Around 75% of total population. Covering 42 districts out of 77 districts (Status on April 2019)	Less than 1% of total population	Automatic	Not started yet	72% of the target population	70 % of all the employees of the Private enterprises receive some health benefit	Not started yet	8,250 poor citizens utilized services	Target 10 lakhs formal employees
BASIS FOR COVERAGE OR ENROLLMENT	Automatic	Currently, voluntary enrollment (Mandatory according to the Health Insurance Act 2017)	Voluntary	Automatic	Automatic	Automatic	Voluntary	Mandatory	Automatic	Automatic

CRITERIA	Public System	National Health Insurance	Voluntary Private Insurance	Safe Motherhood Program	Basic Health Care Package Service	Free Health Care	Enterprises Private Insurance by the Employers	SSF	Impoverished Citizens' Service	Health Insurance by Employee Provident Fund
BENEFITS OR ENTITLEMENT	<p>Immunization, Nutrition, IMNCI, Family Planning, Safe motherhood and newborn health, PHC ORC disease control vertical programs such as HIV/AIDS, tuberculosis, malaria, leprosy, polio, and so on.</p> <p>User fees exist for most curative services, but with exemptions for the poor, physically and mentally impaired people, senior citizens over 70 years</p>	<p>All services beyond free health care package worth NPR up to 200,000, including additional NPR 100,000 coverage for 8 listed chronic diseases and additional NPR 100,000 for every elderly population above 70 years with exception of negative list, according to the Health Insurance Regulation of 2018.</p>	<p>Benefit package varies according to the private insurance providers and insurance polices</p>	<p>ANC, Institutional delivery (normal, assisted and surgical);</p> <p>PNC perinatal care, including cash transfer to service user as transportation cost</p>	<p>Benefit package under development phase</p>	<p>Free OPD at the health posts, primary health care centers and up to 25-bedded public hospitals and up to 70 drugs provided free of cost.</p>	<p>Depends on enterprises insurance policy choice: private insurance policy, lump-sum cash/reimbursement to the medical bills.</p>	<p>OPD, IPD, diagnostics surgical, medical, including drugs and maternity care.</p>	<p>Chronic disease such as heart and kidney (renal failure) diseases, Alzheimer and Parkinson, cancer, head and spinal injuries up to NPR 100,000</p>	<p>Only IPD cases included worth up to NPR 100,000 and additional IPD cases worth up to NPR 1 million.</p> <p>OPD cases are excluded</p>

CRITERIA	Public System	National Health Insurance	Voluntary Private Insurance	Safe Motherhood Program	Basic Health Care Package Service	Free Health Care	Enterprises Private Insurance by the Employers	SSF	Impoverished Citizens' Service	Health Insurance by Employee Provident Fund
REVENUES SOURCES	Tax funded (budget allocations), external/ donor funds (Pool Fund), user charges	Tax funded - MOF provides annual block grant to subsidize premiums for poor and vulnerable population; Contribution collection from members (premium) NPR 3,500 per five family members per year (Health Insurance Regulation 2018)	Premium collection from enrollees	Tax funded	Tax funded	Tax funded	Enterprises internal revenues/pr ofits	Payroll contribution collection from employer (20 percent) and employees (11 percent) and contribution collected from the informal sector worker voluntarily	Tax funded	Paid by EFP
POOLING ARRANGEMENTS	Salaries are determined and paid centrally for the MOHP staff at all the levels of governments Salaries are determined and paid locally for the locally hired staff Municipalities (local government agencies) receive	Single pool at the national level managed by the Health Insurance Board	Separate pool at private health insurance providers managed individually	Central budget reimbursement at the facility level by the MOHP	Central budget reimbursement at the facility level by the MOHP	Central budget pooled and distributed at the federal, provincial, and local governments (municipalities)	Enterprises managed individually (No pooling)	Single national pool for its members managed by the SSF	Central budget managed by the MOHP	The MOF pool the EPF funds on a government agency called Rastriya Beema Company Limited

CRITERIA	Public System	National Health Insurance	Voluntary Private Insurance	Safe Motherhood Program	Basic Health Care Package Service	Free Health Care	Enterprises Private Insurance by the Employers	SSF	Impoverished Citizens' Service	Health Insurance by Employee Provident Fund
	conditional grants, fiscal equalization funds, matching funds specified for health that cover non-salary inputs Pooled donor assistance ("pool fund") goes directly to the central treasury.									
PURCHASING MECHANISMS	There is no purchaser-provider split. The MOHP is responsible for national/ specialized hospitals. Local governments are both owners and purchasers of health services at the provincial level and below.	Purchaser-providers split HIB purchases the services from both the public and private providers on behalf of enrolled members.	Purchaser-providers split. Individual private insurance providers purchase the services from both the public and private providers on behalf of enrolled members.	Purchaser-providers split (partial for private providers) The MOHP purchases the services from both the public and private providers.	There is no purchaser-provider split. Provincial and local governments are both owners and purchasers of the BHCP services at the health posts, primary health care centers, and public hospitals.	There is no purchaser-provider split. Provincial and local governments are both owners and purchasers of the primary-level care services at the health posts, primary health care centers up to 25 - bedded	Enterprises purchase the health care services from providers on behalf of their employees or affiliates.	Purchaser-providers split. SSF purchases the services from both the public and private providers on behalf of enrolled members.	There is no purchaser-provider split. The MOHP is both provider and purchaser of the eight chronic diseases from enlisted public hospitals.	EPF - Rastriya Beema Company Limited is the purchaser agent

CRITERIA	Public System	National Health Insurance	Voluntary Private Insurance	Safe Motherhood Program	Basic Health Care Package Service	Free Health Care	Enterprises Private Insurance by the Employers	SSF	Impoverished Citizens' Service	Health Insurance by Employee Provident Fund
						public hospitals.				
PROVIDER PAYMENT	Input-based line item budgets	Fee-for-service payments for the OPD package Case-based payment of IPD Fee for services for the diagnostics services except those not included in OPD and IPD package	Various practices at the individual insurance providers such as reimbursement of the bills of the enlisted services along with deductibles/copayments based on the insurance policy	Capitation-based payments from the MOHP Cash incentives depending on the level of facility and cases of delivery	Capitation-based payments for the OPD by local governments	Capitation payments for the OPD by local governments	Conditional reimbursement for enterprises	Conditional reimbursement	Conditional grant Reimbursement up to NPR 100,000	Conditional reimbursements
SERVICE DELIVERY AND CONTRACTING	All public health facilities; Private facilities for specific services (for example, dialysis); No explicit contracting takes place with public facilities	HIB contracts both public and providers	No specific contract by private insurance providers	Selected public and private facilities Explicit contracting takes place with public and private facilities	All public health facilities up to 25-bedded hospitals No explicit contracting takes place with public facilities	All public health facilities up to 25-bedded hospitals No explicit contracting takes place with public facilities	Few have explicit contracting with service providers	—	Public facilities for specific services No explicit contracting takes place with public facilities	In the case of EPR, Rastriya Beema Company Limited has contract with some service providers

Source: Bajracharya and Karn (2019).