Assessment of the Government Health Financing System in Nepal: Suggestions for Reform

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A year ago the Ministry of Health and Population and GIZ jointly developed six broad options for expanding social health protection in Nepal ('Nepal at the Crossroads: Setting the Stage for Improved Social Health Protection'). These options ranged from improving the current health financing system to expanding community based health insurance and a triple financing system covering the formal and informal sectors. The six options laid the foundations for discussions about how an improved health financing and social health protection system could look in Nepal.

Reforming the health financing system in Nepal will take time and effort. This assessment has been commissioned to take forward the debate on reform. It focuses on the government health financing system and options for improvement. Taking the first option of the previous report forward – providing value for money – this report concretises the argument for improving the government health financing system through efficiency gains and sets out the next steps. Any implementation of a more complex system would build on these steps.

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Dr. Sudha Sharma
Secretary

Acronyms

ANC	antenatal care
CBHI	community based health insurance
DDC	district development committee
DfID	Department for International Development
D(P)HO	district (public) health office
DoHS	Department of Health Services
FY	fiscal year
GDP	gross domestic product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HDI	Human Development Index
HP	health post
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
NHEICC	National Health Education, Information and Communication Centre
NHTC	National Health Training Centre
NHSP-IP	Nepal Health Sector Programme – Implementation Plan
NGO	non-governmental organisation
NPC	National Planning Commission
NPR	Nepali rupees
OPD	outpatient department
ORC	Outreach Clinic
PHC	primary health care
PHCC	primary health care centre
PNC	postnatal care
RTI	Research Triangle Institute
SHP	social health protection
SHPC	Social Health Protection Centre
TB	tuberculosis
VDC	village development committee
WHO	World Health Organization

Executive Summary

The Government of Nepal has shown a strong commitment to health, declaring "the right to basic health services free of cost to every citizen" in the Interim Constitution of 2007. The Ministry of Health and Population (MoHP) has introduced several social health protection interventions to increase citizens' access to health care services and enhance their financial protection from the risks associated with accessing such services. Past experience has shown that the expansion of social health protection needs to go hand-in-hand with improvements in the health financing system in order to enhance equity, access and efficiency in the health sector. In order to improve maternal health substantial funding was earmarked for service delivery and cash transfers given to mothers under the Safe Motherhood Programme (*Aama Karyakram*)[1]. As part of this programme, the MoHP introduced a provider payment mechanism that links budget allocations to the actual delivery of services. These efforts have contributed to a substantial improvement in the production and utilisation of services and may have played an important role in bringing down maternal mortality rates.

Building on these steps taken by the MoHP, this report aims to contribute to the reform process of the health financing system to ensure social health protection for Nepalese citizens. It has a particular focus on purchasing mechanisms and makes recommendations on how to move towards better utilisation of resources and strategic purchasing.

The report focuses on the government health financing system in Nepal and explores ways to support the system to be more efficient and equitable. The analysis follows the World Health Organization's three health financing functions – revenue collection, risk pooling and purchasing – leading to the following assessment of the key challenges:

- The Government of Nepal has limited capacity to generate more resources on a substantial scale.
- The health financing system has limited ability to address inequities and identify and protect the poor.
- There are inefficiencies in the system due to fragmented resource allocation.
- The Government of Nepal has limited power to negotiate the price and quality of services due to the practice of passive purchasing.

The key reforms recommended in the report are as follows.

1. Improve access of the poor to specified services

Access of the poor to specified health services, which are in theory being provided by the government for free, should be facilitated by allocating sufficient financial resources and simplifying procedures for utilisation. The use of proxy indicators to identify beneficiaries, such as place of residence, type of disease or demographic profile, while minimising bureaucratic steps, is needed to enhance access to services for the poor. Access can also be enhanced by increasing publicity about what people can expect from health facilities and how they can avail themselves of benefits.

2. Merge funding arrangements for social health protection

The merging of scattered funds under the proposed Social Health Protection Centre would help to allocate resources more efficiently and simplify administrative and reporting procedures, thereby reducing the administrative costs of managing funds. The merging of vertical programme funding would end the current earmarking of funds at the district level, allowing district authorities to be more responsiveness to local needs. This merger should be incremental, with the first phase focusing on clustering similar programmes and later gradually transferring them to the Social Health Protection Centre. Centralising funding arrangements would pave the way for strategic purchasing and facilitate the implementation of procedures to improve the access of the poor to health services.

3. Introduce strategic purchasing

Government resources should be allocated where they have the most impact using budgets and reimbursements that mitigate the differences between rich and poor areas and that reward facilities that are performing well. The introduction of formulas to allocate budget resources could help to build a stronger link between the resources distributed and the performance of health facilities, taking into account local needs. Separate formulas could be used to pay for hospital services and primary health care services, which may help in allocating resources while promoting health system objectives at the same time.

Value for money can be increased through the introduction of provider payment mechanisms that incentivise providers to scale up the production of services in an efficient manner and improve quality. Nepal can build on its success stories, such as the output-based budgeting method that is being used to pay providers under the Safe Motherhood Programme. Other provider payment methods need to be explored to establish an explicit and transparent relationship between the resources allocated and the output produced.

[1] Under the Safe Delivery Programme, operated since 2005, financial incentives were given to mothers and health workers and user fees were waived in target districts. In 2009, the programme was expanded to the Safe Motherhood Programme and user fees were removed for all types of delivery.

Chapter 1

Introduction

This chapter sets out the background and rational for this assessments of Nepal's health financing system, as well as the methodology used and its limitations.

Background and rationale

Nepal is in a time of dynamic change including drafting a new constitution and, with it, restructuring the state. Discussions on reforming the health financing system and expanding social health protection have gained momentum. The Ministry of Health and Population (MoHP) is developing a comprehensive health care financing strategy (NHSP-II), which will set out the government's vision and strategy for expanding social health protection in Nepal.

Over the past few years, the MoHP has embarked on a process to improve the health financing system and expand social health protection to citizens through interventions such as the Free Health Services Programme (FHSP). Under this programme, a package of basic health services is being provided free of charge in all districts. The MoHP has also introduced other programmes and interventions, such as the Safe Motherhood Programme (*Aama Karyakram*) and the Screening and Treatment of Uterine Prolepses, to provide specific health care services to the population. In 2005, the MoHP introduced the output-based allocation of resources for the first time with the introduction of the Safe Delivery Incentive Programme (now the Safe Motherhood Programme). Through this mechanism, the MoHP is linking budget funds to desired outputs, rather than just financing inputs. This payment mechanism has now been extended to other programmes and is proving successful. Alongside the introduction of these programmes, the central government budget for the health sector has increased as a percentage of the total budget. Funds for essential health care services (EHCS) as a share of the total MoHP budget have also increased. Consequently, the use of health services has gone up and health outcomes have improved. Nepal was recently honoured at the Millennium Development Goals (MDGs) review for its significant progress in decreasing maternal mortality rates. The country is on track to achieve most of the MDGs targets, particularly those related to health[1].

The success of the Safe Motherhood Programme demonstrates how the provision of social health protection (in the form of free treatment and cash transfers) together with improvements in the health financing system (the use of output-based budgeting to pay providers) can increase the utilisation of health services and improve health outcomes.

The MoHP has started exploring ways to improve equity, access and efficiency by redesigning the health financing system with the support of external development partners such as the Department for International Development (DfID), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the World Health Organization (WHO) and the World Bank. In August 2010, the MoHP

and GIZ developed several policy options ranging from improving the current system through efficiency gains to establishing a national insurance scheme. These options are further elaborated on in a draft report currently being prepared for the MoHP and funded by WHO.

Based on these findings and ideas, the MoHP organised a workshop on health financing and social health protection on 22 March 2011. The workshop was attended by MoHP officials, representatives from other ministries and development partners. At this workshop participants agreed to improve the current system by creating a Social Health Protection Centre (SHPC) to bring existing social health protection interventions under one management system. The consolidation of existing scattered initiatives for social health protection (SHP) is considered to be a key to improving the current health financing system. It will also enable the government to promote social health protection through efficiency gains and engage in the active purchasing of health services, thereby ensuring better value for money.

Building on this, and to support the MoHP in the reform process, this report provides an assessment of the government health financing system in Nepal. It has a particular focus on purchasing mechanisms and makes recommendations as to how to move towards better utilisation of resources and strategic purchasing. The report touches briefly upon budgeting and planning processes, particularly on their strengths and weaknesses, as their general features are described in other documents in more detail[2].

Methodology

This review of the government health financing system builds on existing studies[3] and ongoing discussions on the direction of reforms. It provides a rapid assessment of the different provider payment systems in use and identifies ways of improving social health protection in Nepal. The assessment relies on secondary information from various agencies and primary information gathered from interviews with key informants and consultations with stakeholders.

Consultations were held with officials from the MoHP, Department of Health Services (DoHS), Ministry of Finance (MoF), National Planning Commission (NPC), Financial Comptroller General Office (FCGO), and various district (public) health offices (D[P]HOs), district development committees (DDCs), district treasury controller offices (DTCOs), and village development committees (VDCs). The study team (consisting of an international consultant and GIZ staff) visited Banke, Surkhet and Dang districts from 23 to 28 March 2011 to gather data and interview key informants; they also met with officials from Sindhupalchowk. Interviews were conducted at two government hospitals (regional and zonal), two primary health care centres (PHCCs), three district (public) health offices and a community based health insurance (CBHI) scheme. The list of people met and consulted is provided in Annex H.

Terminology

For the purpose of this report, 'social health protection' is defined according to the common understanding of the Providing for Health (P4H) partners (Germany, France, the International Labour Organization, WHO and the World Bank)[4] as:

- a system based on pre-payment and financial risk pooling that ensures equitable access to needed quality health services at affordable prices in which contributions to the system are based on capacity to pay and benefits are based on need; and

- a set of measures against ill health related cost of treatment, social distress, loss of productivity and loss of earnings due to inability to work[5].

Accordingly, 'social health protection interventions' are defined as programmes and activities that offer financial protection and are funded by prepaid pooled government resources. These can be either universal interventions, which are in principle accessible to everybody, or interventions targeted at certain population groups, which provide either in-kind benefits (in the form of services and goods) or cash transfers or both. Funds to providers (such as hospital grants) that are used to provide unspecified services to patients are also included in this definition. For a detailed list of social health protection interventions see Annexes B and C.

Limitations

This review is based on observations and interactions with a number of government officials at the central level and in four districts (Banke, Surkhet, Dang, and Sindhupalchowk), providing a limited snapshot of the whole system. Secondary data was compiled from the Financial Management Information System and Annual Work Plan and Budget of the MoHP. Activity-wise expenditure data for health sector programmes are not available under the existing Financial Management Information System of the health sector; hence, the assessment is based on budgetary allocations. The total public health sector budget refers to the total budget of the MoHP in this report.

Structure of report

The report is structured as five chapters. Chapter 1 deals with the background, rationale and methodology of the assessment. Chapter 2 outlines the conceptual framework of health financing systems in general and describes the existing health financing system in Nepal. Chapter 3 analyses the performance of the existing system in terms of what it is trying to achieve. Chapter 4 presents the key challenges that need to be overcome and discusses the direction of the suggested reforms including parallel processes and key health policy decisions that will affect any reforms. It also looks at some preconditions that need to be in place for the reforms to be successful. Chapter 5 makes some conclusions and proposes some recommendations and immediate next steps.

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[1] National Planning Commission; United Nations Country Team of Nepal (2010) *Nepal Millennium Development Goals progress report 2010*. Kathmandu: NPC, Government of Nepal.

[2] National Council for Economic and Development Research (2010) *Public expenditure review on health sector*. Unpublished report of MoHP, Government of Nepal, Kathmandu; Ministry of Health and Population (2010c) *Nepal Health Sector Programme. Audited financial statement/ fiscal year 2008/09 (2065/066)*. Kathmandu: MoHP, Government of Nepal; RTI International (2008) *Bottleneck study for the timely disbursement of funds*. Research Triangle Park, NC, USA: RTI International.

[3] GIZ; Ministry of Health and Population (2010) *Nepal at the crossroads. Setting the stage for improved social health protection*, Final report of a joint assessment of MoHP-GIZ. Kathmandu: Health Sector Support Programme, GIZ; World Bank (2010) *Nepal: Public expenditure review*. Washington, DC: World Bank; National Council for Economic and Development Research (2010) *Op. cit.*

[4] Providing for Health (P4H) is an initiative established to implement decisions taken by the G8 summits in Gleneagles (2005), St Petersburg (2006), Heiligendamm (2007) and Toyako (2008) in support of strengthening health systems through social health protection for the whole population and particularly for the poor.

[5] Adopted from WHO web site: http://www.who.int/providingforhealth/topics/shp_p4h/en/index.html

Chapter 2

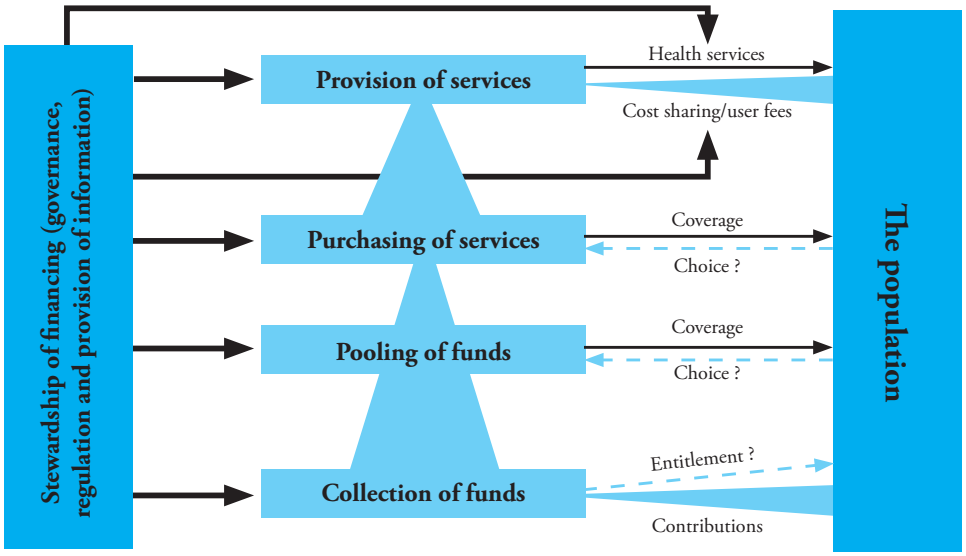
Health Financing System in Nepal

This chapter outlines the conceptual framework of health financing systems, including the three main health financing functions and their characteristics. It also looks at fund flows in the Nepali health financing system.

Conceptual framework

It is important to understand the main functions of a health financing system and their interrelationships before looking at the systems working mechanisms. The three main functions of a health financing system are the collection of funds, the pooling of these funds and the purchasing of services. These functions and their linkages with the population and stewardship role are illustrated in Figure 1.

Figure 1: Conceptual framework of health financing systems



Source: Adapted from Kutzin, J (2000) 'A descriptive framework for country-level analysis of health care financing'. *Health Policy* 56, 171–204

Collection of funds

According to WHO, "the function of collection of funds deals with how financial contributions to the health system are collected from different sources"[1]. For example, they may be collected by the government as taxes or by an insurance scheme from member contributions. The method used to collect the funds determines the fairness of the health financing system. Some methods, such as direct taxes, through which the rich pay more than the poor, are considered fairer than other methods, such as fees for services (out-of-pocket expenditure), through which the rich and the poor pay the same for services based on use.

Pooling of funds

The function of pooling deals with how funds (revenue and contributions) are put together (in a pool) so that the risk of having to pay for health care is not borne individually. The main advantage of pooling is that it allows for cross-subsidies between the rich and poor, healthy and sick, young and elderly people, and singles and families. Additionally, the pooling of resources means that there is a larger pool of money available in a single fund. This increases the capacity of the government to negotiate with providers and review the performance of contracted providers on behalf of the population, resulting in more output from the same resources.

Purchasing arrangements

Purchasing is the process by which pooled funds are used to pay providers for delivering a specified or unspecified set of health interventions[2]. Purchasing can be performed passively or strategically. In passive purchasing, a predetermined budget is followed or bills are simply reimbursed retrospectively. In contrast, strategic purchasing involves a continuous search for ways to maximise health system performance by deciding which interventions and in what volume should be purchased, how, for what price and from whom. It entails ensuring a coherent set of incentives for providers to encourage them to offer priority interventions efficiently. Review of the performance of contracted providers against predefined financial and medical yardsticks is also an integral part of strategic purchasing. In all settings, fairly distributed prepayment and the strategic purchasing of health interventions is desirable[3]. The purchasing function can play a key role in determining the overall performance of the health system. The World Health Report 2010 highlights the strategic purchasing of health services as a way for countries to move towards universal coverage[4]. The principles of strategic purchasing are often already incorporated into health financing systems through the linking of health needs, plans and priorities to the allocation of resources[5].

Fund flows in the Nepali health financing system

Applying this conceptual framework to the health financing system in Nepal, Figure 2 shows the flow of funds from the sources that collect funds (financing sources) to agencies involved in pooling and managing funds and making payments to providers (financing agents). The Government of Nepal pools funds from various financing sources (tax and non-tax revenue, pool funds from external development partners) and pays providers (hospitals, health posts, sub-health posts, primary health care facilities, etc.) through the health sector budget managed by the MoHP (the main financing agent), mainly on a historical basis. Other bodies also act as financing agents, such as community based health insurance schemes, which manage resources on behalf of members and pay providers for services used by their members.

In most countries, including Nepal, not all resources for health are pooled by financing agents. Only slightly more than half of the resources in Nepal's health financing system are pooled. Non-pooled resources consist mainly of out-of-pocket expenditure; under this method of payment every patient has to pay their own expenses with no support from others to mitigate the financial risk. Some financing agents, such as the district (public) health offices, do not pool resources and are just intermediary agents in the planning and budgeting cycle and perform some public health interventions.

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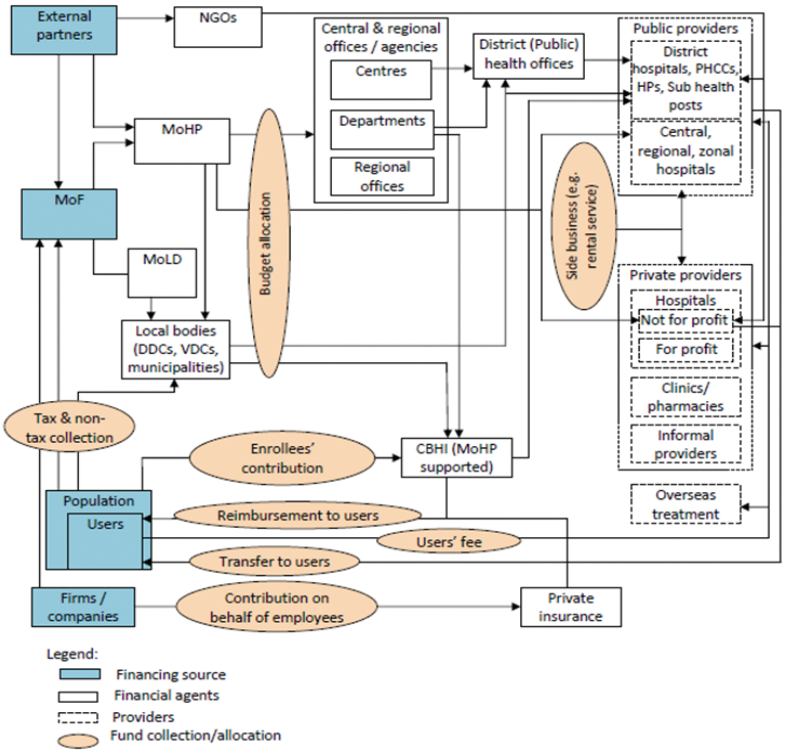
Figure 2: Financial flows in the health financing system in Nepal



Note: The lines connecting the parts of the figure do not give any indication of the size of fund flows.

Out-of-pocket expenditure/user fees and government funds (tax and non-tax revenue) make up more than three quarters of the financial flows in the overall system.

Collection: Where is the money for health coming from?

Financing sources in Nepal can be classified by contribution mechanism as government, private (households and institutions) and 'rest of the world'. Rest of the world refers to financial support from foreign sources (to both the public and private sector). Out-of-pocket expenditure is the largest source of funding in Nepal, followed by government expenditure. Out-of-pocket expenditure comes from the 'general public' as user fees and goes directly to health providers including pharmacies. This payment method should be reduced, as it is the most unfair/regressive way of funding health services.

The second largest financing source in terms of volume is public (government) funds and includes taxes, non-tax revenue and support from external development partners, and comes through different administrative levels. The contribution of external development partners is a substantial part of Nepal's total health expenditure, although its share has decreased in recent years.

Nepal's National Health Accounts (NHA) provide health expenditure data up to 2005/06. No government data is available after the introduction of the Free Health Services Programme in 2007. However, WHO estimates that total health expenditure in Nepal reached 57.6 billion Nepali rupees (NPR) in 2009, which is 5.8% of Nepal's Gross Domestic Product (GDP)[6]. Health spending per

Table 1: Total health expenditure in Nepal by source of funding (2004–2009)

Source of funding	Percentage of total expenditure on health					
	2004	2005	2006	2007	2008	2009
General government expenditure on health	**23.4**	**23.9**	**27.8**	**36.0**	**37.7**	**35.3**
Ministry of Health and Population	12.0	13.5	15.7	22.7	26.0	27.6
Other ministries	11.4	10.4	12.1	13.3	11.7	7.7
Private expenditure on health*	**76.6**	**76.1**	**72.2**	**64.0**	**62.3**	**64.7**
Private health insurance	0.2	0.2	0.2	0.2	0.2	0.2
Non-profit institutions serving households (e.g., NGOs)	15.7	16.6	16.1	16.0	15.8	16.4
Out-of-pocket expenditure	51.7	51.1	47.1	46.6	45.1	46.8
Rest of the world/external resources (partly channelled as government expenditure and partly as private expenditure)	**19.6**	**18.6**	**19.6**	**13.1**	**11.0**	**13.7**
Total health expenditure (in million NPR)	**33,131**	**34,810**	**36,915**	**43,322**	**48,955**	**57,645**

Source: Based on WHO National Health Accounts database: http://www.who.int/nha/country/npl/en/

Note: *The figures for the categories under 'Private expenditure on health' don't add up to the total. This is due to data discrepancies on the WHO National Health Accounts database.

capita was around USD 25 in 2009[7]. Table 1 presents the evolution of funding sources in Nepal from 2004 to 2009.

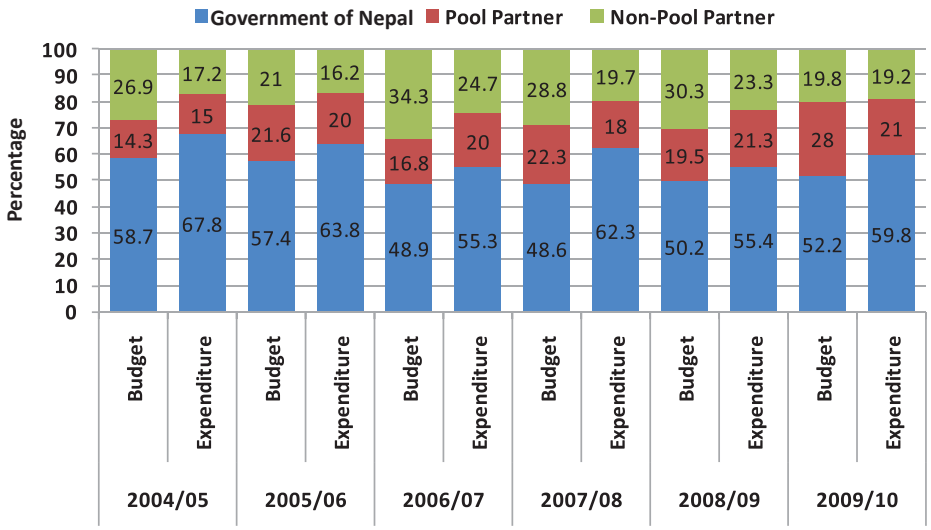
Out-of-pocket expenditure represented approximately 47% of total health expenditure in 2009 and its share of total health expenditure has shown a slightly decreasing trend from 2004 to 2009. Out-of-pocket expenditure includes fees paid at facilities, medicines purchased from drug outlets, fees paid to laboratories for diagnostic procedures and other direct payments to providers. These payments are made directly by individuals when receiving services[8]. In Nepal, as in many other countries, fees paid by households to providers are unregulated and the government's capacity to protect citizens from unfair prices and inappropriate or unnecessary care is weak. Prices in unregulated markets are fixed according to supply and demand. This prevents a substantial portion of the population from accessing services as they cannot afford the prices established by the market, or don't try to use the services for fear of high prices or because of uncertainty about prices. The government should give priority to reducing the proportion of out-of-pocket expenditure as it improves people's access to health services while reducing catastrophic health expenditure.

However, decreasing reliance on out-of-pocket expenditure involves increasing prepaid resources, which are usually controlled and managed either by government bodies or other purchasing agencies such as insurance companies/schemes. Without designing a comprehensive prepaid scheme, it is difficult to control out-of-pocket expenditure as it depends on unregulated transactions between health providers and users. Health care costs tend to be higher in systems that rely mainly on out-of-pocket expenditure because they are not negotiated or regulated, as in the case of a prepaid scheme. Designing a comprehensive mechanism to generate financial resources in a prepaid manner is the only way to reduce out-of-pocket expenditure while ensuring people's access to needed health services with minimal or no direct payment at the time of service utilisation.

Before exploring this, it is necessary to better understand the composition of government spending in Nepal. Figure 3 summarises the share of annual budget and expenditure of the Government of

Nepal, pool partners and non-pool partners[9] from FY 2004/05 to 2009/10. General government expenditure on health[10], along with external development partner contributions, has increased substantially in recent years, in both absolute and relative terms (Ministry of Health and Population, 2010a), gaining weight as a source of funding.

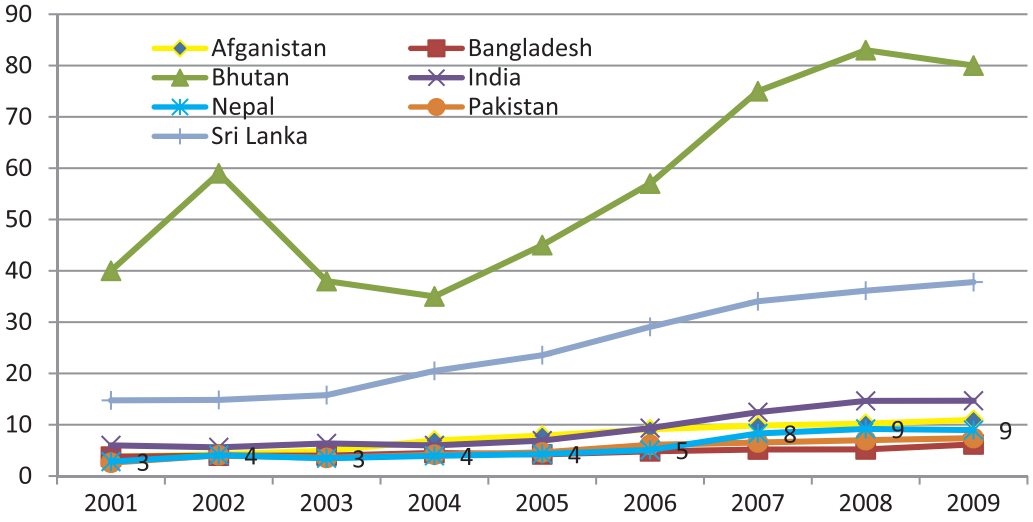
Figure 3: Government and external partners' share of health (MoHP) budget and expenditure



Source: Ministry of Health and Population (2010a) *Financial management performance review. Report of NHSP-IP (FY 2004/05 to 2009/10)* Unpublished report of MoHP, Government of Nepal, Kathmandu

Contributions from external development partners (pool and non-pool partners) are substantial in the health sector in Nepal. From 2004/05 to 2009/10, external development partners' share of total MoHP expenditure ranged between 32 to 45% (Figure 3). WHO estimates that per capita general government expenditure on health is increasing in Nepal, albeit marginally. However, in comparison to other South Asian countries, per capita general government health expenditure in Nepal is still very low[11] (Figure 4)[12].

Figure 4: Trend of general government expenditure on health (per capita in USD)



Source: Based on WHO National Health Accounts database website: http://www.who.int/nha/country/en

Pooling: Who manages the resources?

Funding for the health financing system in Nepal is scattered and fragmented, preventing any kind of cross-subsidy between different sources of funding. This fragmentation can be categorised into two groups: financing agents that pool resources and those that do not. Many external partners, mainly international non-governmental organisations (INGOs), act as both source and financing agent, with parallel mechanisms for the allocation of resources, and without pooling their resources between them or with other sources.

Financing agents that pool resources are the government, community based health insurance (CBHI) schemes and other private insurance schemes. The main way that the government pools resource is by collecting and managing its revenue (tax and non-tax). The government, through the MoHP and some other institutions which controlled 35.3% of total health expenditure in 2009, decides where to allocate pooled resources across the health sector[13]. Some external development partners, such as the members of the 'Pool' including DfID, AusAid and the World Bank, are also channelling their funds through the government, turning them into 'on-budget' mechanisms, thereby combining tax-based resources. Lower administrative levels of the government, such as district and village development committees and health facilities, also pool some resources for health. At the district level, district development committees pool resources from the central government together with local taxes.

CBHI schemes also pool resources, some of these adding tax-based subsidies received from the MoHP with premiums collected from their members. Over the last few years, the MoHP has been supporting six CBHI schemes[14], which are operating as pilot programmes in six districts. In a non-orthodox approach, the insurance function and the provision of care is under the same management team, combining the roles of purchaser and provider. Contributions to these schemes come from a subsidy provided by the government (accounting for approximately half of all resources intended to cover the poor) and a premium paid by voluntary members, which are pooled into a single fund/pool. These contributions, both from subsidies and premiums, entitle members and their dependents to use services up to a determined ceiling.

Purchasing: How are health services paid for?

The Government of Nepal, CBHIs, and households use different ways of paying health providers for the goods and services that they provide. These are known as provider payment mechanisms and their characteristics, such as financial incentives, determine the behaviour of providers. For example, if a hospital is paid by length of stay, its incentive will be to keep patients as long as possible in order to maximise income. In contrast, if the funder pays a primary health care provider based on the number of inhabitants in its catchment area, the provider will try to see as few patients as possible, as every patient is associated with extra costs, but not with extra revenue. The choice of provider payment mechanism is crucial in policy making and will yield different system outputs in terms of quality, access and efficiency. There is no perfect provider payment mechanism; all have strengths and weaknesses. The selection of payment method depends on the policy objective of the payer, the design of the mechanism, the technical capacity of the purchaser and the provider, and the implementation modality.

The main provider payment mechanism in Nepal is payments directly to health providers by the general public, i.e., 'fee-for-services/out-of-pocket payments'. This is both a collection of funds and a purchasing of services at the same time. The next main provider payment mechanism is line item budgeting, which is used by the Government of Nepal, the biggest financing agent.

Government funds are mainly allocated to public providers through line item budget allocation to pay for inputs and, under some interventions, as per the volume of services provided by the provider. Other payment mechanisms used by the government include case payments/output-based budgeting and capitation. Other channels include funding to non-governmental organisations (NGOs), subsidies to CBHI schemes and household contributions to insurance schemes. Also relevant are cash transfers from the government to users to cover transportation costs and use of health services, although this is not a provider payment mechanism as it transfers money to users, not providers. Its inclusion here is important as it complements other provider payment mechanisms and might partially explain their ability to achieve intended goals. The main feature of each mechanism is described here. More detailed information on each provider payment mechanism can be found in Annex A.

Fee-for-services

Fee-for-services refers to the reimbursement mechanism under which health workers and hospitals are paid for each service they provide. In Nepal, households directly pay for most health services using this method. Under this arrangement, patients shoulder the entire financial risk, as payments are related to every service that they receive, without pre-established limits on quantity or price. The six CBHI schemes supported by the MoHP also use this method to pay providers, but with some slight differences. There is an annual ceiling on the benefits that CBHI members are entitled to receive. After this ceiling is reached, every service used by the member is charged at the fee established by the facility.

Line item budgeting

Line item budgeting (which account for more than 80% of total public health spending in Nepal) is a prospective input-based resource allocation mechanism by which health facilities receive resources to fund their inputs, including operational costs, in advance. This mechanism does not directly link funding received with the performance of health facilities.

The allocation of budget funds follows general public finance management rules. According to these rules, the MoHP and other health institutions prepare their budget proposals following the Government of Nepal planning calendar. In theory, at the beginning of the fiscal year, up until the approval of the annual budget by the parliament, authorisation letters are sent to each ministry and subsequently to their subordinates, informing them of the amount they will be able to spend and giving detailed allocation by line item or input/activity. Most informants conceded that the annual budget allocations are mainly based on last year's budget adjusted by a percentage.

Disease-specific case payment (output-based budgeting)

Disease-specific case payment (also known as output-based budgeting) is a retrospective payment or budgetary allocation linked to the health facility's performance in specific pre-defined interventions. Budget allocations for specific diseases can be made in addition to the budget provided under line items. Expected reimbursements per case are known in advance by health facilities.

The MoHP has introduced a set of interventions that reimburse providers for treatment provided for specific health conditions. These interventions, managed by the Department of Health Services, include, among others, the Safe Motherhood Programme, Screening and Treatment of Uterine Prolepses and cash incentives for permanent sterilisation under the Family Planning Programme. This system is known as 'output-based budgeting' because payments to health facilities are made prospectively through district (public) health offices, using the budget flow mechanisms of the Government of Nepal. For example, in the Safe Motherhood Programme, the annual budget is allocated based on forecasted outputs and then the services are provided. At the end of the fiscal year, adjustments are made depending on whether the allocated resources fall short or exceed the total output delivered by the provider.

Population-specific case payment (output-based budgeting)

Population-specific case payment is a retrospective extra budget allocation linked to services provided to specific pre-determined groups within the population. It can be used to pay for the treatment of certain conditions, for example, in citizens above 75 years of age. Expected reimbursements per case are not known in advance by health facilities, as the discount applied to patients may vary from case to case.

Some interventions, such as the Social Service Conditional Grant, use this mechanism to reduce the financial risk to specific groups within the population. Payments to providers are attached to the cost of providing health services to the defined group. Despite reimbursement being provide in each case, this mechanism may also be described as 'output-based budgeting' as funds are provided prospectively as an extra budget allocation to health facilities based on an estimate of the amount needed to cover the expected discounts to patients.

Capitation

Capitation is a prospective budget allocation linked to the number of inhabitants in a determined catchment area. The use of capitation in Nepal came after the abolition of user fees under the Free Health Services Programme. 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 inhabitants.

Cash transfers to patients

Cash transfers to patients are retrospective payments made to users to (a) compensate them for transportation costs incurred when seeking care; (b) subsidise a specific objective, such as nutritional support for tuberculosis patients; or (c) simply incentivise the use of health services. This method does not constitute a provider payment mechanism, as it is paid to users not health service providers. This mechanism was introduced to complement case payment/output-based budgeting and initially developed as part of the Safe Motherhood Programme. Other schemes have followed the same approach.

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[1] http://www.who.int/health_financing/functions/functions/en/index.html

[2] World Health Organization (2000) *The world health report 2000: Health systems: Improving performance*. Geneva: WHO.

[3] *Ibid.*

[4] World Health Organization (2010) *The world health report: Health systems financing: The path to universal coverage*. Geneva: WHO.

[5] Figueras, J; Robinson, R; Jakubowski, E (2005) 'Purchasing to improve health systems performance, drawing the lessons'. In: Figueras, J; Robinson, R; Jakubowski, E (eds) *Purchasing to Improve Health Systems Performance*, European Observatory on Health Systems and Policy Series. Maidenhead: Open University Press.

[6] WHO National Health Accounts database: http://www.who.int/nha/country/npl/en/

[7] Taskforce on Innovative Financing for Heath System (2010) *Constraints to scaling up the health Millennium Development Goals: Costing and financial gap analysis*. Working Group 1: Constraints to Scaling Up and Costs, Taskforce on Innovative Financing for Heath System. Geneva: WHO. Available at: www.internationalhealthpartnership.net//CMS_files/documents/working_group_1_technical_background_report_(world_health_organization)_EN.pdf (accessed 1 August 2011).

[8] A household survey by RTI International in 2010 found that the wealthiest quintile paid more than double the poorest quintile during last health facility visit in Nepal. The same survey found that three-quarters of the out-of-pocket expenditure was on drugs. See: RTI International (2010a) *Pro-poor health care policy monitoring: Household survey report from 13 districts*. Research Triangle Park, NC, USA: RTI International.

[9] Under the Sector Wide Approach, some of the external development partners pool their financial support together with Central Treasury of Nepal, which is accounted for as 'pool funds'. Not all the support of the non-pool partners is reflected in the budget details in the Red Book (published by the MoF); the figure only captures the part reflected in the Red Book. See: Ministry of Health and Population (2010a) *Financial management performance review. Report of NHSP-IP (FY 2004/05 to 2009/10)*. Unpublished report of MoHP, Government of Nepal, Kathmandu.

[10] Note that WHO and MoHP data are not fully consistent.

[11] However, general government health expenditure in Nepal is relatively high among South Asian Countries as a proportion of GDP and total public expenditure.

[12] Per capita general government health expenditure in the Maldives (not included in the figure) is much higher (USD 214 in 2009) than in other countries in the region.

[13] WHO estimates that 78% of total general government expenditure on health in 2009 was spent by the MoHP and the rest was spent by other government institutions such as the Ministry of Defence and Ministry of Finance.

[14] Besides the CBHI schemes supported by the MoHP, there are a number of CBHI schemes supported and implemented by NGOs, which are not included in this review.

Chapter 3

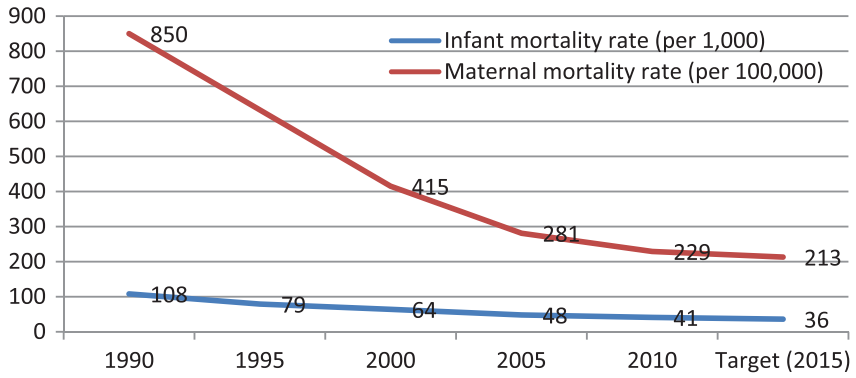
Analysis of the System

This chapter analyses the performance of the health financing system in Nepal in terms equity, access and efficiency. It explores the causes of underperformance of the system and how they affect the performance of the system, as well as identifying some solutions.

Introduction

Analysing the performance of the health system requires studying the resources spent and outputs (and outcomes) obtained. Nepal shows a substantial improvement in the performance of the health care system in priority areas such as reducing infant and maternal mortality rates (see Figure 5). Nepal's progress report on the Millennium Development Goals states that Nepal is on track to achieve most of its MDG targets, with a few exceptions, if prevailing trends persist and efforts are continued or improved[1]. However, it is difficult to determine the factors that have led to these improvements.

Figure 5: Progress of Nepal towards reducing infant and maternal mortality rates, 1990–2010



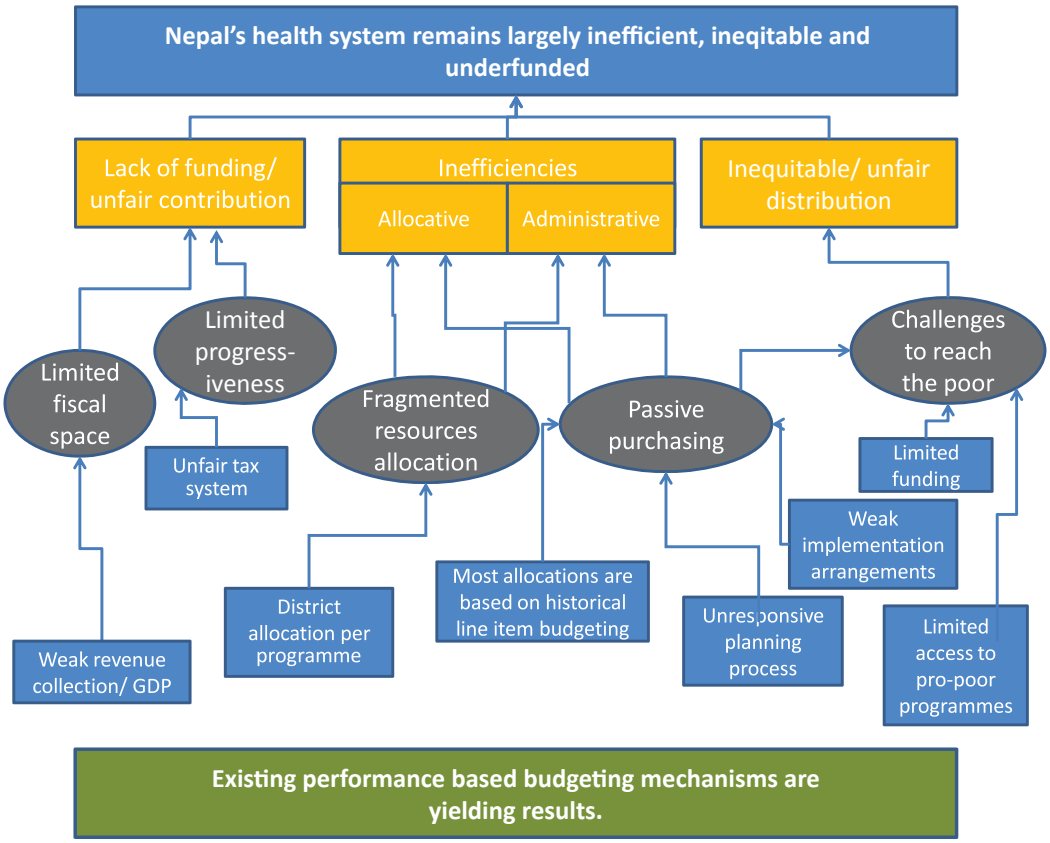
Source: Based on the data from National Planning Commission; United Nations Country Team of Nepal (2010) *Nepal Millennium Development Goals. Progress report 2010*. Kathmandu: NPC, Government of Nepal

An increase in resources for the Safe Motherhood Programme may be the main cause of the substantial increase in the number of deliveries conducted in health facilities (output) and the reduction in the maternal mortality rate. However, determinants of this reduction are multiple and, despite the fact that a positive correlation does exist, it is not possible to directly attribute all of this achievement to the increase in resources to health services.

The increase in overall system performance cannot be attributed to an increase in government and external development partner resources alone, as these account for less than a quarter of total health expenditure in Nepal (see Table 1). Moreover, according to Nepal's National Health Accounts, a substantial share (33%[2]) of maternal health expenditure is still funded by out-of-pocket expenditure.

The high proportion total health expenditure covered by out-of-pocket expenditure (i.e., fee-for-services) as a provider payment mechanism is a barrier to access to health services and increases the financial risk to users/patients. Hence, it is one of the key challenges facing the system. Moreover, health facilities remain underfunded and a number of inefficiencies prevent the system from achieving its goals. Figure 6 looks at what keeps the health financing system in Nepal underperforming and existing mechanisms that yield results.

Figure 6: Root causes of health financing system underperformance in Nepal and existing mechanisms that yield results



Limited fiscal space

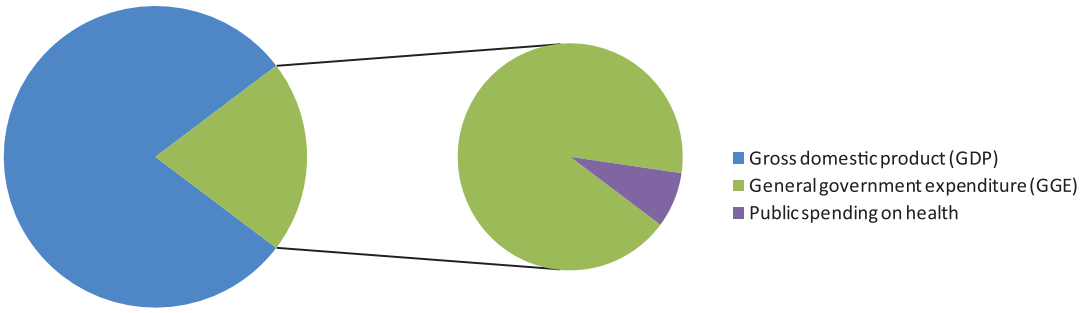
Total health expenditure in Nepal is 5.8% of GDP[3] and health spending per capita is around USD 25, which is below the USD 44 per capita estimated by WHO's Taskforce on Innovative Financing for Heath System in 2009 as necessary to provide key health services to everyone in a low income country[4]. Hence, there is a clear need to mobilise more resources for health in Nepal.

Theoretically, the government has several options for increasing funding for health: (a) enhance nationally controlled tax collection and prioritise the health sector when allocating the budget;

(b) increase revenue collection from local taxes; (c) introduce a payroll contribution scheme; and (d) (re)introduce or increase user fees for health services with waivers for the poor or make fees income dependent. However, not all of these options are practical or desirable, considering their impact on financial risk protection and health system goals. For example, increasing resources through out-of-pocket payments should be avoided, as it would increase the burden on the sick, especially the poor, and may further impoverish them.

Of these ways of increasing funds for health, the only option that is practical in Nepal is to increase public revenue collection by the central government through tax and non-tax sources and prioritise the health sector when allocating the budget (option a). Increasing income from tax and non-tax sources would increase the share of government revenue as a proportion of GDP. Government revenue currently stands at around 15.1% of GDP and public expenditure, which includes grants and loans, is less that 23% in Nepal (See Figure 5). This figure is rather low, although it has increased considerably in the last few years. The government could also prioritise the health sector and allocate some of the increases in revenue or resources from other sectors to health. Figure 7 shows general government expenditure as a proportion of Nepal's GDP (in larger circle on the left). This represents the size of public spending compared to the size of Nepal's economy. The smaller circle on the right shows the share of general government expenditure spent on health, which accounts for around 2% of GDP.

Figure 7: General government expenditure, as a proportion of GDP and public spending on health out of total general government expenditure, 2009



Source: WHO National Health Accounts database

An increase in government income is usually desirable as it widens the scope of the government to expand its services to the population. In fact, government revenue has been increasing rapidly (at more than 20% of annual growth over the last four years) as a result of more effective taxation and the campaign against tax evasion[5]. Aside from increasing government revenue as a proportion of GDP, an approach to increase resources for health was initiated more than a decade ago. A special earmarked tax was introduced on cigarette consumption (a 'sin tax') and funds were collected in a Health Tax Fund. Although this fund still exists with annual allocation of around NPR 400

Table 2: Fiscal structure of Government of Nepal, 2005/06

	Expenditure share %	Revenue share %
Central government	92	95
Local bodies (DDCs, VDCs, municipalities)	8	5

Source: Based on data in Cyan, MR; Pokharel CP; Adhikari CM (2009) *Regional Development Strategy*, A report submitted to Asian Development Bank/Ministry of Local Development, Kathmandu

million, it is no longer funded by the sin tax, but from excise taxes on cigarettes[6]. The potential and relevance of generating revenue from such sources should be explored (e.g., an earmarked tax on alcohol) to increase public resources for the health sector.

Option b, increase revenue collection from local taxes, is not feasible at the moment. In the current centralised tax structure, revenue collection by local bodies is very low and not a viable option for generating more public resources for the health sector. Revenue collected by local bodies accounted for only 5% of total government revenue in 2005/06 (Table 2).

Although this data is relatively old, the data collected during the field visits undertaken for this review also show a low level of revenue generation by local bodies in recent years. For instance, Banke DDC generated only 4.2% of its total budget through internal sources in 2009/10. Similarly, Salkot VDC in Surkhet collected only 0.17% of its resources from local revenue in 2009/10. Besides the small share of national revenue generated by local bodies, they allocate a very nominal share of their resources to the health sector, as confirmed in interactions during the field visits. According to DDC and VDC officials, most of the revenue generated by local bodies is allocated to roads and water. In fact, the District Health Accounts of Surkhet district found that the contribution of local bodies to total government health expenditure was only 1.2% in 2006/07.

Table 3: Government revenue, in billion NPR and percentage, FY 2009/10

Source of government revenue		Revenue collected	
		Billion NPR	%
Indirect taxes	Trade duty	35.2	19.5
	VAT	54.9	30.5
	Excise tax	24.5	13.6
Direct taxes	Income tax	33.8	18.8
	Other	7.9	4.4
Non-tax revenue		21.7	12.1
Principal refunds		1.9	1.1
Total		**179.9**	**100.0**

Source: Ministry of Finance (2011) *Economic Survey 2010/11*. Kathmandu: Ministry of Finance, Government of Nepal

Option c involves establishing a contribution scheme based on payroll. Depending on the size of the formal sector, this approach can generate substantial extra resources earmarked to health in a more effective way than taxes. However, in the case of Nepal this option would only generate a small amount of additional resources considering the small size of the formal economy and the considerable effort needed to implement an institutional arrangement for contribution collection. The impact of payroll contributions on the competitiveness of the economy and formal employment should also be considered before introducing such a scheme, as its makes formal labour expensive and affects different sectors of the economy.

Option d, (re)introduce or increase user fees in public health facilities, is also not an option available to the Government of Nepal, as user fees are not considered government revenue in the existing system and can adversely affect people's access to health services. In theory, user fee payments are the revenue of public facilities and form an integral part of their resources. User fees in public facilities should be regulated and consistent with the government's policies, especially the policy objective to protect the poor. Currently, this revenue is not deposited in the government treasury, even in districts where the Treasury Single Account (TSA) system is in operation. Revenue from

user fees collected by public health facilities is spent at their own discretion, without informing any superior government entity. Even the Ministry of Finance is not aware of how much money is collected and spent by public facilities, although these resources are subject to periodic audits. User fees were abolished in sub-district health facilities a few years ago, but are still charged in hospitals, except through some programmes for specific services or population groups. The World Bank has recently made a more in-depth assessment of the fiscal space for health[7]. By assessing different sources of fiscal space, the report identifies efficiency gains as the main potential source of additional fiscal space.

Limited progressiveness of taxation system

Fairness in revenue collection is considered by WHO as an intermediate goal of a health financing system, i.e., citizens should contribute according to their ability to pay. Fairness in government revenue collection depends on the progressiveness of the taxation system and other resource generation measures that the government uses. In Nepal, government revenue is derived mainly from taxes. Most of these taxes are indirect, representing 64% of total revenue collected during fiscal year 2009/10 (see Table 3). With approximately 350,000 registered taxpayers in the country (of which only 277,000 are active – 1% of the population), the share of income tax of total government revenue is 19% (including revenue from corporate taxes).

The share of income tax paid by workers, mainly formal employees, is around 10% (less than 2% of GDP). There is no fairness in indirect taxes such as sales taxes, custom duties and excise taxes as they are reflected in the price of goods and services so apply to everyone, including the poor. The relatively low share of direct taxation in the overall government tax system raises concerns about the progressiveness of taxation in Nepal.

Fragmented resource allocation

Inefficiencies in the health financing system in Nepal can be categorised as allocative and administrative. The former relates to the inability of the system to put resources where they yield the most results. The latter involves excessive expenditure on administration, instead of on the provision of services. The fragmentation of funding is one of the causes of this inefficiency – and leads to both allocative and administrative inefficiency.

The introduction of the output-based budgeting system in 2005 as part of the Safe Motherhood Programme was not accompanied by a reduction in funding measures from input-based budgeting (line item budgeting). Money from line item budgeting and output-based allocations are mixed at the facility level. This raises concerns about whether these two channels are funding the same activities or are earmarked for different ones. Some interventions specify that funds are to be used as annual budget or as reimbursements. However, when payment is made for the provision of specific services, interventions do not specify conditions for their use. Consequently, facilities can be receiving resources to provide, for instance, uterine prolepses treatment while at the same time receiving budget funds to meet operational costs. This is a clear example of funding overlap; in other words, the government is paying for the same service twice through different channels. This means that the MoHP is paying for inputs as well as outputs without a clear distinction between them. Despite this duplication of funding, anecdotal evidence indicates that government health facilities still lack sufficient financial resources.

Another potential source of inefficiency is the 'verticalisation' of funding. There are more than a dozen interventions aiming to provide financial protection to target groups including the poor and to increase the delivery of priority interventions. These programmes are administered by different institutions such as the MoHP, divisions of the Department of Health Services and national centres under the MoHP. In total, these programmes represent less than 15% of the MoHP's resources, exclusive of salaries and operational expenses. All of them have their own reimbursement and reporting procedures, despite the purchaser (MoHP) and the providers (health facilities under the jurisdiction of MoHP) being the same in many instances. Budgeting for vertical programmes includes the administration costs of running programme activities at the district level. This means that every programme forecasts, for instance, the money needed for fuel for their transportation needs. Then, the district's budget for fuel is offset by adding all fuel needs from the programmes plus the fuel budgeted in the district health office operational budget. While this might secure budget funds for administration and the activities of individual programmes, it complicates local management as the budget is fenced and resources cannot be moved around freely. This can lead to resources being returning at the end of the fiscal year, while some programme activities remain unimplemented because of lack of funds. Merging programmes and streamlining procedures could enhance efficiency and reduce the amount of administrative work for the MoHP, the facility and any intermediary institutions.

Another source of inefficiency is the procurement of medicines. Decentralised procurement of medicines has implications for efficiency. Although the procurement of medicines under the Free Health Services Programme is done mostly at the central level, district offices and even individual facilities are also buying medicines to meet their needs. The volume of purchases at these levels is relatively small, hence prices tend to be high. Central procurement would enable facilities to obtain better prices through economies of scale. Nonetheless, it must be noted that the decentralised procurement of medicines is helpful in fulfilling the immediate needs of the districts and health facilities when centrally supplied medicines are out of stock.

Passive purchasing

Inefficiencies are also caused by the passive role of the MoHP as a purchaser of services. Line item budgeting is used to allocate the vast majority of MoHP resources. In this system, the budget is directed to fund health facility inputs, without directly linking funds to outputs delivered. This passive method of purchasing does not incentivise efficiency and does not help the MoHP in its goal to boost the performance of providers. Passive purchasing does not allow the MoHP to strategically incentivise service providers to deliver the desired outputs. This does not imply that the MoHP is not trying to pursue efficiency gains when planning and budgeting, but the explicit focus on funding inputs weakens its leverage as a funder of health services.

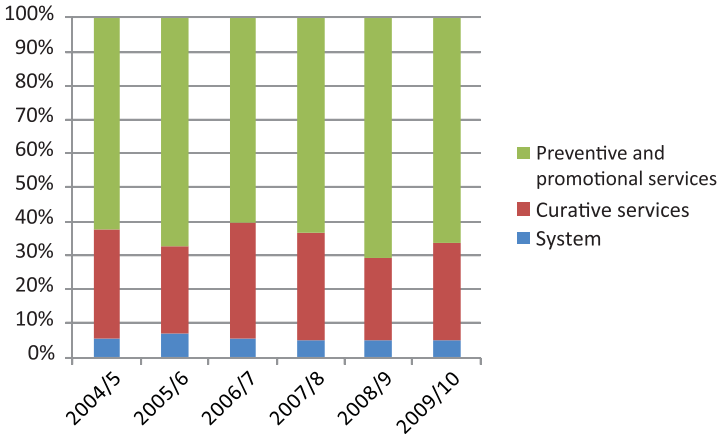
However, the MoHP has successfully introduced output-based budgeting for selected interventions. Under this mechanism health facilities are rewarded for their extra work, incentivising them to increase performance. Line item budgeting cannot do this and only prescribes the inputs on which resources should be spent. Output-based budgeting allows the MoHP to play an active role in directing resources to the areas/outputs that it wants. The following sections assess allocations by the MoHP in terms of their impact on the efficiency of the public health financing system and outlines why budget allocation does not promote efficiency gains in the current system.

Allocations to priority sectors

Government spending on health is restricted by overall fiscal space and limited capacity to obtain resources previously belonging to other sectors. The amount of public money for health depends on decisions by officials outside the health sector. However, once resources have been allocated to the sector, it is the responsibility of health decision-makers to allocate and manage them in the best possible way. Is the MoHP allocating resources where they produce the most health benefits for the greatest number of people?

Data on MoHP expenditure since 2004/05 shows that 'preventive and promotional services', which in theory should have a greater impact on overall health status than 'system expenditure', have enjoyed the largest share of expenditure. System expenditure, which includes the operational costs of central level institutions, has been kept relatively low, suggesting that most of the funds are devoted to the provision of services (see Figure 8).

Figure 8: MoHP recurrent expenditure by main functions, from FY 2004/05 to 2009/10



Source: Based on data from Ministry of Health and Population (2010a) *Financial management performance review. Report of NHSP-IP (FY 2004/05 to 2009/10)*

The largest spenders by intervention are: primary health services (24%); Integrated District Health Programme (21%); hospital services (18%); drugs and equipment supplies (7.5%); general administration (7%), the Expanded Programme for Immunisation (7%), and remaining programmes (16%).

Under both classifications of expenditure, the vast majority of resources do go to priority programmes. In theory, the allocation to these programmes, which should include only cost-effective interventions, should maximise the output and outcomes from these resources. However, a more detailed analysis is needed to explore how large the share devoted to the provision of services is of the total budget for programmes. The balance between preventive interventions and hospital based curative ones should also be explored. For instance, there are doubts as to whether allocating resources to expensive curative heart and kidney disease treatments is justified, when no comprehensive preventive care is available. Hence, although allocations point in the right direction, further investigation is needed.

Allocations not linked to outputs

Once budget funds are allocated to priority areas it is necessary to assess whether such allocations are spent in a way that maximises health facility outputs and promotes efficiency. The analysis should look into the ability of the system to boost performance while executing its role as a purchaser.

Hence, the next step in the analysis is to take a closer look at the impact of the MoHP spending on the efficiency of health facilities. Resources should be allocated where they will have the most

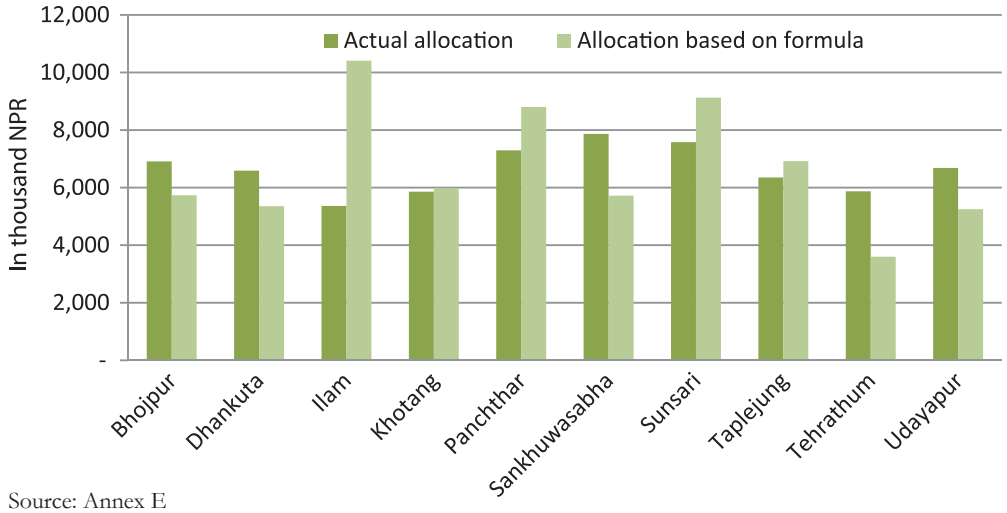
impact in terms of the quantity and quality of services provided to the population. One way of assessing this is by analysing government resource allocations to a specific health facility and the number of services provided. This can be done using available budget allocation and activity data. The objective of the analysis is to explore whether or not higher budget allocations lead to more outputs.

Notwithstanding, some issues must be considered before comparing budget allocations and expenditure with activity and output data. First, output in health services may be difficult to determine, as hospitals produce a mix of activities, such as consultations, X-rays and lab tests, which are not easily comparable and complicated to aggregate. Also, every discharge involves a different degree of complexity, which makes it unfair to compare one with another. Many countries have tried to overcome this challenge by developing composite indicators, ranging from the sophisticated Diagnostic Related Groups (DRGs), which simplify hospital output records creating groups with certain clinical and economic homogeneity into easier composite units that add on different clinical services weighting them according to the average amount of time that health workers spend on each service. However, such tools are not available in Nepal so, for the purpose of analysing whether the MoHP has distributed resources fairly among district hospitals, a formula for the allocation of resources has been developed that uses a set of indicators. Each indicator is intended to serve as the basis for allocating criteria. For instance, it is in the MoHP's interest to keep the current capacity of hospitals. Hence, the number of beds can be considered as a proxy indicator of the size of the facility and, thus, its maintenance needs. Also, the MoHP should reward facilities that perform a lot of surgeries, as they involve considerable extra costs. In this case, the number of surgeries should also be considered as an indicator in the formula (see Box 1 for more details on formulas as an allocation tool). The following list includes the criteria, the indicators, and their relative weights used in the formula. Note the suggested relative weights are based on experiences in other countries and might not represent the best combination for Nepal.

- Capacity (number of beds): 25%
- Volume of services (number of inpatient days): 40%
- Volume of services (number of OPD visits): 20%
- Complexity (number of major surgeries): 10%
- Maternity priority (number of deliveries): 5%

Figure 9 shows the differences between budget allocation using this formula and actual budget allocation for 10 sample hospitals in FY 2009/10. The differences between districts are substantial, with a lower budget allocation being recommended for low performing district hospitals such as Tehrathum, and a higher budget allocation for well performing district hospitals such as Ilam.

Figure 9: Comparison of actual budget allocation and budget allocation based on the formula in 10 district hospitals in Nepal, 2009/10



Source: Annex E

From these results it is apparent that there is a need to reward well performing hospitals through the inclusion of output-based criteria in budget allocations, while at the same time supporting those that are not performing well to improve their services and outputs.

Box 1: Introducing formulas: Moving towards linking policy and resource allocation

The current system of budget allocation in Nepal does not have a concrete mechanism to reward performance or recognise needs as it generally follows historical trends, and advanced systems such as the case mix based payment of providers are not an option for Nepal right now. Such advanced systems are resource intensive in terms of hospital information systems and statistics, as they need extensive information which must be produced on time. However, there are other solutions that could substantially improve the efficiency and equity of allocations. One option is to use formulas where criteria are mixed in a single mathematical formula using indicators produced by the existing Health Management Information System.

The choice of criteria and the weighting of each criterion in the formula also allows different objectives to be pursued simultaneously. A simple formula could mix, for instance, proxy capacity indicators (number of beds), indicators of production of services (number of patient discharges or inpatient days), and complexity indicators (number of major operations), and give priority to key programmes (number of deliveries). The weight given to each indicator is a policy decision for the MoHP. The only restriction on choosing indicators should be their availability in the Health Management Information System.

The implementation of any formula should be subjected to a 'non-loser' clause, where no facility receives less money than the previous year. Another possibility is to make the transition to formulas gradually. For example, Portugal introduced to its hospital payment system over 10 years, changing the rules of the game incrementally. In the case of a 'non-loser' clause, the formula should be applied to the extra resources allocated to the provision of services. The formula should only be used for non-salary and non-capital costs; salaries and capital costs should follow another allocation system, such as the number of workers or the plan to enhance the health facilities network. Finally, revision, improvement and adjustment of the formula should be done periodically to update the link between policy and resource allocation.

Unresponsive planning process

The process of preparing the government's annual budget combines historically based, top-down allocation with bottom-up activity, which is mostly disregarded by central level offices. Both procedures contribute to the government's passive role as a purchaser of services. Some of the weaknesses of the budget system are: delayed budget processes; weak relationship between bottom-up and top-down budgeting; and unhelpful expenditure classifications.

Delayed budgeting processes: The budgeting process does not usually happen on time. Health related programmes and budgets are scattered across different line agencies and ministries. Budget heads are categorised as per the nature of the programme. There are 53 budget heads and more than two-thirds of these are recurrent and capital costs. Moreover, most health institutions handle more than two programmes. The large number of budget heads and delayed reporting complicate the execution of the budget and administrative procedures. Other bureaucratic procedures, such as the sending of authorisation letters or development of the procurement plan, take place only after approval of budget, causing further delays.

Weak relationship between bottom-up and top-down budgeting: Planning and budgeting processes in Nepal are guided by a top-down approach rather than a bottom-up, needs-based approach. For the health sector budget, limits are fixed by the National Planning Commission in close consultation with the Ministry of Finance. The MoHP then re-programmes its activities to fit into these budget ceilings, irrespective of the plans it has already developed. The fact that planners at the MoHP do not know the financial ceilings in advance hampers the budgeting process. The accounting and reporting systems of the government are based on line item expenditure heads, and its financial and accounting systems are not properly harmonised with health related programmes and sub-programmes. The specificities and complexities of the health sector in Nepal may justify some coaching of district level authorities by the central level, which could, however, lead to the central level heavily influencing these plans. For example, taking decisions on resource distribution requires knowledge of epidemiology in order to forecast demand. Hence, some technical support from the central level is needed. Timing also matters. District plans are sometimes prepared when the MoHP submits its budgeting proposals to the National Planning Commission, thus disregarding all bottom-up plans.

Unhelpful expenditure classifications: Despite the programme-based budgeting system in Nepal, planning, budgeting and monitoring processes are input based rather than results based. For financial management and accounting purposes, expenditure is categorised as: (a) consumption expenditure; (b) office operating and management expenditure; (c) service and production expenditure; (d) capital expenditure; and (e) transfers/grants/subsidies. This level of detail is not sufficient to be of use in the policy formulation process and health sector budgeting, as there is no link between resources allocated and what is being delivered.

Weak implementation

Weak budget implementation also contributes to the government's role as a passive purchaser. Some of the weaknesses in implementation are: low budget execution and limited management freedom.

Low budget execution: Low budget execution is an issue in Nepal, although it has improved in recent years[8]. The MoHP recognises multiple reasons for this including 'spending a significant volume of the budget in the last trimester', 'inadequate skill of procurement staff', 'frequent transfer of staff and absenteeism of staff from their office' and 'not penalising non-compliance with financial administrative regulations'. Moreover, according to a financial management performance review of the MoHP conducted in 2010[9], the execution of the overall government budget is higher than of the health sector budget.

Limited management freedom: Devolved administrative levels have no effective power over resources, as most of them are earmarked for specific purposes by the central level. District development committees do not have the power to reallocate resources across different sectors. This earmarking also contributes to low budget execution, as the money that is not spent at the end of the year in one activity cannot be transferred to another one. This lack of discretionary power at the lower levels, combined with the trend of historically based increases to budget allocation, reduce the motivation of planners and managers and can lead to loss of interest in the process.

Challenges in reaching the poor

The government has attempted to make its budget as pro-poor as possible with the limited resources available. The introduction of the Free Health Services Programme shows its strong commitment to increasing the financial protection of the poor. However, the government's ability to increase financial protection depends on how effective its policies are in benefiting the poor. This section evaluates the current situation.

Identifying the poor

In recent years, the MoHP has introduced several social health protection interventions to provide financial protection to determined groups, particularly the poor. These interventions range from covering motherhood services to catastrophic conditions treated in tertiary hospitals (see Annex A for a list of such interventions).

One of the challenges of such interventions is to reach the intended beneficiaries. Towards this, the government uses targeting methods that range from identifying beneficiaries by age group to identifying the poor and ultra poor. However, while the former is straightforward, there are no effective and objective tools to identify the poor and ultra poor. This results in uncertainty in terms of who is entitled to receive benefits and who is not. The methods currently used are subjective and non-systematic. For instance, the Free Health Services Programme identifies the poor and ultra poor on the basis of their 'economic condition'. The Guidelines for the programme define the ultra-poor as patients who are able to feed their family for less than six months in a year. While conceptually this approach might seem reasonable, the means of verification may not exist or may be too difficult or time consuming to obtain, jeopardising the whole process.

The Social Services Conditional Grant, managed by the MoHP, relies on treating doctor and nurses to certify who is entitled to be exempted from hospital fees. Lack of training in this area for health personnel plus lack of appropriate tools to assess poverty indicates the need for this procedure to be revised.

Table 4: Comparison of actual budget allocation to districts in the Eastern Development Region with estimated allocations using a formula combining proxy indicators, FY 2009/10

District	Workload	Quality/ coverage	Quality/ coverage	Need	Extra cost of access	Equity	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation		Per capita allocation (in NPR)	
	Total people served (by PHCC, HP, SHP and ORC) per day	Immunisation coverage (average of BCG, DPT, polio, measles in %)	Deliveries conducted as % of expected pregnancies	Size of population	Inverse of population density	Human Poverty Index	Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %	Actual	Using formula
Bhojpur	666	62.8	53.3	228,983	0.009	43.6	44,297	41,451	44,149	(2,846)	-6%	193	181
Dhankuta	480	70.4	29.6	192,889	0.013	34.4	40,834	33,538	38,222	(7,297)	-18%	212	174
Ilam	611	70.5	41.2	334,376	0.003	33.7	45,305	40,354	44,998	(4,952)	-11%	135	121
Jhapa	1288	97.4	60.5	801,041	0.003	29.2	57,821	75,433	57,427	17,612	30%	72	94
Khotang	686	66.8	43.9	264,129	0.014	42.8	47,668	42,894	47,592	(4,774)	-10%	180	162
Morang	1998	91.1	49.2	1,000,114	0.002	34.4	74,630	96,259	74,330	21,629	29%	75	96
Okhaldhunga	694	68.9	55.2	181,009	0.012	46.0	46,948	42,411	46,848	(4,537)	-10%	259	234
Panchthar	595	64.2	35.9	234,926	0.007	42.1	35,899	37,072	35,619	1,174	3%	153	158
Sankhuwasabha	489	75.0	40.6	183,832	0.008	43.5	33,782	35,064	33,737	1,283	4%	184	191
Saptari	2029	89.6	85.8	673,056	0.003	40.2	112,582	93,332	111,429	(19,249)	-17%	167	139
Siraha	1831	103.1	113.0	677,957	0.003	47.1	110,125	94,415	109,340	(15,710)	-14%	162	139
Solukhumbu	425	59.2	76.2	123,960	0.028	45.8	26,721	39,638	26,717	12,917	48%	216	320
Sunsari	1963	85.5	95.7	756,321	0.003	32.2	66,065	94,636	66,012	28,571	43%	87	125
Taplejung	466	75.1	59.8	155,540	0.010	38.4	42,249	36,533	42,202	(5,716)	-14%	272	235
Teharthum	371	70.0	55.1	129,959	0.025	40.9	33,741	35,648	35,297	1,907	6%	260	274
Udaypur	756	76.3	30.4	344,588	0.005	40.0	47,624	43,858	47,624	(3,767)	-8%	138	127

Other more straightforward targeting approaches are also being used, including selecting who is entitled to the services linked to age or membership of a specific group, such as female community health volunteers. These methods are definitely simpler and easier to effectively implement.

Overall, the weakness of the available targeting procedures lies in their inability to identify the real poor and, thus, their inability to ensure that the poor are benefiting from the social health protection interventions. Moreover, the limited amount of resources and the total number of people using these services might indicate that a substantial proportion of the poorest population are not accessing these services[10]. A benefit incidence analysis would clarify the real scope/effectiveness of social health protection interventions in Nepal.

Minimising inequities across regions

Budgetary allocation tools translate policy decisions into the distribution of resources for priority interventions at different levels and in different geographical areas. The MoHP and its departments distribute resources to districts, hospitals and other institutions using certain criteria. These criteria may be based on reported indicators, past experience, historical trends or other factors such as political pressure. The resulting allocation should lead to a fair system under which no district is discriminated against.

Fairness involves rewarding performance, covering expected volume of services and maintaining the installed capacity, among other things. When aiming to build a fair resource allocation system, a different approach may be used for every level of care. Hospital care has a higher range of complexity than primary health care services; therefore, introducing complexity indicators when developing a system to pay/allocate budgets to hospitals seems reasonable. On the primary health care level, where services seem more similar across regions and facilities, complexity can be ignored to some extent. However, other aspects such as the quality of services, rewarding extra workload, or compensating a facility or area for the extra costs imposed by its geographical isolation should also be considered.

Table 4 shows the resulting allocation if a set of indicators measuring different aspects of the provision of services are put together into a single resource allocation formula. The allocation is made in relative terms, where a district receives its allocation based on the relative weight of its indicators compared to other districts. Thus, the higher/better the indicators the more the district receives. Obviously, an increase in an indicator from a district implies the reduction of resources for other districts. The criteria included are: (a) workload of health facilities in the area measured by the number of people served; (b) quality of coverage, measured by the average BCG (tuberculosis), DPT (diphtheria, pertussis, tetanus), polio and measles vaccination coverage; (c) quality of coverage measured by deliveries conducted as a percentage of expected pregnancies; (d) need, using population as proxy indicator; (e) the extra cost of providing services in remote areas, measured using the inverse of population density; and (f) equity, measured by the Human Poverty Index (HPI) for each district. The weight of each indicator in the final formula should be related to the priority given by policymakers to each criterion.

For the purpose of comparing the results of a formula and the actual allocation, the weight of each criteria are:

- Workload/production: 40%
- Coverage (vaccines): 15%
- Coverage (deliveries): 15%
- Need (population): 20%
- Extra cost of reach (density) 5%
- Equity (poverty): 5%

Table 4 compares the actual budget allocation to districts in the Eastern Development Region in FY 2009/10 with how budget funds would be distributed following the above formula. The discrepancies between the two are considerable. For instance, Saptari district received NPR 19 million more than what it would receive under the formula. Alternatively, Sunsari received NPR 28 million less than what it would have received had the formula been applied.

These results are in line with a World Bank-led Public Expenditure Review in 2010[11], which pointed out that "there are marked differences in health spending across regions and ecological belts" and "health spending in the central region is seven times more than that spent in the Far-western Region".

Limited funding for specified services for the poor

Strong government commitment to protect the poor is being materialised through the implementation of the Free Health Services Programme and other interventions that target the poor. Many of these interventions directly or indirectly include services consumed by the most vulnerable. However, little is known about whether these interventions have effectively protected the poor against financial risk in relation to health services, and to what extent. One of the key elements of the government's ability to provide this protection is the amount of resources allocated to the Free Health Services Programme. Are there enough resources to fund existing social health protection interventions in Nepal?

To answer this question, expenditure on all social health protection interventions must be estimated. In the FY 2008/09, the major interventions, including the Safe Motherhood Programme, Free Health Services Programme, Screening and Treatment of Uterine Prolepses, plus other five interventions, received a budget of approximately NPR 2.5 billion for the benefit package, which is less than NPR 90 per capita[12]. Although the government has made a substantial effort to increase financial resources for health in the past years, the current level of government health expenditure is clearly insufficient, as is overall public spending per capita[13]. Even the inclusion of benefits in kind, such as medicines under the Free Health Services Programme, estimated as more than NPR 1 billion, does not change the general picture.

Although different interventions have been implemented to improve people's access to health services, adequate funding is not guaranteed. In many instances, the scope of interventions is limited during their implementation due to inadequate funding. In addition, how they are funded, in terms of disbursements, varies from intervention to intervention. For example, a programme such as the Safe Motherhood Programme, which is a priority programme of the government[14], has guaranteed funding. Additional budgets are arranged for the Safe Motherhood Programme to reimburse health facilities in case the allocated budget falls short. This does not apply to other

interventions. Moreover, reimbursements under the Safe Motherhood Programme are based on actual costing calculations. Some other interventions have set arbitrary limits for reimbursements, with the financial capacity of the government as the main criteria. For example, the degree of financial protection offered by the MoHP through the medical treatment for catastrophic diseases is not known as the cost of the treatment has not been estimated. Moreover, the number of people availing themselves of such services is rather small, suggesting that many people in need remain uncovered. According to the Progress Report of the Ministry of Finance, 300 people benefited from medical treatment for haemodialysis (treatment for kidney disease) while 648 persons below 15 years benefited from free treatment of heart disease in 2009/10[15].

The fact that existing funds available for social health protection interventions cannot cover the entire population in need means that some kind of rationing of service delivery is needed. Restricting access to services (rationing) may be active or passive, making it more or less explicit. Nepal's approach to rationing free health services is both passive and active. The MoHP restricts services passively by limiting budget allocations and making access to services bureaucratically complicated. For instance, the requirements for claiming financial compensation for the treatment of catastrophic diseases are too complicated, including the approval of the district development committee of the patient's district. Developing a list of medicines covered by the Free Health Services Programme is an example of explicit or active rationing as it limits the services available to the population under the programme. In the case of essential medicines, running out of stock also constitutes a form of passive rationing, as the patient must purchase medicine instead of receiving it for free. The consequence of this kind of rationing is to shift the financial burden from government to the providers and users, resulting in a reduction in the protection provided by the Free Health Services Programme. Notwithstanding, the existence of this rationing makes these interventions affordable for the MoHP.

Output-based budgeting mechanisms yield results

Since 2005, the Government of Nepal has been introducing the output-based allocation of resources. This mechanism was initiated under the Safe Motherhood Programme and has since been expanded to several other programmes and interventions, such as the Screening and Treatment of Uterine Prolepses and cash incentives for permanent sterilisation under the Family Planning Programme.

This mechanism, which links reimbursement/budget allocation to the delivery of a determined service, has helped to boost the production of services and population coverage for prioritised interventions. Institutional deliveries jumped from 27% in 2005 to 47 in 2009[16], which might have contributed to the reduction of maternal mortality in Nepal.

The successful implementation of the Safe Motherhood Programme can be credited to a combination of factors, including: (a) a high degree of awareness about the programme among mothers; (b) an incentive scheme for hospitals, attendant workers and mothers based on real costs; (c) policy adjustments made during the implementation of the programme; (d) priority given by the government to the Safe Motherhood Programme giving it certain privileges in terms of financial management and securing the necessary resources on time; (e) a robust forecasting and reporting system; (f) confidence that the programme is working and that funds are guaranteed, which translates into health facilities mobilising their own resources to avoid disruption in the provision of benefits when there are delays in fund transfers; and (g) substantial financial and technical

support from external development partners. In addition, cash transfers to mothers to cover transportation costs and to incentivise the completion of antenatal care (ANC) and postnatal care (PNC) have proved effective in bringing more mothers to facilities.

Linking budget allocations to outputs improves the performance of the system. However, the current successes are also linked to other advantages of the programme such as administrative shortcuts and privileges in terms of public finance management, such as the continued flow of funds, even at the end of the fiscal year. But is expanding the use of these advantages to other areas manageable and affordable for the system? If all programmes enjoy administrative shortcuts it would overload the administrative system as all of them would require special attention. Alternatively, a more systemic solution should be explored. For instance, merging the interventions performed at each level under the same payment and administrative procedure would reduce the administrative workload. It would also help to enhance the allocation of resources at lower levels, providing local managers with more margin to manoeuvre. Any steps toward the development of provider payment mechanisms should consider these issues.

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[1] National Planning Commission; United Nations Country Team of Nepal (2010) *Op. cit.*

[2] WHO National Health Accounts database: http://www.who.int/nha/country/npl/en/.

[3] *Ibid.*

[4] Taskforce on Innovative Financing for Heath System (2010) *Op. cit.*

[5] Ministry of Finance (2010b) *Op. cit.*

[6] The budget under the Health Tax Fund is allocated to Bharatpur Cancer Hospital and other cancer related programmes.

[7] World Bank (2011) *Assessing fiscal space in Nepal.* Health Nutrition and Population, South Asia Region, the World Bank

[8] Ministry of Health and Population (2010a) *Op. cit.*

[9] *Ibid.*

[10] Different health facility surveys by RTI found that drugs out of stock is a severe problem in the effective implementation of the Free Health Services Programme in Nepal. Seventy-two per cent of health posts and sub-health posts reported stock-outs of drugs lasting longer than a week in the fourth round of the survey, increasing to 90% in the sixth round; see: RTI International (2010a) *Op. cit.*

[11] World Bank (2010) *Nepal: Public expenditure review.* Washington, DC: World Bank.

[12] Financial Management Information System, MoHP and Department of Health Services.

[13] Total annual health expenditure per capita in Nepal was USD 25 in 2009, below the USD 44 estimated by WHO's Taskforce on Innovative Financing for Heath System as the minimum required to fund key health services in low-income countries; see: Taskforce on Innovative Financing for Heath System (2010) *Op. cit.*

[14] The National Planning Commission prioritises programmes and projects as per the Budget Formulation Guidelines. The Guidelines have defined seven criterion with different weights for the purpose of prioritising programmes as level one, two or three. These criterion are: national objective (20); regional objective (15); regional balance (10); participation (20); contribution to national priority areas (10); status of the programme (15); and guarantee of financing source (10). In FY 2010/11, 78.8% of the health budget was allocated to priority one programmes, 18.8% to priority two and 2.4% to priority three programmes. See: Ministry of Finance (2006) *Budget formulation guidelines* (in Nepali). Kathmandu: MoF, Government of Nepal.

[15] Ministry of Finance (2010a) *Progress report of sector ministries. Fiscal year 2008/09 and 2009/10.* Kathmandu: MoF, Government of Nepal.

[16] Powell-Jackson, T. et al. (2010) *An early evaluation of the Aama "Free Delivery Care" Programme.* Unpublished report submitted to DfID, Kathmandu.

Chapter 4

Reforming the System

This chapter outlines the key challenges that need to be addressed in reforming Nepal's health financing system and the main reforms needed. It presents the rationale for the creation of a Social Health Protection Centre and describes its institutional set up, scope of work and tools. It describes the contextual factors to consider when designing and implementing reforms including the phase-wise implementation steps. Finally, it touches upon parallel processes that may affect the success of any reforms, policy decisions that will determine the shape of the reforms, and preconditions for reform.

Key challenges

For Nepal's health financing to develop its full potential, several issues need to be tackled, which will entail considerable changes in the way the MoHP has been working. Some successful interventions (such as the Safe Motherhood Programme) have proved that the system can deliver good results.

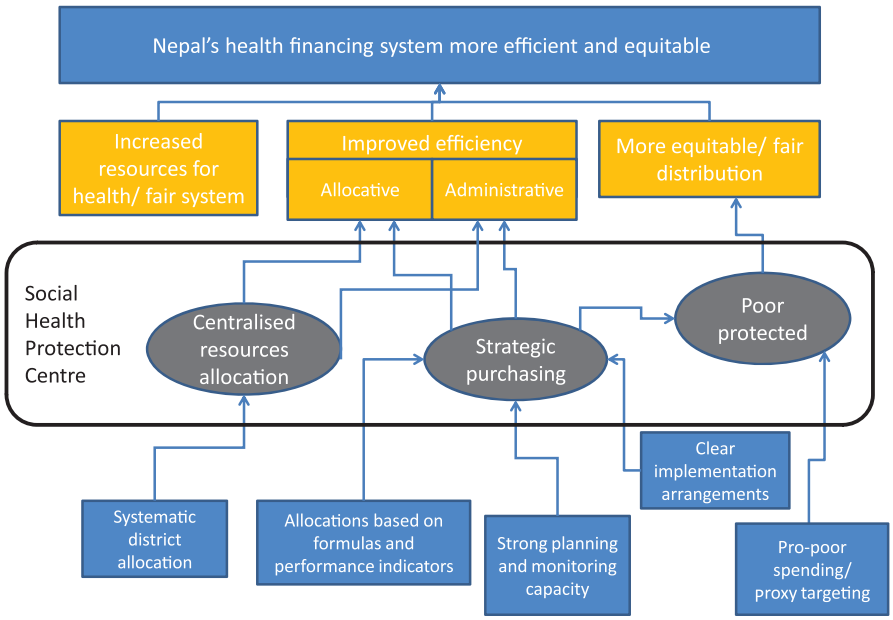
The last chapter identified three key challenges to be addressed by health financing system reforms:

1. The Government of Nepal has limited capacity to generate more resources on a substantial scale.
2. The health financing system has limited ability to address inequities and identify and protect the poor.
3. There are inefficiencies in the system due to fragmented resource allocation.
4. The Government of Nepal has limited power to negotiate the price and quality of services due to the practice of passive purchasing.

Addressing these challenges requires political will, which has to be translated into continuous support in terms of resources and reforms, and an enhanced capacity to design and implement sound technical solutions to address these issues. Addressing some of these challenges will involve both health sector and non-health sector actors. For instance, increasing resources for health will require better revenue collection, which is the responsibility of the Ministry of Finance. However, many of the challenges presented can be tackled with reforms within the health sector. This will require a strategic approach in order to make feasible changes and to address challenges efficiently.

Figure 10 outlines some actions that are within the control of the MoHP that would address many of the key causes of health financing system underperformance in Nepal.

Figure 10: Key reforms to address the causes of government health financing system under-performance in Nepal.



Centralising resource allocation (and merging funding arrangements) into a single decision-making body (the proposed Social Health Protection Centre) will make resource allocation more efficient and facilitate the introduction of a strategic purchasing function and the implementation of procedures to improve the access of the poor to health services.

The introduction of strategic purchasing using tools such as formulas, output-based budgeting and strategic purchasing will increase the leverage of the system, enabling the government to obtain more value for money.

Reshaping current pro-poor interventions to make them more user-friendly to beneficiaries and including poverty as a criterion in distributing resources would make the system more equitable and improve access to services for the poor.

The responsibility of implementing these key reforms (centralising resource allocation/merging funding arrangements, introducing strategic purchasing and improving access to services for the poor) should lie with the MoHP. The MoHP is in the best position to develop an institutional arrangement for the strategic purchasing of health services and to address inefficiencies and inequities across the health system.

A step forward in reforming the current health financing system was taken at the workshop organised by the MoHP on 22 March 2011. At this workshop the MoHP, supported by a number of development partners, decided to gradually integrate the existing vertical social health protection interventions and their respective health service purchasing functions and block grants under one management and administration system. This implies the creation of a Social Health Protection Centre, which would then act as a fund manager and introduce strategic purchasing, including output-based budgeting.

Creating a Social Health Protection Centre

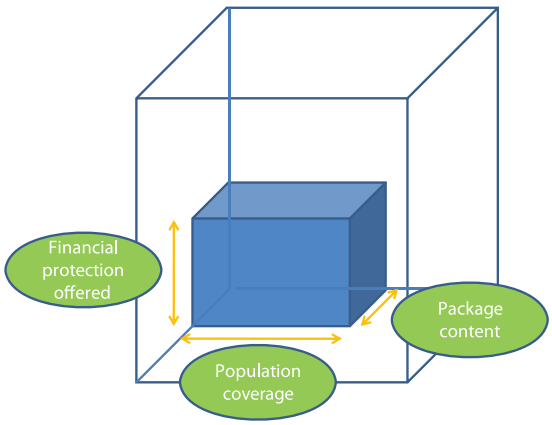
Purchasing services strategically will address some of the inefficiencies of the current health financing system. The main goal of strategic purchasing is to reorganise MoHP resource allocation tools and transform them into mechanisms that link policies with the funding of activities, rationalise administrative efforts and effectively protect the poor. Under strategic purchasing, the MoHP will define what is being purchased, at what price and from whom, making its decisions according to its policies. This section present the rationale for creating a Social Health Protection Centre, the institutional arrangement of the proposed Centre, its scope of work and the tasks that need to be done to achieve this goal.

Rationale: Universal coverage

The main goals of creating a Social Health Protection Centre can be better understood using the universal coverage conceptual framework developed by WHO, which defines coverage in three dimensions: (i) percentage of population covered/entitled; (ii) the benefits available to them; and (iii) the share of costs covered. According to this framework, Nepal needs to address the following challenges: (a) unsatisfactory coverage of the poor; (b) unclear definition of who is entitled to benefits; and (c) low financial protection with a high prevalence of out-of-pocket expenditure, even for key health interventions.

It must be noted that the creation of a Social Health Protection Centre will not fully address all these challenges as its main focus will be points (b) and (c), i.e., to define benefits and enhance financial risk protection. Figure 11 shows the space that could be filled with the proposed reform measures: the inner cube represents the current situation and the outer cube the final goal, in terms of full population coverage and provision of a determined set of interventions with full financial protection.

Figure 11: Nepal's position on the three axes of the WHO universal coverage framework



The Social Health Protection Centre would need to tackle the three dimensions outlined in WHO's universal coverage framework:

1. **Population coverage:** The Centre will need to clarify who is entitled to services under the various packages, making access to services as user-friendly as possible.

2. **Package of services:** The Centre will need to define the content of its package of services (i.e., list of interventions covered) and integrate them under a single management system in order to prioritise and rationalise the interventions.

3. **Financial protection:** Some programmes, such as the Safe Motherhood Programme, provide full coverage of services without the need for co-payments from beneficiaries; this will need to be expanded to all of the services in the package. However, fixed co-payments for non-poor may be necessary when the affordability of benefits is compromised. For this, the cost of the resources required to fully cover the services provided must be estimated.

Institutional arrangements

Concentrating the strategic purchasing function in a single unit within the Department of Health Services or MoHP requires analysing which institutional setting would best fit this role. Crucial in this discussion is the question of whether to move the purchasing function outside the MoHP, creating a new agency. This might be a long-term goal as it could overburden the capacities of the system in the current context. To answer this question, it is necessary to study where social health protection interventions are currently managed (see Table 5).

Four units are currently engaged in managing social health protection funds in Nepal. The interventions focused on services provided in secondary and tertiary hospitals are concentrated within the MoHP. The interventions under the control of the two divisions of the Department of Health Services mainly provide funding for primary level interventions delivered at the district

Table 5: Funding arrangement for social health protection funds by type and management unit

Type of social health protection funds	Management unit				
	MoHP	**Family Health Division**	**Primary Health Care Revitalizing Division**	**Centres (TB, HIV/AIDS)**	**Other units**
Extra funds to providers	Medical treatment for important personalities and the poor for serious illnesses (kidneys, heart, cancer) and for other target groups Social Service Conditional Grant to provide subsidised services Medical Treatment for Victims of Conflict/People's Movement	Safe Motherhood Programme (payments to health facilities and incentives to health workers) Screening and Treatment of Uterine Prolepses Family Planning Programme (cash incentives for permanent sterilisation)	Free Health Services Programme – compensation for users' fees Social Services Conditional Grants to subsidise services to target groups (senior citizens, *Dalits*, disabled people, the poor) Social Inclusion Programme (referrals incentives for target groups: senior citizens, *Dalits*, disabled people, helpless, poor, and other deprived groups)		
Cash transfers to patients	Medical treatment for important personalities and the poor for serious illnesses (kidneys, heart, cancer)	Safe Motherhood Programme Incentives for ANC and PNC Screening and Treatment of Uterine Prolepses Family Planning Programme (cash incentives for permanent sterilisation)	Social Inclusion Programme (referral incentives for target groups: senior citizens, *Dalits*, disabled people, helpless, the poor, and other deprived groups)	Incentives for tuberculosis patients – Directly observed treatment, short course	Incentives for malaria and kalazar patients (Epidemiology and Disease Control Division, DoHS)

Type of social health protection funds	Management unit				
	MoHP	Family Health Division	Primary Health Care Revitalizing Division	Centres (TB, HIV/AIDS)	Other units
In kind		Free family planning measures under the Family Planning Programme	Free Health Services Programme – listed essential medicines	Free medicines	Immunisation; Nutrition Support to Children (< 5 years of age); vitamin A, polio (Child Health Division, DoHS); Free Ayurvedic Medicines (Department of Ayurveda)

level. The fourth group includes centres for specific diseases such as tuberculosis and HIV/AIDS, which are also funding vertical activities at the district level. These differences, related to the type of interventions funded and the level of care, should support the decision as to which interventions can be clustered. It makes sense to start merging those that could use unified procedures.

As pointed out above, the Social Health Protection Centre should aim to consolidate all the social health protection interventions in Nepal. This Centre should play a leading technical role in the clustering process, in providing tools for budget allocation, conducting performance reviews of providers and producing analysis to inform the policy-making process. Lastly, it is important to note that creating any new division or centre would require the explicit approval of the Ministry of General Administration and National Planning Commission. Therefore, the direct involvement of MoHP top managers is needed to secure this new institutional structure.

Skill mix and scope of work

The proposed Social Health Protection Centre will centralise functions that are now performed elsewhere, as well as creating new ones. The main functions of a health services purchasing unit are to: (a) define the benefit package (the kind of services to be purchased); (b) define membership or entitlement (identify who should receive benefits and how to identify them); (c) quality assurance (develop standards and monitoring tools to check that the services provided are appropriate, necessary and of an acceptable quality); (d) financial management (ensure that reimbursements are made on time, preventing fraudulent billing, detecting actual fraud and ensuring that the overall financial management of the unit is correct); (e) manage information systems (ensure that information is reported and processed on time for decision-making); and (f) handle legal aspects (define the relationship between the Social Health Protection Centre and the provider of services).

Ultimately, these six components need to be covered, but they do not need to be fully developed in the first phase of the establishment of the Centre. For instance, the financial flows procedures required to pay providers might use the overall public finance management system of the government, instead of developing this function within the Centre. The development and management of an accreditation system that fosters quality improvement can be given to another agency (government or non-government) to avoid conflicts of interest and to cater to providers

that offer services not included in the benefits package. The effective implementation of the accreditation system requires external assessment capacity, internal improvement mechanisms and quality management at the provider level. The licensing system, which is a core function of the MoHP, should be effectively used to ensure minimum services delivery standards and the proper distribution of services across regions.

Table 6 presents the six functions of the proposed Social Health Protection Centre, the kind of expertise needed and the tasks that should be undertaken.

Table 6: Functions of the Social Health Protection Centre

Functions	Expertise required	Institutional arrangement	Implementation timeframe	Tasks
Benefit package	Public health specialists, health planners Costing/package financing (see Box 2)	SHPC and vertical programmes	From the beginning	List of basic health package interventions Basic health package system costing
Entitlement procedures	System analysis Targeting Social services	SHPC	From the beginning	Non-demanding/ survey-based targeting
Quality assurance	Health quality specialist	SHPC	Second phase	Implementing tools for accreditation such as prescription guidelines and clinical protocols Licensing standards Medical audits
Financial management	Financial managers, accountants, auditors and the capacity to manage them	MoF	From the beginning	Explore compatibility of Treasury Single Account with retrospective payments Audits/ fraud detection
Information systems	Health statistics Information technology	Health management information system	From the beginning	Introduce hospital specific indicators
Legal services/ contracting	Experts on contracts Complaints and appeals handling Arbitration mechanisms	SHPC Independent appeal and arbitration committee	Second phase	Contracts Agreements Complaint appeal protocols Arbitration guidelines/ procedures

The development of all of these functions will take time. In some areas, the required expertise might not be available in the Nepalese market. Moreover, other factors may also limit the extent of development of each function. For instance, a degree of autonomy of facilities and their ability to control their own resources is a precondition for making them responsible for meeting accreditation standards. Hence, the scope of development of the Social Health Protection Centre will need to go hand-in-hand with other reforms in the sector.

Box 2: Essential health care package and explicit rationing of services

An essential health care package in a low-income country consists of a limited list of public health and clinical services provided at the primary and/or secondary care level. In contrast, in wealthier countries, packages are described in an explicit description of services and by what is excluded. Essential health care packages aim to concentrate scarce resources in interventions that provide the best 'value for money'. By doing this, essential health care packages are often expected to achieve multiple goals: improved efficiency, equity, political empowerment, accountability, and altogether more effective care.

Source : World Health Organization (2008) *Essential health Packages: What are they for? What do they change?* Draft Technical Brief No. 2, 3 July 2008, WHO. Available at: http://www.who.int/healthsystems/topics/delivery/technical_brief_ehp.pdf

When building an essential health care package, two approaches can be taken. The package can be defined as a 'right', and details provide to citizens regarding entitlements, or the package can be designed in such a way that recognises the capacities and realities in the country, both technical and financial. Despite the fact that the former might seem more comprehensive and attractive, most countries have failed to translate it into an effective package due to limited resources and the orientation of funds to non-cost effective interventions, which make their provision unaffordable. Earmarking funds to clearly defined cost-effective interventions or to the inputs necessary for the provision of essential services helps in implementing an essential health care package. Nepal has experience of this, having defined a list of medicines as part of the content of its Free Health Services Programme. Essential health care packages should not only list the services covered, but also the providers that offer the services, including other relevant provisions such as for referral and co-payment.

In Nepal, where the Interim Constitution of 2007 defines health care as a basic right, a balanced approach is suggested. Hence, the definition of an essential health care package as a right could be used as a negotiation tool when the health sector bargains for more resources with the cabinet. However, its implementation should be guided by matching the content of the package with the available resources to serve the entire population. This should be seen as an opportunity to bring together interventions currently designed and funded by vertical programmes.

Finally, WHO warns that implementing an essential health care package is not just a technical exercise. Political and institutional processes need to be engaged, because successful implementation involves dialogue on purpose and design, decisions on financing and delivery arrangements, and adaptation over time. It is also important to highlight that developing an essential health care package means explicitly recognising what the government will not fund. This, in turn, might not be politically attractive, complicating the process.

Tools to be developed

The Social Health Protection Centre must develop some tools in order to fulfil its mandate. The development of such tools requires a comprehensive functional analysis in which the institutional arrangement is linked with the required skills and the tools needed to support its operations. The tools that must be developed include: (1) provider payment mechanisms; (2) provider performance reviews of the system that will monitor the quantity, appropriateness and quality of services provided; (3) an information system that links finances and activities; and (4) contracts that define what will be purchased, at what price, and when payment will be made, as well as any

Table 7: Provider payment mechanisms

Provider payment mechanism	Type of service to be purchased	Main feature	Short or long term	Provider	Remarks
Output-based budgeting	Merged disease specific interventions	Payments are based on capitation plus bonuses for providers for good performance and/or meeting targets	Short term	PHCC, HP, sub-health post and public hospitals	The MoHP has experience in the implementation of this payment mechanism. This payment mechanism provides incentives for efficiency gains and quality improvement.
Output/need based budgeting using pre-established formulas	Hospital activity: both ambulatory and inpatient	The allocation of resources through a balanced formula that takes into account capacity, production, need and poverty	Short term and long term	Public hospitals	Application of a formula will make hospitals more responsive to government policies. Transparency is enhanced. This mechanism provides incentives for efficiency gains and promotes equity.
Capitation	Basic health package provided by primary health care facilities	Introduces performance-based incentives with bonus payments linked to predefined targets	Long term	PHCC, HP, sub-health post	This mechanism is easy to administer. Provision of bonuses helps to boost provider performance.
Line item budgeting	Training, workshops, research, policy making	Budget linked to activities	Long term	Departments and divisions	Performance of regulatory bodies and vertical programmes is difficult to assess under this mechanism.
Line item budgeting	Salaries	Salaries follow general government rules for public servants	Short term	All public providers	Salaries will still be paid through line item budgeting for hospital workers who are public civil servants.

other necessary conditions of the purchaser-provider relationship including arbitration and appeal handling.

Different provider payments mechanisms will provide different incentives to providers. Their administrative complexity may also vary. Based on the existing provider payment mechanisms in Nepal, the MoHP needs to explore pragmatic options for the future. A gradual start can be made by choosing those options that can be implemented in the short term and leaving the more

demanding ones to be implemented in the long term. Table 7 summarises the main provider payment options that the MoHP could consider for short and long-term payments.

The development of provider payment mechanisms will require a substantial amount of preparatory work. For example, the preparation of capitation payments should be based on an extensive system costing to estimate the cost of the health facility network in a determined geographic area. This exercise should be done instead of the interventions costing (or vertical costing) studies that were used in the past to estimate reimbursements under the Safe Motherhood Programme. Under this new approach, costs are determined by costing all resources needed (personnel, operational costs, medicines and capital depreciation) to attend to a certain population with an estimated epidemiological profile and a forecasted level of consumption of resources.

When developing new payment mechanisms, user fees collected by public facilities should also be considered as a key variable. At present, these fees are not regularly reported and their volume is unknown to decision makers at the central level. It is difficult to improve fairness across the system without considering the internal revenue of health providers when distributing resources. This is because internal revenue capacity differs from one health facility to another. For example, health facilities in urban areas such as Kathmandu may be able to generate more fees than those in poor rural areas. Any new system should allocate resources to counterbalance this, thus providing extra resources to facilities in areas with less capacity to mobilise fees from patients.

A second set of tools involves developing standards of care to ensure that services provided are of sufficient quality. Normally, the process of enhancing quality starts from the simplest licensing model. The MoHP could strictly link licensing and licensing renewal provisions with quality standards. A further step towards quality involves the accreditation of facilities, where processes are also defined and facilities have to follow such processes and meet certain quality standards to be accredited. Health facilities would also be required to have an internal quality monitoring and improvement system. Among other aspects, the accreditation (or credentialing) of health facilities may require personnel to undergo courses on the treatment of a specific disease or that an operational theatre follows a checklist involving the availability of equipment, trained personnel, coordination bodies and clinical protocols. These functions could be externalised to third parties, with the MoHP retaining the regulation role. These advanced quality assurance approaches should only be considered after the establishment of basic licensing procedures.

Another key issue to address is fraud prevention. Misreporting and intentional fraud has already being observed under the current payment mechanisms. This calls for the development of supervision protocols and an alarm system to trigger audits of facilities exhibiting suspicious behaviour. Substantial penalties and fines must be imposed to discourage fraud. These correctional measures must be part of any formal purchasing agreement between the Social Health Protection Centre and health provider. The credibility of the process depends heavily on presenting the Social Health Protection Centre as a reliable, but serious, purchaser with clear rules.

The third set of tools aims to enhance the Health Management Information System. The current system already provides basic hospital indicators; a comprehensive picture of activities and coverage; and the epidemiological profile of districts and facilities. However, misreporting[1] and delays[2] in data processing and publication are commonplace.

More sophisticated provider payment mechanisms require a more complex and dynamic Health Management Information System. For instance, case payment would require a reporting mechanism that classifies every case into a category related to its complexity. These systems are very demanding and require years to develop. In any case, the Social Health Protection Centre will need to update the current Health Management Information System to accommodate new provider payments mechanisms.

Lastly, the capacity for contracting, including the development of sample contracts or templates, needs to be developed to govern the relationship between the Social Health Protection Centre and providers. A clear separation between funders and providers, where the quantity of outputs produced determines reimbursements, requires the development of a clear relationship between both parties. The Social Health Protection Centre will need to specify the terms and conditions of its relationships. All this information needs to be known and agreed by both funders and providers. Moreover, penalties for breaching the agreement must be included.

Phase-wise implementation of the Social Health Protection Centre

The introduction of the Social Health Protection Centre should be incremental. The length of each phase will be determined by factors internal and external to the health sector. Inside the health sector, the speed of incorporating changes and the development of capacities will be key to moving ahead. External factors such as the political endorsement of reforms and the effects of decentralisation on the sector should also be considered.

The proposed reform is divided into three phases. Ultimately, the reform will lead to a full-fledged purchasing unit within the MoHP or an independent purchaser outside the MoHP. Whether the purchasing unit is inside or outside the MoHP will not affect the development of a new mechanism of revenue collection, i.e., contributions.

A preliminary step is to review the current purchasing capacity of the executive divisions/units of the MoHP and Department of Health Services. This will inform the choice of which division or unit would be best suited to start acting as purchaser while leaving open the final configuration and location of the Social Health Protection Centre.

1. **Clustering**

   The first phase, 'Clustering', will consolidate the existing social health protection interventions into a few clusters managed by MoHP departments and centres. The intention is to merge reporting and administrative procedures to reduce the workload of institutions and study how to bring them together in a coherent approach. Management will still be with the divisions and centres where they are currently managed. In parallel, the Social Health Protection Centre will be created, providing technical assistance to divisions and centres in their effort to consolidate programmes. The Social Health Protection Centre will also start using budget allocation tools such as formulas and produce studies to prepare for the second phase.

2. **Transitioning to systems funding**

   The second phase, 'Transition to systems funding', will concentrate all social health protection interventions under the Social Health Protection Centre. A single reporting system, integrated

in the Health Management Information System, will be implemented. At this stage, all service delivery funding for vertical programmes will be integrated into a single essential health care package. The definition of the package and its costing will be prepared in the previous phase. The basic package will be funded using a mix of capitation with bonuses, aiming to have an easier payment mechanism but also keeping health workers motivated through financial incentives.

3. Fully-fledged purchasing agency

The last phase of the reform is the realisation of a 'Fully-fledged purchasing agency', which will purchase the services of most health providers in the country on behalf of the population. This agency, which may administer contributions collected via taxes, will be under the regulatory frame of the MoHP. Nonetheless, the agency will enjoy extensive freedom in setting standards, reimbursements and procedures, within the created legal framework. At this stage, and depending on how responsive the Health Management Information System is, the agency might opt for whichever provider payment mechanism best fits the objectives of health system.

Table 8: Moving towards strategic purchasing: Key features of the three reform phases

	Reform phases		
	Clustering	**Transition to systems funding**	**Fully-fledged purchasing agency**
Institutional arrangement	- In current divisions, centres, units	- Social Health Protection Centre under MoHP - Regulatory institutions	- External agency attached to MoHP or - Independent SHPC - Regulatory institutions
What is paid (what is included in the 'package')	- Hospital services - Programme funding mixed with operations - Activities of vertical programmes	- Hospital services - Essential health care package (programme plus operation costs) - Activities of vertical programmes (trainings, research etc.)	- Hospital services - Basic essential health care package - Operational research function
From whom are services purchased	- Hospitals clustered by level (then formula) - D(P)HO - PHCC, HP, sub-health post	- Hospitals - D(P)HO - PHCC, HP, sub-health post -	- Hospitals - D(P)HOs, PHCCs, HPs, sub-health posts
Provider payment mechanism	- Output-based budgeting - Formula for hospitals - Line item budgeting	- Capitation plus bonuses - Formula for hospitals	- Capitation plus bonuses - Eventually case payment, case-mix based budgeting once the system is in place and if it becomes feasible given other constraints

Parallel processes influencing reform

Any reform of the health financing system will be affected by other parallel processes such as Nepal's decentralisation process and the implementation of the Treasury Single Account model. These processes, which are not under the direct control of the MoHP, must be taken into account when designing and implementing health financing reforms.

Decentralisation process

Health financing system reform initiatives must be compatible with the existing framework of decentralisation and should take account of future plans. The Local Self-Governance Act 1999 and its Regulations 2000 brought in significant decentralisation reforms. It widened the roles and responsibilities of local bodies (district development committee in each district and village development committees at the sub-district level) including in revenue collection and expenditure. Thus, decentralisation has expanded the scope of local level functions since 2000. Nevertheless, the data for 2005 to 2006 reveals that only 8% of total government expenditure is at the local level with the remaining 92% in the hands of the central government. In the absence of elected representatives at the local level, implementation of the decentralisation process has been slow[3].

Implementation of the Local Self-Governance Act was initiated from 1999 with four areas designated for decentralisation. Basic health up to the level of sub-health posts, primary education, agriculture extension and livestock services, and postal services were to be decentralised. However, the decentralisation of functions did not follow the spirit of the law. In relation to the health sector, the Act provided that local bodies would be responsible for sub-health posts. However, in practice, sub-health posts in 14 districts have been handed over to local management while the rest remain directly under the control of the MoHP.

In summary, despite more than a decade of decentralisation in Nepal, most decisions are still controlled by the centre. Some other indicators support this, such as the fact that more than 80% of government employees are controlled by the central government and 50% of professional level civil servants are in Kathmandu.

The Interim Constitution 2007 declares Nepal a federal state, and while the structure of the state is yet to be finalised in the new constitution, it is likely that much of the power and financial resources will remain with the central government. Extensive competencies, including health services, are likely to be given to the provinces, although these will probably be mainly executive and administrative. Below the province level, a third tier will involve the current local bodies (municipalities and village councils).

The most significant sources of revenue in Nepal include Value Added Tax (VAT), customs duty, excise tax, income tax and foreign grants; these will continue to be collected by the central level government agencies. Fiscal transfers to the lower tiers (provinces and municipalities) may be based on formulas to address the significant regional development gaps. It is expected that local bodies will have a slightly higher share of revenue collection, doubling their current share from 5% to 10%. However, they will continue to be dependent on the central level, not representing a substantial change from the current situation.

These changes will involve new methods of planning and budgeting as well as significant changes in roles between policymakers and providers. For example, the central level will not be involved in local/facility planning, as it will focus only on services delivered, rather than inputs availability or activities.

In contradiction to the decentralisation process, the proposed stronger purchasing role of the MoHP will consolidate most of the power at the central level. Nevertheless, depending on the

administrative competence of local bodies and the expansion of health service providers at the local level, purchasing arrangements could be designed in accordance with the decentralised framework. The type of resources that will be retained at the central level will also determine the scope of the power at lower levels. In any case, decentralisation must be considered as an exogenous variable with a considerable impact on any intended reform.

Treasury Single Account model

The Treasury Single Account model, which is in its pilot phase as the cornerstone of public finance management reform, may also affect reform measures in the health sector. Introduced in January 2010, this system is currently being implemented in 18 districts and was planned to reach 22 districts by the end of FY 2010/11. Based on the principle of unity of cash and unity of treasury, a Treasury Single Account is a bank account or a set of linked accounts through which the government transacts all its receipts and payments[4]. The Treasury Single Account system eliminates the independent bank accounts held by public institutions, such as hospitals, district health offices, and health facilities, and centralises cash management and payments in a single account under the management of the Ministry of Finance. This makes cash flow requirements lower because idle cash is not held in multiple bank accounts.

The implementation of a Treasury Single Account in the pilot districts has brought all government payments to the district treasury controller office. All cheques are issued by the district treasury controller office after the 'Spending Unit', including the health sector and other public institutions, prepares the required documentation. However, this procedure does not translate into active control by the district treasury controller office over every payment.

The shift towards this new model has not disrupted normal activities in public institutions. Officials interviewed[5] reported that the district treasury controller office is able to accommodate the workload and suppliers usually receive payments within 2 to 3 days.

Implementation of the Treasury Single Account system may have significant implications for health financing reforms in Nepal. In particular, a Treasury Single Account system is incompatible with certain provider payment mechanisms. For instance, per case reimbursements can require funds to be transferred retrospectively (after the services have been provided) from the payer (MoHP) directly to health providers without linking it to the current central government budget, and hence without any restrictions on how to spend it. Treasury Single Account rules, which are linked to the overall public finance management of the government, would require a budget allocation in advance, thus jeopardising this possibility. However, the current way of implementing the Treasury Single Account in Nepal allows payments to be made retrospectively to providers. This is possible because health facilities are still authorised to retain their bank accounts to manage their internal revenue, including user fees. This provision leaves the health facilities autonomous to mobilise cash with no direct control from the district treasury controller office/MoHP. On the other hand, payments under output-based budgeting, such as in the Safe Motherhood Programme, are accounted for as budgets of district (public) health offices, not as budgets of their subordinate health facilities. Therefore, health facilities can deposit the money received under the Safe Motherhood Programme in their bank accounts (which are under the control of the hospital development committee or health facility operation and management committee), making it

possible for them to use these funds at their discretion. In this way health facilities play the role of 'suppliers' of district (public) health offices, such as a petrol station or a drug store, and have full power to spend funds without restriction, beyond the guidelines provided by the MoHP for each intervention.

Policy decisions affecting reform

The successful implementation of strategic purchasing in the health sector depends on policy decisions in other sectors. Therefore, the strategic purchasing function should be introduced in an incremental manner, while considering other ongoing processes. A general consensus among the MoHP and other key agencies, such as the Ministry of Finance and National Planning Commission, is important to move towards strategic purchasing.

The implementation of strategic purchasing will also be constrained by other health policy decisions, which will either expand or limit the scope of the intended reform. The most influential policy will be the shift from supply side funding (line item budgeting) towards demand side funding (output-based budgeting). This shift will mean that the purchaser (MoHP) will have a separate role from providers. This shift must go hand-in-hand with increasing the degree of autonomy of health facilities. The higher the margin that health facility managers have to manoeuvre with, the more impact demand-side funding will have. Note that managers without power over resources will not be sensitive to the incentives attached to some of the provider payment mechanisms. For example, facilities managers will not be incentivised to produce more if they cannot use the rewards attached to higher performance freely.

Finally, the role of vertical programmes will impact on the implementation of the strategic purchasing reform, as most of the resources that they are currently managing will be integrated under the strategic purchasing function. It is clear that these critical policy decisions must be considered in the process of implementing reforms. The following sections will look at these issues in more detail.

Moving to demand-side funding

Supply and demand-side funding differs substantially with regards to the type of relationship with providers. Supply-side funded systems usually focus on funding the production of services and making patients go where the money has been invested/spent. In the case of demand-side funding, the focus is on what and where the patients are getting the services, so money goes where the patients go. Nepal's current system is mainly a supply-side system, although some funding has demand-side characteristics. Some countries with both systems, such as the Philippines, are tackling the eventual confusion/overlapping through comprehensive health financing reform. In places where social health insurance is being introduced, such as Ghana, conflicts are common among advocates of user fee removal, who are defending a supply-side model increasing financial protection through extra budget allocations, and social health insurance supporters, who are calling for defined packages/reimbursements to negotiate/cover these user fees. This basic policy debate needs to be resolved before implementing reforms.

The decision to stay on the supply side or move to the demand side has far-reaching implications for the way in which service provision is organised. Among other things, the degree of autonomy of facilities and the planning processes will be very different under the two funding system. For

instance, in demand-side funding, the payer (the MoHP or attached agency) will have a contractual relationship with the provider and will not have direct control over its ownership or organisation. In fact, public health facilities will be treated in the same way as private ones. The planning process for demand-side funding will involve organising the purchasing of services on behalf of the population, thus sending the money where patients go, instead of organising service delivery systems and helping service providers to prepare work plans and budgets.

Granting autonomy to facilities

Granting autonomy to facilities implies that facility managers will have control over their own resources, and be able to move them to cover different inputs and activities. This is critical to effect a behavioural change in health facilities and improve their efficiency. Incentives attached to new provider payment mechanisms will only work if facilities can manage their resources at their own discretion. The motivation of managers and health facility workers will be enhanced if they are rewarded for increases in performance.

Currently, all central, regional, sub-regional and zonal hospitals and some district hospitals are operating under the Development Board Act 2056. For management and operational decisions, hospital development committees have been formed in these hospitals. Each of the hospital development committees has the autonomy to prepare its own regulations to regulate activities and managerial functions. However, for major decisions, such as bed capacity, the purchase/sale of land/building, creation of new human resource positions, they must obtain approval from the MoHP.

Non-autonomous district hospitals are subordinate to the MoHP and are supervised by the Department of Health Services. In their day-to-day operations, such non-autonomous hospitals are directly controlled and managed by their respective cooperation committees. These cooperation committees consist of representatives of the district level government offices and members of the community.

Sub-district health facilities (primary health care centres, health posts, sub-health posts) are under the direct supervision of district (public) health offices, and these facilities have a health facility operation and management committee. As per the government's decentralisation policy, the management and operation of 1,433 sub-district level health facilities has already been handed over to the respective health facility operation and management committees.

Hospital development committees and health facility operation and management committees are authorised to hire human resources by themselves, but must find the resources to pay their salaries. In practice, most of the human resources are civil servants deputed by the MoHP. This is not a bad thing in itself, as centralising staff management can secure a fairer distribution of personnel in remote areas than a decentralised system.

Autonomous hospitals receive unconditional block grants for administrative expenses and conditional grants for social services and capital costs from the MoHP. Non-autonomous district hospitals receive funds under the regular budget through the Department of Health Services.

Health facility operation and management committees are formed to look after the managerial and operational activities of the sub-district level health facilities. Local health facility management and

operation guidelines[6] have defined the composition of health facility operation and management committees. Although the exact composition varies according to the level of the health facility, committees generally include representatives from local administrative bodies (the DDC or VDC), the health focal person from the village development committee, female community health volunteers, the headmaster of the local school, representatives of women's groups and ethnic groups from the local community, and the health facility in-charge.

Role of vertical programmes

Vertical programmes are health programmes that are organised and funded from the central level. The MoHP's vertical programmes include disease specific programmes controlled by the Department of Health Services and a few centres (e.g., tuberculosis and HIV/AIDS). Some vertical programmes, such as the Maternal and Child Health Programme and the Integrated Management of Childhood Illnesses (IMCI) Programme, enjoy substantial power within the Department of Health Services. These programmes perform three different roles: (a) regulation and policy design at the central level; (b) training, supervision and monitoring activities at the district level; and (c) the funding the provision of services at the district and facility levels.

In most countries, vertical programmes perform only the two first roles, leaving the funding of service provision to the decentralised levels or planning divisions within the relevant ministries. In Nepal, vertical programmes are scattered across the MoHP, Department of Health Services and national centres and play a role in purchasing for their own activities, albeit very limited. This reality affects the organisation of services at lower levels, as the corresponding division/institution allocates resources to fulfil the logistical requirements of their respective programmes. Currently, the Integrated District Health Programme is trying to bring all the district level programmes from different divisions under the Department of Health Services. Nevertheless, each of the programmes relies on its own planning and reporting system, without proper alignment among them. Hence, the final district budgets are an add-on to vertical programme budgets, instead of a coherent comprehensive budgeted plan for all activities at that level. This results in substantial inefficiencies in terms of extra work, lack of management flexibility, lack of synergy between programmes and overlapping of funds in similar areas, such as administration. Consequently, wastage and lack of funding of non-programme areas are commonplace.

The decision as to whether or not to keep it this way will be determinant of the reforms chosen. The implementation of strategic purchasing will involve centralising resources, thus bringing together decisions that are now scattered across vertical programmes. This does not imply that they will not contribute to the process of defining where the resources are allocated, but, under a strategic purchasing system, they would be organised in a single direction.

Preconditions for reform

Implementing reforms is a demanding task in any setting. There are some key issues that might threaten progress in some of the proposed structural changes. Among other issues, power shifts, the need to enhance capacities, and the speed of accommodating changes in other systems may pose serious challenges to reforms to the health financing system in Nepal.

Firstly, the merging of social health protection resources into a single strategic purchasing agency means concentrating power in few hands. Part of the direct control over substantial amounts of resources under vertical programmes will be transferred to the Social Health Protection Centre managers. Such a transfer will downsize the discretionary power of vertical programmes. Therefore, an incremental approach should be adopted to consolidate and shift the financing arrangements from individual programmes to a separate agency, taking into account the development of the purchasing capacity of the new agency.

An effective supervision and monitoring mechanism should be developed together with the establishment of the Social Health Protection Centre and expansion of its mandate. Current oversight responsibilities need to be adjusted and redefined. Political will and the support of key decision-making and implementing officials is crucial for success in effecting this power shift.

Secondly, changes must be made to the current *modus operandi* of planning and budget execution. Under the current system, district health offices, health facilities and community level officials are receiving earmarked funds for which key allocation decisions have been made upstream. While this limits the power of local implementing agencies, it also provides them with a comfortable role as mere executors of orders. A more horizontal approach, where district health offices' operational costs and 'programme' resources are mixed, will require local implementing agencies to play a more active role attached to a higher degree of freedom in decision-making. With this, a substantial enhancement of capacity and a change in the mindset of managers will be needed. Current bottom-up planning activities can serve as starting point for enhancing capacity. However, a clear and simple process that effectively merges top-down budget allocation with local planning will be needed.

Lastly, reforming the health financing system will depend on the robustness of the Health Management Information System, the full development of the Treasury Single Account system, and on the increase in managerial power and capacity at lower administrative levels, among other things. These factors will constrain the process and, therefore, cannot be ignored.

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[1] The Free Health Services Programme has found some district data misreporting, including non-credible increases in first outpatient department visits.

[2] The annual report of the DoHS is usually produced up to 9 months after the completion of a fiscal year.

[3] Local body elections have not been held since 2002.

[4] Pattanayak, S; Fainboim, I (2010) *Treasury single account: Concept, design and implementation issues*, IMF Working Paper 10/143. Washington: International Monetary Fund

[5] Surkhet District Treasury Controller Office issues an average of 60 cheques per day, covering 72 spending units. Cheques above NPR 25,000 are paid by bank transfer.

[6] National Health Training Centre (2006) *Revised guidelines for the management and operation of local health facilities* (in Nepali). Kathmandu: National Health Training Centre, Department of Health Services, Ministry of Health and Population, Government of Nepal.

Chapter 5

Conclusion and Recommendations

This chapter summarises the main conclusions of the analysis and presents the recommendations. It also suggests some steps that could be taken immediately.

Conclusion

The health financing system in Nepal is characterised by a high prevalence of out-of-pocket expenditure and a tax-based system that allocates line item budgets to public health facilities. It has fragmented vertical programmes each with their own operations and activities at central, district and health facility levels resulting in an inefficient approach. There are limited measures to promote equitable resource distribution, including to hospitals, and poverty and performance are generally not considered in current allocation methods.

The Government of Nepal has recently introduced output-based budgeting schemes to fund priority interventions and reduce the financial risk attached to seeking treatment. Despite their limited coverage, some have had a substantial impact on outputs, including an increase in institutional deliveries under the Safe Motherhood Programme. Notwithstanding these changes the system has not yet secured comprehensive financial protection for the poor. Cumbersome procedures for claiming benefits and problems with identifying the poor have restricted access to social health protection interventions.

The key challenges to the health financing system are: (a) the government has limited capacity to generate more resources on a substantial scale; (b) the health financing system has limited ability to address inequities and identify and protect the poor; (c) there are inefficiencies in the system due to fragmented resource allocation; and (d) the government has limited power to negotiate the price and quality of services due to the practice of passive purchasing.

The government currently has limited capacity to mobilise more resources for health through taxes or a contribution based scheme. Getting better value for money out of the system is the most feasible option to increase budgetary resources and address inequities. The leading causes of inefficiency and inequality are linked to the line item dominated budget allocations, which are neither linked to productivity nor addressing inequities. A radical change is needed to introduce tools that link policy objectives, such as rewarding health facility performance, with budget allocations. Also, the fragmented planning and budgeting of several social health protection interventions multiplies administrative costs. Lastly, the mix of supply and demand side funding is not properly aligned and some activities/costs, such as administrative costs at the district levels, are funded from both sides while, overall, services remain underfunded. Addressing these issues

calls for in-depth policy restructuring, where roles are clarified and in which the government moves from passive resource allocation to strategic purchasing.

The establishment of a Social Health Protection Centre is proposed as a driver of reforms to the health financing system. The main goal of the reforms is to introduce strategic purchasing and provide better value for the public money that is spent on health.

Setting up the Social Health Protection Centre will involve working on its institutional arrangement, deciding on its scope of work and designing a set of tools to make the Centre functional. An incremental implementation is recommended starting with the merging of current interventions under the direct supervision of the Department of Health Services. In parallel, a 'virtual' Social Health Protection Centre should start preparing for the different reform steps and put in place the conditions for absorbing the purchasing function currently undertaken other parts of the MoHP. This Social Health Protection Centre should: (a) define the contents of a benefits package; (b) specify membership or benefit entitlement procedures; (c) develop quality assurance standards and monitoring tools; (e) improve information systems; and (f) develop agreements/contracts with providers. In order to perform these tasks, the following areas need to be explored: (a) provider payment mechanisms; (b) a licensing/accreditation system; (c) an information system that links funds to activities; and (d) standard contracts; these tasks should be done in coordination and consultation with the MoHP.

Improving the health financing system in Nepal also depends on the general context, and there are many external factors that could affect the success or failure of any reforms. One such factor is the overall governance of the health sector; political instability in Nepal has led to personnel fluctuations (and frequent transfers) within the MoHP. There is also uncertainty about the future of the new federal structure, which is yet to be defined. Any new power distribution will require capacity enhancement at the local level and changes in mandates, among other things. Ongoing processes, such as the current decentralisation process and the introduction of a Treasury Single Account will affect the options available within the reforms. All these factors must be taken into consideration when designing and implementing reforms.

Recommendations: Key reforms

This section makes some recommendations based on the information presented in previous chapters. The specific actions taken to achieve these reforms will depend on the choices made by the MoHP and the Government of Nepal. For the time being, the recommendations are presented broadly as three key reforms.

1. **Improve access of the poor to specified services**

   To increase access of the poor to services, targeting should be based on proxy measures that do not require income related assessment. This would allow social health protection interventions to target beneficiaries based on age, sex, geographic location, level of care and disease criteria. The reason behind this recommendation is that income-based tools are normally unreliable and living conditions-based tools, where a team of interviewers check the assets and living conditions of every household, are time consuming and expensive. Complementarily, income/social status based targeting can be used at the facility level, only by well-trained professionals, using proxy means-testing tools (i.e., non-income based tools).

Nepal has experienced some behavioural changes in patients as a result of informing them of the availability of services. For example, an increase in institutional deliveries was seen after mobilising civil society organisations to spread information[1] on what women should receive when accessing services. However, awareness of entitlements is low. The MoHP could increase the access of the poor by increasing publicity about what people can expect from health facilities and how they can avail themselves of benefits. The presence of community members on health facility operation and management committees is an opportunity to increase public awareness of the benefits provided by government-supported programmes. Making access to benefits user friendly should be a goal of the system.

2. Merge funding arrangements for social health protection

The merging of scattered funds under a single decision-making body, like the proposed Social Health Protection Centre, would overcome numerous problems with the current Government health financing system. It would help to allocate resources more efficiently and simplify administrative and reporting procedures, thereby reducing the administrative costs of managing funds. The merging of vertical programme funding would also end the current earmarking of funds at the district level, providing some managerial freedom to district authorities to allow them to be more responsiveness to local needs. The operationalisation of this merger should be incremental, with the first phase focusing on clustering similar programmes in terms of management and administrative procedures and still operating them from where they currently are managed. Later, the clustered programmes should be gradually transferred to the Social Health Protection Centre. Centralising funding arrangements would also pave the way for strategic purchasing and facilitate the implementation of procedures to improve the access of the poor to health services.

3. Introduce strategic purchasing

In the budget processes, both top-down allocations and operational or bottom-up planning must be more effectively linked. To ease the process, budget items should be divided into: (a) provision of services; (b) administrative costs; and (c) discretionary activities. Bottom-up, or programmatic activities, would come under discretionary activities, and include campaigns, training, supervision and other non-routine activities. The first category – provision of services – should move from the current input-based budgeting towards output-based budgeting, where resources are allocated based on the delivery of services. The use of top-down formulas that take outputs delivered and other criteria such as population or number of beds as a proxy indicator of capacity could be a good starting point. However, strategic purchasing calls also for maximising the overall efficiency of the sector and securing equity across regions. Consequently, resources such as investments in health facilities, including civil works and heavy equipment, plus medicines and medical supplies for essential items, should be controlled by the central level in order to secure equal access to all areas and enable the system to profit from economies of scale.

Output-based financing has yielded results in Nepal and should be expanded to become the main way of funding all health services delivery. This will require explicit agreements under which both the funder (the MoHP through the proposed Social Health Protection Centre) and the providers (health facilities) know what is going to be purchased, in what quantity (how many activities), at what price, how they will be delivered and when payment will be made.

Control mechanisms, including fines and penalties, must be defined and included in these agreements. However, output-based financing will require a certain degree of management autonomy at the health facilitiy level, to allow managers to move resources from different areas and organise resources in the most efficient way in order to gain from efficiency improvements. Hence, a process towards warranting more autonomy must start.

Finally, the introduction of active purchasing must be accompanied by the first elements of a quality assurance system. In other words, the basis on which funds are paid to providers must steer how services are provided. The process should be incremental, starting with an input-based licensing system and moving to more comprehensive and complex methods such as accreditation. These functions may be performed by the MoHP or any capable third party under the regulatory supervision of the MoHP.

Immediate steps

The workshop organised by the MoHP in March 2011 proposed improving the health financing system in Nepal while working towards the establishment of a central purchasing agency. Both the MoHP and its external development partners have a common position and are committed to this option. While the long-term vision might differ as to whether to have an independent agency outside the MoHP or not, there is a clear idea on how to move forward. This section outlines five steps that could be taken immediately:

Step 1: Merge reporting procedures: Programmes with similar characteristics could be merged. For instance, four interventions under maternal health (the Safe Motherhood Programme, incentives for ANC and PNC, Screening and Treatment of Uterine Prolepses, and cash incentives for permanent sterilisation under the Family Planning Programme) could have a single reporting system.

Step 2: Start developing tools: Some budget allocation tools, including formulas, can be developed immediately. Initially, these formulas should be used for facilities of a similar level of complexity, such as district hospitals. The preparation of the budget for FY 2012/13 is a good opportunity to test these formulas, at least in a simulation mode. A formula has been conceptualised and proposed for discussion in this report (see Annex D and E).

Step 3: Develop mechanisms to better identify the poor: The use of proxy indicators to identify beneficiaries, such as area of residence, type of disease or demographic profile, while minimising bureaucratic steps, is needed to enhance access to services for the poor.

Step 4: Essential health care package delivery system costing: An analysis of the services provided at the district level, including all health interventions, should lead to an initial definition of an essential health care package. Then, conduct a system costing to provide such a package, estimating the cost per capita of providing a list of interventions for a defined catchment area/ population at the current level of consumption of services.

Step 5: Prepare the Health Management Information System for reforms: Create an interface with the Health Management Information System that gives decision makers comprehensive information on time. This should also include identifying which areas of the Health Management Information System could provide more extensive information.

[1] Powell-Jackson, T. et al. (2010) *An early evaluation of the Aama "Free Delivery Care" Programme*. Unpublished report submitted to DfID, Kathmandu

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Annexes

Annex A: Analysis of current provider payment mechanisms

Annex B: Features of social health protection interventions

Annex C: Budgetary allocations for social health protection interventions

Annex D: Proposed formula for district resource allocation

Annex E: Proposed formula for district hospital resource allocation

Annex F: Budget formulation and execution process

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Annex A: Analysis of current provider payment mechanisms

Provider payment mechanism	Main features	Purchasing agency/ provider	MoHP budget allocation (%)	Allocative and technical efficiency	Administrative efficiency	Equity
Line item budgeting	Funding inputs (salaries, medicines, etc.) Top-down allocations, earmarking resources for operations and some health interventions; resources channelled to different administrative levels and institutions Allocation based on historical trends	MoHP/ Public health facilities	> 80%	Unknown: no studies available analysing the impact of resource allocations through budgets over outputs delivered	Well established mechanisms, consistent with the overall public financial management system Substantial delays in budget execution Cumbersome planning and budgeting procedures Weak reporting system	Budget allocation criteria do not include adjustments for poorest districts or relative variations in needs
Case payment/output-based budgeting (disease specific): Safe Motherhood Programme	Allocation of a determined amount of money for every delivery performed in a health facility; the forecasting of resources is based on expected deliveries and records from previous year Outputs delivered are easy to verify Reimbursements are split between mothers (see below), health facility and health workers (incentives) Advanced allocation through budgeting mechanisms	MoHP/ Specified public and not-for-profit private hospitals Health workers	NPR 494 million (2009/10) ~3%	Increase in number of activities performed Increase in institutional deliveries (proxy of quality)	Enjoys privileges in terms of government prioritisation – financial resources for the programme do not freeze at the end of the year and justified extra allocations can be made at any time	Unknown effect Data suggest that the increase in institutional deliveries has been higher in high HDI districts than in low HDI ones (data from the Early Evaluation of the Safe Motherhood Programme)

Provider payment mechanism	Main features	Purchasing agency/ provider	MoHP budget allocation (%)	Allocative and technical efficiency	Administrative efficiency	Equity
Case payment/output-based budgeting (disease specific): Screening and Treatment of Uterine Prolepses Family Planning Programme (cash incentives for permanent sterilisation)	Budget allocation linked to volume of cases treated Includes incentives to workers and operational costs Uterine prolepses fees are adjusted for the services provided through mobile camps	MoHP/ Public and private hospitals	Uterine prolepses: NPR 210 million (2009/10) ~1.2%	No systematic review of providers conducted	Weak monitoring mechanisms	Mobile camps increase access to the treatment, which has the potential to benefit the poorer segments of the population.
Case payment/output-based budgeting (population specific): Subsidy for treatment of the poor Free treatment for citizens >75 years and above and <15 years and below and all the citizen of endangered ethnic groups for the treatment of catastrophic diseases Medical Treatment for Victims of Conflict/ People's Movement	Treatment costs for cancer, heart disease and kidney disease Provision of one-off discounts up to NPR 50,000 to patients using public hospitals for specified illnesses of a catastrophic nature[1], unknown remainder to be paid by patient Reimbursement is activated on admission and requires clearance from the district health officials. Entitlement requires approval from the poor identification committee of the district that the patient belongs to. This system might be prone to abuse for political reasons. Allocations to hospitals often made in advance to avoid delays	MoHP/ Public hospitals and particular community and NGO hospitals	Subsidy for treatment of the important personalities and the poor: NPR 72 million (2009/10) ~0.4% Valve replacement for poor: NPR 22 million (2009/10) ~0.1% Free treatment >75 and <15/ heart and kidney: NPR 90 million (2009/10) ~0.5% Victims of conflict: NPR 7 million (2009/10) <0.1%	Focusing the treatment on tertiary care might not be the most cost effective option Might slightly increase activity in areas covered	Complicated and slow reimbursement mechanism Weak enforcement of MoHP guidelines	Higher financial protection for catastrophic conditions may increase access among the poor. However, an out-of-pocket expenditure/ household survey is necessary to clarify this, together with a benefits incidence study. Limited resources allocated and number of patients using services suggests that most needs remain uncovered. Unclear targeting leading to potential leakage of benefits to non-poor

Provider payment mechanism	Main features	Purchasing agency/ provider	MoHP budget allocation (%)	Allocative and technical efficiency	Administrative efficiency	Equity
Case payment/output-based budgeting (population specific): Social Service Conditional Grant (to hospitals to provide subsidised services to target groups)	Discounts are offered to poor families (ranging from 25% to100%), which is compensated from budget allocations Extent of discount and selection of beneficiaries are decided by the treating doctor or ward sister. This system is prone to abuse and subjectivity. Allocations to hospitals are made in advance to avoid delays	MoHP/ Semi autonomous hospitals	Not available	Might slightly increase the production of health services and the number of cases treated	Complicated and slow reimbursement mechanism	Such financial protection to targeted patients has the potential to increase their access to services. Unclear targeting leading to potential leakage of benefits to non-poor
Output-based budgeting (capitation): Free health services for outpatient and inpatient care	User fees (registration fees) abolished at district hospitals, PHCCs, HPs, sub-health posts, and to compensate for the loss of revenue to these providers the MoHP allocates: • NPR 5 to 15 for every first visit to sub-health post, HP, PHCC • NPR 15 to district hospitals for each first OPD visit • NPR 100 to district hospitals for free inpatient care to target groups In the case of OPDs, only the first visit is compensated. Due to misreporting of patients' visits, the DoHS has started using population size as allocation criteria with some flexibility. Advance allocation through budgeting mechanisms	MoHP/ Public health facilities	Free health services for outpatients and inpatients: NPR 92 million (2009/10) ~0.5% In kind medicines: NPR 1 billion (2009/10) 5.5%	Use of fee for services as a payment method led to an increase in number of OPD visits Once fee for services was replaced by capitation, there was no longer an incentive to boost number of OPD visits as extra visits are not rewarded separately. One consultation[2] per inhabitant is far too low consumption of health services	Easy to calculate Slow reimbursement mechanism	Promotes the use of services in facilities located in rural setting where poor are more likely to go (proxy indicator) Not sensible to differences between districts or population groups

Provider payment mechanism	Main features	Purchasing agency/ provider	MoHP budget allocation (%)	Allocative and technical efficiency	Administrative efficiency	Equity
Cash transfers to users: Mothers under the Safe Motherhood Programme + Incentives for ANC and PNC Incentives for tuberculosis patients (directly observed treatment) Screening and Treatment of Uterine Prolepses Referral and other support organised by PHC Revitalization Division	Conditional transfer of money to mothers that deliver at health facilities. Money is intended to pay for transportation costs, which has been identified as a key barrier to access Mothers receive the payment at time of discharge. Conditional transfer of money to TB patients for nutrition support Fund allocations are made in advance based on expected number of deliveries/ TB patients using budgeting mechanisms. Cash transfer to the targeted patients for referral services – applicable when public facilities refer patient to another hospital	MoHP/ Mothers TB patients Uterine prolepses patients (transportation incentives to prolepses patients) Target groups (referral incentives and health services)	< 0.5% Support for transportation/ referral: NPR 9 million (2009/10) <0.1	Increase in number of activities at facilities due to financial incentive	Considerable paperwork required to secure reimbursement from MoHP Referral support activation might be subjective	Reducing indirect costs through subsidies may increase the access of poor patients. A higher subsidy in geographical areas where transportation costs are higher is a fair form of positive discrimination likely to benefit those most in need.
Fee for services: Community based health insurance	MoHP provides subsidies to 6 CBHI schemes, to subsidise the premium of poor members (around 30% of total membership) Members and dependents are entitled to receive services up to a predetermined ceiling For every service, fees are charged against the ceiling Ceilings are divided into different categories (such as transportation, medicines, lab tests, etc.) and it is not possible to transfer the balance from one to the other	CBHI pilot schemes	NPR 5.7 million(2009/10) 0.25%	Anecdotal evidence suggests a higher level of utilisation among members, increasing consumption of services	Real administrative costs of the scheme are unknown, but are expected to be high compared to total reimbursements	Provides some financial protection to members Conflict with Free Health Services Programme as CBHI also aims to cover the same services at that level

Provider payment mechanism	Main features	Purchasing agency/ provider	MoHP budget allocation (%)	Allocative and technical efficiency	Administrative efficiency	Equity
Fee for services: Households	Payment for each service provided Fees set by providers	Families/ Public and private providers, including drug outlets	Not applicable	Increase in number of services provided - may lead to oversupply	Requires a detailed billing system Administrative burden supported by facilities	Most inequitable way to fund services – no risk sharing

Note: Features and budgets of social health protection interventions are provided in Annex B and C.

[1] Severe diseases such as cardiac, kidney, cancer, Parkinson's and Alzheimer's are included under this programme. The guidelines make provision for medical treatment up to the sum of NPR 100,000, as per the recommendation of the Hospital Medical Board. The guidelines allow the Government of Nepal to establish a separate fund for this programme.

[2] Europe and countries in Central Asia have 7.56 outpatient visits per year per capita (in 2006) and upper middle income countries 4.77 outpatient visits per capita per year (in 1995). See http://www.nationsencyclopedia.com/WorldStats/HNP-outpatient-visits-capita.html

Annex B: Features of social health protection interventions

SN	Intervention	Features				
		Universal	Targeted to specific groups	Social protection to beneficiaries		Other (e.g., conditional grants/payment to facilities)
				In-kind	Cash transfer	
1	Free Health Services Programme	×		×		×
2	Safe Motherhood Programme (free delivery care)	×		×	×	×
3	Incentives for ANC and PNC	×			×	
4	Screening and Treatment of Uterine Prolepses	×		×	×	×
5	Social Inclusion Programme (referral incentives and other services)		×	×	×	×
6	Medical Treatment for Victims of Conflict/People's Movement		×	×		×
7	Medical treatment for important personalities and poor		×	×	×	×
8	Valve Replacement for Poor Patients		×	×		×
9	Medical Treatment to Heart Patients (<15 and >75 years of age)		×	×		×
10	Medical Treatment to Kidney Patients (<15 and >75 years of age)		×	×		×
11	Family Planning Programme	×		×		×
12	Family Planning Programme (incentives for permanent sterilisation)	×			×	
13	Incentives for tuberculosis patients	×			×	
14	Incentives for malaria and kalazar patients	×			×	
15	Nutrition Support to Children (<5 years of age)		×	×		
16	Expanded Programme for Immunisation	×		×		
17	MoHP grants to Community Health Insurance Schemes (to enrol poor)		×			×
18	Social Service Conditional Grant (to hospitals to provide subsidised services to target groups)		×			×
19	Free Medicines for Specific Diseases (e.g., TB, HIV, leprosy)	×		×		
20	Free Ayurvedic Medicines	×		×		

Annex C: Budgetary allocations for social health protection interventions

SN	Programme	Budget (in thousand NPR)				
		2006/07	2007/08	2008/09	2009/10	Remarks
1	Free Health Services Programme (medicines)	-	210,500	438,290	1,051,143	Procurement of medicines
2	Grant to health facilities (under Free Health Services Programme)	-	-	192,200	92,000	Payment to facilities as compensation for users fee
3	Safe Motherhood Programme (free delivery care)	159,200	195,250	444,600	494,490	Payment to facilities and health workers and transportation incentives to mothers
4	Incentives for ANC and PNC	-	-	-	90,000	Payment to pregnant women
5	Treatment and Screening for Uterine Prolepses	15,000	25,000	182,500	209,660	Payment to hospitals and transportation incentives to beneficiaries
6	Social Inclusion Programme (referral incentives and other services for *Dalits*, senior citizens, marginalised, disabled, urban poor)	-	17,600	45,000	45,000	Grant to facilities/ district offices to provide referral incentives/services to patients
7	Medical Treatment for Victims of Conflict/People's Movement	-	-	3,271	7,015	Payment to hospitals
8	Medical treatment for important personalities and poor (for cancer, heart, kidney and other serious diseases)	-	18,089	7,837	72,000	Payment to hospitals and individuals
9	Valve replacement for poor	10,000	20,000	20,000	22,000	Payment to hospitals
10	Medical Treatment to Heart patients (<15 and >75 age groups)	-	40,000	40,000	50,000	Payment to hospitals
11	Medical Treatment to Kidney Patients (<15 and >75 age groups)	-	-	-	40,000	Payment to hospitals
12	Family Planning Programme	131,320	208,655	162,500	270,000	Procurement of family planning measures
13	Family Planning Programme (incentives for permanent sterilisation)					Cash transfers to beneficiaries
14	Incentives for tuberculosis patients	-	1,500	1,998	2,160	Cash transfers to patients
15	Incentives for malaria and kalazar patients	140	420	2,000	1,675	Cash transfers to patients
16	MoHP grants to Community Health Insurance Schemes (to enrol poor)	na	2,361	3,000	5,700	Subsidy to enrol poor
17	Free Ayurvedic Medicines	23,300	25,573	27,340	26,268	Procurement of medicines

SN	Programme	Budget (in thousand NPR)				
		2006/07	2007/08	2008/09	2009/10	Remarks
18	Social Service Conditional Grant (to hospitals to provide subsidised services to target groups)	Na	Na	Na	Na	
19	Free Medicines for Specific Diseases (e.g. TB, HIV, leprosy)	Na	Na	Na	Na	
20	Nutrition support to Children (<5 years of age), Expanded Programme for Immunisation	Na	Na	Na	Na	
	Total budget for SHP interventions	**338,960**	**764,948**	**1,570,536**	**2,479,111**	
	Total programme budget of MoHP	**6,548,008**	**8,886,359**	**10,859,135**	**13,260,545**	
	Total MoHP budget	**9,230,000**	**12,098,583**	**14,945,964**	**17,840,466**	
	Budget for SHP interventions as % of total programme budget of MoHP	**5.2**	**8.6**	**14.5**	**18.7**	
	Budget for SHP interventions as % of total budget of MoHP	**3.7**	**6.3**	**10.5**	**13.9**	

Note: Na= not available; '-' = not applicable

Source: Ministry of Health and Population (2006) *Annual Work Plan and Budget of MoHP for Fiscal Year 2006/07, 2007/08, 2008/09*. Unpublished documents available from MoHP, Government of Nepal, Kathmandu; Ministry of Health and Population (2010a) *Financial management performance review. Report of NHSP-IP (FY 2004/05 to 2009/10)*

Annex D: Proposed formula for district resource allocation

District (a) allocation = TRA * 40% * (TPS(a)/TPS(total)) + TRA * 15% * (ACV(a)/ACV(total)) + TRA * 15% * (CED(a)/CED(total)) + TRA * 20% * (Pop.(a)/ Pop. (total)) + TRA * 5% * (IDP(a)/IDP(total)) + TRA * 5% * (HPI(a)/HPI(total))

Where:
TRA: total resources available
TPS: total people served
ACV: average coverage of vaccines
CED: coverage of expected deliveries
Pop.: population
IDP: inversed density of population
HPI: Human Poverty Index

District	Workload	Quality/ coverage	Quality/ coverage	Need	Extra cost of access	Equity	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation		Per capita allocation (in NPR)	
	Total people served (by PHCC, HP, SHP and ORC) per day	Immunisation coverage (average of BCG, DPT, polio, measles in %)	Deliveries conducted as % of expected pregnancies	Size of population	Inverse of population density	Human Poverty Index	Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %	Actual	Using formula
Eastern Development Region													
Bhojpur	666	62.8	53.3	228,983	0.009	43.6	44,297	41,451	44,149	-2,846	-6%	193	181
Dhankuta	480	70.4	29.6	192,889	0.013	34.4	40,834	33,538	38,222	-7,297	-18%	212	174
Ilam	611	70.5	41.2	334,376	0.003	33.7	45,305	40,354	44,998	-4,952	-11%	135	121
Jhapa	1288	97.4	60.5	801,041	0.003	29.2	57,821	75,433	57,427	17,612	30%	72	94
Khotang	686	66.8	43.9	264,129	0.014	42.8	47,668	42,894	47,592	-4,774	-10%	180	162
Morang	1998	91.1	49.2	1,000,114	0.002	34.4	74,630	96,259	74,330	21,629	29%	75	96
Okhaldhunga	694	68.9	55.2	181,009	0.012	46	46,948	42,411	46,848	-4,537	-10%	259	234
Panchthar	595	64.2	35.9	234,926	0.007	42.1	35,899	37,072	35,619	1,174	3%	153	158
Sankhuwasabha	489	75	40.6	183,832	0.008	43.5	33,782	35,064	33,737	1,283	4%	184	191
Saptari	2029	89.6	85.8	673,056	0.003	40.2	112,582	93,332	111,429	-19,249	-17%	167	139

District	Workload	Quality/ coverage	Quality/ coverage	Need	Extra cost of access	Equity	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation		Per capita allocation (in NPR)	
	Total people served (by PHCC, HP, SHP and ORC) per day	Immunisation coverage (average of BCG, DPT, polio, measles in %)	Deliveries conducted as % of expected pregnancies	Size of population	Inverse of population density	Human Poverty Index	Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %	Actual	Using formula
Siraha	1831	103.1	113	677,957	0.003	47.1	110,125	94,415	109,340	-15,710	-14%	162	139
Solukhumbu	425	59.2	76.2	123,960	0.028	45.8	26,721	39,638	26,717	12,917	48%	216	320
Sunsari	1963	85.5	95.7	756,321	0.003	32.2	66,065	94,636	66,012	28,571	43%	87	125
Taplejung	466	75.1	59.8	155,540	0.01	38.4	42,249	36,533	42,202	-5,716	-14%	272	235
Teharthum	371	70	55.1	129,959	0.025	40.9	33,741	35,648	35,297	1,907	6%	260	274
Udaypur	756	76.3	30.4	344,588	0.005	40	47,624	43,858	47,624	-3,767	-8%	138	127
Central Development Region													
Bara	1698	81.9	74.8	675,072	0.002	45.5	71,421	83,079	71,364	11,658	16%	106	123
Bhaktapur	432	68.7	27.1	270,107	0.006	29.9	34,824	32,242	34,644	-2,582	-7%	129	119
Chitwan	846	66.5	80.3	568,495	0.003	31.9	52,717	57,905	51,515	5,188	10%	93	102
Dhading	975	81.3	50.1	398,915	0.005	47.7	41,728	54,739	41,636	13,011	31%	105	137
Dhanusha	1969	91.8	132.9	793,609	0.002	41.4	106,449	102,241	105,751	-4,208	-4%	134	129
Dolkha	739	67.2	32.7	238,628	0.01	44	45,944	41,254	45,715	-4,691	-10%	193	173
Kathmandu	1294	95.4	154.3	1,363,512	0.002	25.8	82,273	104,804	81,551	22,530	27%	60	77
Kavrepalanchowk	1245	65.9	48.5	451,595	0.005	33.5	88,811	60,050	88,535	-28,761	-32%	197	133
Lalitpur	661	97.3	98.9	405,469	0.009	25	51,852	55,440	51,272	3,588	7%	128	137
Mahottari	1562	98.7	80	657,220	0.002	50.6	77,312	82,051	76,057	4,739	6%	118	125
Makawanpur	675	65.6	24.2	465,293	0.003	35.3	42,332	42,640	42,209	308	1%	91	92
Nuwakot	597	61.4	45.1	336,873	0.004	43.8	57,718	40,413	57,711	-17,306	-30%	171	120
Parsa	1079	90.2	71.8	599,199	0.004	35.5	60,747	66,120	60,741	5,373	9%	101	110
Ramechhap	694	63.4	38.1	245,534	0.014	53.4	49,504	42,180	47,880	-7,324	-15%	202	172
Rasuwa	161	84.9	46.9	52,687	0.107	54.5	17,222	46,935	17,211	29,713	173%	327	891
Rautahat	1477	104.2	87.3	654,723	0.002	51	81,317	81,505	80,681	188	0%	124	124
Sarlahi	1518	98.8	75.2	759,631	0.004	49.8	94,454	83,542	93,609	-10,912	-12%	124	110
Sindhuli	616	75.6	68.8	331,736	0.007	48.3	49,900	46,654	49,900	-3,246	-7%	150	141

District	Workload	Quality/ coverage	Quality/ coverage	Need	Extra cost of access	Equity	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation		Per capita allocation (in NPR)	
	Total people served (by PHCC, HP, SHP and ORC) per day	Immunisation coverage (average of BCG, DPT, polio, measles in %)	Deliveries conducted as % of expected pregnancies	Size of population	Inverse of population density	Human Poverty Index	Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %	Actual	Using formula
Sindhupalchowk	781	64.7	24.1	356,831	0.006	51.1	58,243	43,601	57,635	-14,642	-25%	163	122
Western Development Region													
Arghakhanchi	631	67.3	43.5	242,159	0.014	40.5	40,631	40,948	39,519	317	1%	168	169
Baglung	786	69.5	63.7	312,830	0.011	35.7	51,326	48,843	50,071	-2,483	-5%	164	156
Gorkha	845	64.7	53.1	334,022	0.001	41.7	57,602	47,217	57,404	-10,385	-18%	172	141
Gulmi	1185	68	56.8	341,828	0	39.4	65,674	56,240	65,509	-9,434	-14%	192	165
Kapilvastu	1626	92.6	81.8	576,769	0.002	48.5	71,223	80,762	70,276	9,539	13%	123	140
Kaski	751	91.4	114.5	455,559	0.003	24.9	53,727	59,487	52,988	5,760	11%	118	131
Lamjung	568	77.8	44.7	205,882	0.008	37.5	45,784	38,142	45,606	-7,642	-17%	222	185
Manang	25	44.2	9.5	12,412	0.163	37.9	15,250	43,559	14,201	28,309	186%	1229	3509
Mustang	76	47.6	23.4	17,005	0.105	41.5	18,792	35,322	17,099	16,530	88%	1105	2077
Myagdi	448	76.5	84.8	132,594	0.009	40.3	34,651	39,125	34,266	4,475	13%	261	295
Nawalparasi	1423	68.6	27.3	672,760	0.002	40.2	101,904	67,705	77,484	-34,199	-34%	151	101
Palpa	812	64.4	54.7	311,021	0.004	33	56,673	46,095	55,974	-10,578	-19%	182	148
Parbat	660	64.7	38.2	181,277	0.044	44.4	47,892	45,263	47,570	-2,629	-5%	264	250
Rupandehi	1328	90.7	75.3	857,291	0.002	29.2	80,278	79,237	79,497	-1,041	-1%	94	92
Syangja	999	65.7	26	362,929	0.006	35.3	54,035	48,452	54,034	-5,583	-10%	149	134
Tanahu	621	65.8	35.5	368,194	0.004	42	45,509	40,970	45,328	-4,539	-10%	124	111
Mid Western Development Region													
Banke	1376	81.6	58.1	466,702	0.001	34.4	60,120	65,966	59,833	5,847	10%	129	141
Bardiya	1320	72	34.4	460,026	0.002	43.2	44,514	60,690	42,387	16,176	36%	97	132
Dailekh	1023	92.5	59.4	264,616	0.005	52.5	56,847	54,664	55,772	-2,183	-4%	215	207
Dang	1253	81.6	45	554,482	0.002	41.4	53,359	64,227	51,388	10,868	20%	96	116
Dolpa	139	87.3	32.3	34,564	0.045	61.9	26,013	31,180	25,859	5,167	20%	753	902
Humla	218	92.9	59.9	47,489	0.008	63.8	26,285	30,457	26,007	4,171	16%	554	641

District	Workload	Quality/ coverage	Quality/ coverage	Need	Extra cost of access	Equity	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation		Per capita allocation (in NPR)	
	Total people served (by PHCC, HP, SHP and ORC) per day	Immunisation coverage (average of BCG, DPT, polio, measles in %)	Deliveries conducted as % of expected pregnancies	Size of population	Inverse of population density	Human Poverty Index	Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %	Actual	Using formula
Jajarkot	499	97.7	45.9	157,874	0.012	57.2	34,884	39,313	34,267	4,429	13%	221	249
Jumla	337	84.4	30.9	104,542	0.011	56.8	37,674	30,111	37,674	-7,563	-20%	360	288
Kalikot	387	100.2	40.2	123,724	0.01	58.9	31,428	34,720	30,560	3,292	10%	254	281
Mugu	194	78.6	53.1	51,696	0.01	61.1	30,461	27,650	30,461	-2,811	-9%	589	535
Pyuthan	787	86.5	32.5	250,148	0.007	47.9	45,299	44,186	45,180	-1,113	-2%	181	177
Rolpa	627	86.6	29.2	245,082	0.008	53.1	44,854	40,172	44,554	-4,682	-10%	183	164
Rukum	584	80.6	43.9	221,859	0.013	53.7	43,398	41,159	43,123	-2,238	-5%	196	186
Salyan	825	76	22.8	249,442	0.01	48.2	44,094	43,229	43,313	-864	-2%	177	173
Surkhet	1280	83.4	74.8	344,237	0.005	44.6	57,790	64,079	55,813	6,289	11%	168	186
Far Western Development Region													
Achham	1015	92.1	39.3	269,504	0.014	59.2	70,064	53,907	66,916	-16,157	-23%	260	200
Baitadi	960	75	28.5	273,219	0.005	48.7	60,195	46,837	58,191	-13,358	-22%	220	171
Bajhang	572	87.4	52.9	196,026	0.009	59.9	57,013	41,585	56,869	-15,429	-27%	291	212
Bajura	511	88.7	33	127,176	0.007	56.4	36,650	34,774	36,262	-1,876	-5%	288	273
Dadeldhura	608	75.8	76	148,217	0.013	46.2	38,715	43,266	36,175	4,551	12%	261	292
Darchula	548	78.1	36.2	143,148	0.008	45.4	51,899	35,142	51,191	-16,757	-32%	363	245
Doti	794	83.2	37.2	244,907	0.006	53.4	48,281	44,616	47,194	-3,665	-8%	197	182
Kailali	1709	67.4	40.9	761,652	0.001	39.5	56,583	78,842	52,932	22,259	39%	74	104
Kanchanpur	796	63.5	46.6	465,912	0.002	35.2	38,246	48,607	35,429	10,361	27%	82	104

Data source: Department of Health Services (2010) *Annual report 2008/2009*. Kathmandu: DoHS, Ministry of Health and Population, Government of Nepal; United Nations Development Programme (2004) *Nepal human development report 2004 empowerment and poverty reduction*. Kathmandu: United Nations Development Programme; Central Bureau of Statistics (2002) *Population census 2001*. Kathmandu: CBS, National Planning Commission, Government of Nepal; Financial Management Information System, Department of Health Services

Note: Resources available to the districts include only recurrent budget allocated to the districts for D(P)HO, TB, NHEICC, NHTC and the Integrated District Health Programme. The Integrated District Health Programme includes the whole set of programmes carried out at the district level under the supervisions of the Department of Health Services.

Note: In this table SHP means sub-health post, not social health protection.

Annex E: Proposed formula for district hospital resource allocation

District hospital (a) allocation = TRA * 25% * (NOB(a)/NOB(total)) + TRA * 40% * (TIS(a)/TIS(total)) + TRA * 20% * (TOD(a)/TOD(total)) + TRA * 10% * (MAJ(a)/ MAJ(total)) + TRA * 5% * (DEL(a)/ DEL(total))

Where:
TRA: total resources available
NOB: number of beds
TIS: total inpatients stay (in days)
TOD: total outpatient department (visits)
MAJ: major surgeries
DEL.: deliveries

Hospital name	Total no of beds available	Total no of inpatients	Total inpatient stay (in days)	Average length of stay (in days)	Bed occupancy rate	Total OPD visits	Major surgeries	Total deliveries	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation	
									Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %
Bhojpur	20	1,724	6,029	3.5	82.6	12,064	0	161	6,911	5,734	6,911	(1,177)	-17%
Dhankuta	22	866	2,619	3.1	32.6	25,139	0	169	6,588	5,353	5,691	(1,235)	-19%
Ilam	25	1,767	5,290	3.2	58.0	13,747	67	545	5,364	10,411	5,146	5,047	94%
Khotang	20	1,581	4,367	2.7	59.8	25,248	0	190	5,859	5,990	5,791	131	2%
Panchthar	25	2,405	6,008	2.5	65.8	18,574	34	299	7,294	8,803	7,224	1,509	21%
Sankhuwasabha	15	2,150	5,062	2.4	92.5	20,202	0	334	7,867	5,722	7,856	(2,145)	-27%
Sunsari	20	3,002	6,090	2.1	83.4	27,021	0	1,449	7,580	9,125	7,580	1,545	20%
Taplejung	28	1,880	5,635	3.1	55.1	19,643	0	195	6,354	6,919	6,354	565	9%
Tehrathum	16	1,330	2,550	1.9	43.7	10,212	0	121	5,872	3,599	5,872	(2,273)	-39%
Udayapur	15	1,506	4,133	2.4	75.5	13,407	0	577	6,682	5,251	6,682	(1,431)	-21%
Dhading	15	1,423	3,616	1.3	66.0	24,858	0	419	7,213	5,561	7,213	(1,651)	-23%
Mahottari	25	2,466	4,366	3.0	47.8	27,102	0	764	6,546	7,616	6,248	1,069	16%

Hospital name	Total no of beds available	Total no of inpatients	Total inpatient stay (in days)	Average length of stay (in days)	Bed occupancy rate	Total OPD visits	Major surgeries	Total deliveries	Budget allocation and expenditure (in thousand NPR)			Difference between actual and formula based allocation	
									Actual allocation	Allocation using formula	Expenditure	In thousand NPR	In %
Makawanpur	50	3,963	9,056	2.3	49.6	39,945	106	1,139	9,623	19,563	9,601	9,941	103%
Rasuwa	15	258	896	3.5	16.4	4,663	0	30	4,294	2,206	4,294	(2,088)	-49%
Nuwakot	25	2,675	10,346	3.9	113.4	14,695	0	621	6,907	9,141	6,907	2,235	32%
Sindhupalchowk	15	1,544	5,444	3.5	99.4	12,862	0	261	6,243	5,236	6,227	(1,007)	-16%
Argakhanchi	15	1,024	2,412	2.5	44.1	3,099	20	335	7,249	4,426	7,233	(2,822)	-39%
Manang	7	86	336	3.9	13.2	5,510	0	4	4,413	1,214	4,400	(3,199)	-72%
Mustang	15	257	658	2.5	12.0	8,543	0	40	4,863	2,396	4,140	(2,467)	-51%
Parbat	15	1,789	4,293	2.6	78.4	9,068	0	297	4,999	4,514	4,966	(485)	-10%
Tanahun (Damauli)	23	1,714	2,796	1.7	33.3	22,529	0	475	7,259	5,884	7,089	(1,375)	-19%
Bardiya	25	1,943	3,604	1.9	39.5	21,369	0	618	5,574	6,605	5,553	1,031	18%
Dailekh	30	2,040	6,155	3.0	56.2	16,655	92	417	8,294	12,643	7,679	4,349	52%
Dolpa	15	247	424	1.9	7.7	19,258	0	73	4,409	3,119	4,403	(1,290)	-29%
Humla	15	421	1,299	3.1	23.7	14,871	0	138	4,306	3,310	4,212	(996)	-23%
Jajarkot	15	1,077	2,364	2.4	43.2	18,389	0	155	5,380	4,069	5,368	(1,311)	-24%
Kalikot	18	1,308	7,924	6.3	120.6	20,942	6	324	4,373	7,652	4,373	3,280	75%
Mugu	15	658	1,272	2.2	23.2	11,869	0	207	5,147	3,206	5,147	(1,942)	-38%
Pyuthan	26	3,250	6,815	2.1	71.8	21,398	40	407	7,013	9,987	7,013	2,974	42%
Rolpa	15	997	3,632	3.8	66.3	10,288	0	94	4,008	3,945	3,987	(63)	-2%
Rukum	15	2,420	7,677	3.4	140.2	21,742	0	219	7,022	6,795	7,022	(227)	-3%
Salyan	15	981	2,701	2.8	49.3	12,972	0	178	5,458	3,871	5,042	(1,587)	-29%
Baitadi	15	445	679	1.6	12.4	18,550	0	175	6,266	3,363	6,159	(2,902)	-46%

Data source: Department of Health Services (2010) *Annual report 2008/2009*. Kathmandu: DoHS, Ministry of Health and Population, Government of Nepal; Financial Management Information System, Department of Health Services

Annex F: Budget formulation and execution process

Legal procedures on financial management including budget formulation and government spending are contained in the Financial Procedures Act 1999. The Budget Formulation Guidelines provide further details on budget formulation and expenditure procedures[1]. The Ministry of Finance is the ultimate agency responsible for the preparation of the budget and release of spending authority to the respective ministries. After receiving the release of authority for spending, the respective ministries pass it on to the departments, centres and district line agencies under their jurisdiction.

Although slow, budget and expenditure planning in Nepal is evolving as per the decentralised framework, gradually involving more actors in the process. Planning procedures for the local bodies (DDCs, VDCs and municipalities) are contained in the Local Self-Government Regulations with a defined timeframe. As per the Local Self-Government Regulations 2000, the planning cycle, including the resource estimation process in the district, starts from early December and annual plan formulation should be completed by March[2]. The planning and budgeting procedure at the central level is scheduled to start from early November and ends with the approval of the budget by the Parliament at the end of the fiscal year, i.e., mid-July[3].

According to the Budget Formulation Guidelines, the Annual Work Plan and Budget preparation within the sectoral ministries starts after the National Planning Commission provides the 'Guidelines and Ceilings for Budget Formulation' by mid-December. There are different levels of discussion and negotiations within a ministry and also together with the National Planning Commission during the preparation of the Annual Work Plan and Budget. However, the timeframe mentioned in the Local Self-Government Regulations and Budget Formulation Guidelines does not effectively link local and central level planning procedures[4]. Hence, the preparation of the Annual Work Plan and Budget starts from the resource envelop estimation through the joint exercise by National Planning Commission and Ministry of Finance, preparation of annual programmes and budget estimation by respective districts and ministries, discussion and approval of the line item budgets and drafting of the budget by the Ministry of Finance, and its approval from the parliament.

After the parliamentary approval of the budget, the Ministry of Finance issues authorisation letters to sectoral ministries, which send their own authorisations to agencies under their jurisdiction including district offices. Remaining within the limit of the authorised amount, the district treasury controller office releases budget funds to the spending units as per their request. However, the district treasury controller office can release up to one third of the budget of a priority one programme, or one-sixth of the previous year's expenditure, whichever is higher, to the spending units even without an authorisation letter. Internal auditing of public expenditure is done by the corresponding district treasury controller office except for the devolved districts/agencies, which is the responsibility of the respective district development committees. A final audit is done by the Office of the Auditor General and disseminated in the annual report. The final audit also includes a performance audit of the institutions/agencies, which is based only on a sample.

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[1] Ministry of Finance (2006) *Budget formulation guidelines.*

[2] In principle, local bodies (DDCs, VDCs and municipalities) are required to prepare their Annual Work Plan based on: (a) guidelines from the centre (NPC and line ministries); (b) the resource envelop (grants and internal resources); and (c) the priorities set in the periodic plan.

[3] Planning and budgetary discussions between the National Planning Commission and the DDCs should start by mid-September.

[4] Planning and budgeting does not usually happen as per the schedule mentioned in the Budget Formulation Guidelines.

Table A. Budget formulation: Activities, responsibilities and timeline

SN	Activity	Responsibility	Timeline
1	**Preparation of overall budget envelop**		
1.1	Preparation of concept paper to estimate budget envelop	NPC, MoF and concerned ministries	End of October
1.2	Submission of preliminary resource estimates (ministerial and sectoral) by resource committee to budget committee	Resource Committee/ NPC	First week of November
1.3	Finalization of total size and budgetary ceilings	Budget Committee/ NPC	End of November
2.	**Sending budget ceiling and guidelines**		
2.1	Preparation of ministerial and sectoral budget ceilings and guidelines	NPC/MoF	Second week of December
2.2	Sending of budget ceilings and guidelines	MoF	Third week of December
2.3	Sending of budget ceiling and guidelines to government departments/district offices and projects	Concerned ministries	
3	**Submission of budget and programmes (including three-year expenditure estimates)**		
3.1	Filling out the budget forms and sending to concerned department in accordance with budget ceiling	Concerned district level offices	Third week of January
3.2	Sending integrated budget forms	Concerned departments	Second week of February
3.3	Discussion on annual work plan and budget with departments	Concerned ministries	Third week of February
3.4	Sending completed budget form to the MoF and NPC	Concerned ministries	First week of March
4	**Discussion on budget and programmes**		
4.1	Policy discussions on central and district level budget and programmes	NPC with participation of MoF and concerned ministries	First week of April
4.2	Sending policy and programmes to the office of the prime minister	Concerned ministries	Second week of April
4.3	Budget head-wise discussion on current and capital budgets	MoF with concerned ministries together with NPC	Third week of April
4.4	Preparation of preliminary draft of budget	MoF	Fourth week of April
4.5	Discussion on principles and priorities of budget in Finance Committee of the Parliament	MoF	Second week of May
4.6	Preparation of final draft of budget	MoF	Second week of May
4.7	Discussion of final draft of budget and programme in NPC meeting	MoF	Third week of May
4.8	Discussion of final draft of budget and programme in cabinet meeting	MoF	Third week of May
4.9	Getting approval from NPC on policy and programme of the budget	MoF	Before submission to parliament

SN	Activity	Responsibility	Timeline
5.	**Presentation of budget and approval from Parliament**		
5.1	Budget speech/public announcement	MoF	Fourth week of May
5.2	Acceptance and approval of budget by the Parliament	Parliament	Second week of July
6	**Acceptance of programme authorisation of expenditure**		
6.1	Acceptance of programme with trimester division of budget	NPC/concerned ministries	First week of July
6.2	Provision of authority to spend budget	Finance Secretary, MoF	Third week of July
6.3	Provision of authority to concerned spending units	Secretaries of concerned ministries	Fourth week of July
7	Monitoring and evaluation		
7.1	Ministry level discussion on policy and programmes each month regarding progress	All ministries	Third week of each month
7.2	Discussion on progress on policy and programmes every two months in MoF	Concerned ministries and MoF	At the end of two months
7.3	Mid-term evaluation of budget implementation	MoF	Fourth week of February

Source: Ministry of Finance (2006) *Budget formulation guidelines.*

Annex G: Nature and structure of taxation in Nepal

1. Central taxation

The resource capacity of a country basically depends on the GDP per capita and income and expenditure capacity of the government. The size of per capita of Nepal's GDP is relatively very low; approximately USD 470 (in 2010)[1]. The revenue GDP ratio of Nepal is around 14–15%; the tax GDP ratio is around 12–13%. Out of total budget/expenditure around 65–70% is covered by revenue and the rest contributed by foreign aid and internal borrowing. The population of Nepal is currently estimated to be 27.6 million (in 2009), but the numbers of the taxpayers is relatively small. The total number of Permanent Account Number (PAN) registrants including businesses and individuals is 354,000 (only 2% of the population). Of these, tax registrants for business purpose are 277,000 (1% of the population). Value Added Tax (VAT) registrants are 69,000. Hence, the base and scope of national tax capacity is limited.

2. Composition of government revenue

Out of total revenue collected by the government, the contribution of tax sources ranges from 80 to 87% (during the period 2007-2010); the rest is covered by non-tax sources such as fees. Out of the total tax revenue, the percentage share of direct tax is around 23–27% and of indirect tax is 73–77%. In relation to total government revenue, direct tax constitutes between 22–24%. Out of total direct tax revenue, around 80% is income tax, of which 70% is corporate income tax and rest (30%) is individual income tax.

Individual income tax is the only that is progressive. Therefore the progressiveness of Nepal's national tax structure is very limited.

Out of total indirect tax, VAT is the dominant one. It constitutes around 30% of total taxes and 49% of total indirect tax; the rest is covered by customs duty and excise duty – tentatively 31% and 21% of indirect tax, respectively. Out of VAT, around 65% is collected at customs points or on imports, and the rest is collected through internal production and sales. This means that the tax structure of Nepal is mainly based on imports and consumption, rather than production and income.

3. Local taxation

Local revenue assignment and its operational details are prescribed through the Local Self-Governance Act 1999, Local Self-Government Regulations 2000 and Local Self-Governance Financial Regulations 2007. The district development committees, which are the first tier of the local bodies, have been given the mandate to levy five taxes, with definitions of their bases and rate caps[2]. In addition, district development committees can also levy charges and fees for services. The most important local revenue items are tax on use of infrastructure, tax on use of natural resources by business, tax on exports from the district and tax on re-usable products. Lower tier local bodies have also been assigned their own sources of revenue in the decentralised framework. For example, the municipalities can levy 16 types of taxes such as house and land tax, Integrated Property Tax[3], rental tax, shop tax, entertainment tax, and advertising tax[4]. The definitions of the base and rate are provided, with a few exceptions, in the legislation, while rates are mostly prescribed by the central government. In a similar manner, village development committees are allowed to levy up to 12 taxes.

4. Revenue collection by local bodies

Despite the different provisions for generating internal resources for local bodies, the revenue collection capacity of local bodies is very low. For district development committees, the share of internal revenue

is around 12–15% of the district development committee annual budget; the rest is covered by revenue sharing as well as central grants. After removal of the Local Development Fee in 2009, municipalities are also heavily dependent on central grant, consisting of around 60–65% of the municipality budget. Similarly, the revenue of village development committees from internal sources covers only around 10–12% of their budget, the rest comes from intergovernmental transfers and grants from central budget.

In aggregate, the share internal revenue generated by local bodies is around 5% of total national revenue. Hence, the ability of local revenue to fund the health sector is very limited.

5. Intergovernmental transfers

Intergovernmental transfers are an important feature of local finance. There are two main types of transfers: revenue sharing and other transfers. Revenue sharing is mandated by the Local Self-Governance Act 1999 and Local Self-Government Regulations 2000. Both documents define principles and mechanisms of revenue transfers. The first type of these transfers is within the local bodies[5]. District development committees receive transfers from the central government under four categories of taxes. For example, from 5–90% of the revenue collected from registration fees on the sale of houses and land by the central government is transferred to district development committees.

[1] Ministry of Finance (2010b) *Economic survey 2009/10*

[2] Local Self-Government Act 1999, Sections 215–219 and Local Self-Government Regulations 2000, Rules 207–210, Schedules 23–25.

[3] The municipalities have the option of either levying house and land tax or integrated property tax.

[4] Local Self-Government Act 1999, Sections 136–148, and Local Self-Government Regulations 2000, Rules 140–148, Schedules 8–20

[5] In some cases, transfers among local bodies are two way. For example, 25% of collections from land tax by VDCs and municipalities are to be transferred to the corresponding DDC. In contrast, 35–50% of the revenue generated by DDCs from certain taxes and sales revenue needs to be transferred to VDCs and municipalities within the same district.

Annex H: List of informants

Meetings and interactions were held with the following people during the review.

Ministry of Health and Population
Padam B. Chand (Chief)
Kabi Raj Khanal (Under Secretary)
Deependra Kafle (Under Secretary)
Mohan Thapa (Account Officer)

Department of Health Services
Management Division:
Ghanshyam Pokhrel (Senior Public Health Administrator)
Pawan Ghimire (Chief, Health Management Information System)
Primary Health Care Revitalization Division:
Bhim Singh Tinkari (Director)

Ministry of Finance
Bodh Raj Niraula (Joint Secretary, Budget Division)
Ramesh Gautam (Budget Division)
Yogendra Gauchan (Senior Instructor, Revenue Training Administration Centre)

National Planning Commission
Atma Ram Pandey (Under Secretary)

Financial Comptroller General Office
Sitaram Karki (Deputy Financial Comptroller)

District Development Committee, Banke
Shambhu Prasad Luitel (Local Development Officer)
Sarad Paudel (Programme Officer)
Ramesh Shah (Officer)

District Public Health Office, Banke
Dhir Jung Shah (District Public Health Officer)

Bheri Zonal Hospital, Banke
Bimal Prasad Dhakal (Medical Superintendent)

District Public Health Office, Surkhet
Mukunda Gautam (District Public Health Officer)
Renu Singh (Focal Person for the Safe Motherhood Programme)
Yograj Pokhrel (Accounts Officer)

District Treasury Controller Office, Surkhet
Shukra Prasad Gautam (Treasury Officer)

Regional Hospital, Surkhet
Bhola Ram Shrestha (Director)
Bishnu Koirala (Account Officer)
Baburam Nepali (Section Officer)

Salkot Primary Health Care Centre, Surkhet
Dilli Ram Sapkota (PHCC In-charge)

Salkot Village Development Committee, Surkhet
Tilak Ram Adhikari (Secretary)

District Health Office, Sindhupalchowk
Rajendra Panta (Medical Superintendent)

Lamahi Primary Health Care Centre, Dang
Mahesh Gautam (PHCC In-charge)
Navin Kumar Mishra (CBHI Focal Person)

Nepal Health Sector Support Programme
Suresh Kumar Tiwari (Advisor, Health Financing)

Health Sector Support Programme, GIZ
Markus Behrend (Programme Manager)
Susanne Grimm (Deputy Programme Manager)
Jan Bultman (consultant)

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