Health Financing for Universal Coverage and Social Health Protection

Bridging the health care divide

Technical Working Group on Health Care Financing

Kathmandu

November 2011

This work is the WHO contribution to the Technical Working Group on Health Care Financing

Contributors

Prepared by Varatharajan DURAIRAJ (WHO) with substantial contributions from (in alphabetical order) Surya ACHARYA (MoHP), Yubraj ACHARYA (Asian Development Bank), Michael ADELHARDT (Providing for Health Network), Shiva Raj ADHIKARI (Tribhuvan University), Franziska FUERST (GIZ), Yogendra GAUCHAN (Ministry of Finance), Ghan Shyam GAUTAM (GIZ), Matt GORDON (DFID), Han KANG (USAID), Kaviraj KHANAL (MoHP), Shenjie LI (ILO), Pankaj MEHTA (UNICEF), Badri Raj PANDE (Nepal Health Economics Association), Devi Prasad PARSAI (NHSSP), Latika Maskey PRADHAN (AusAID), Gunawan SETIADI (WHO), Bal Krishna SUVEDI (MoHP), Suresh Kumar TIWARI (NHSSP), Albertus (Bert) VOETBERG (The World Bank) and Sophie WITTER (AusAID).

Additional inputs came from

Shambhu Prasad ACHARYA (WHO), Lin AUNG (WHO), Bishnu BARAL (Western Regional Health Training Centre, Pokhara), Markus J BEHREND (GIZ), Tekabe BELAY (The World Bank), Amit BHANDARI (DFID), Kewat D BHANDARI (National Women's Commission), Mohan Bahadur BHANDARI (Hemja Sub Health Post, Kaski District), Shiva Hari BHATTA (Naubise Health Post, Dhading District), Vasudev BHATTARAI (Ministry of Finance), Young-Ah DOH (KOICA), Bhogendra Raj DOTEL (District Health Office, Dhading), Riku Edward ELOVAINIO (WHO), David B EVANS, (WHO), Thushara FERNANDO (WHO), Maria FILIO-BORROMEO (UNAIDS), Kehar Singh GODAR (District Public Health Office, Kaski), Tara D GURUNG (AusAID), Kathy HOLLOWAY (WHO), Kim Wah JUN (KOIKA), Athula KAHANDALIYANAGE (WHO), Sudhir KHANAL (UNICEF), Laxmi KONWAR (JICA), Joseph Douglas KUTZIN (WHO), Rishi Prasad LAMICHHANE (District Public Health Office, Lalitpur), Sudhansh MALHOTRA (WHO), Babu Ram MARASINI (MoHP), Inke MATHAUER (WHO), Claude MEYER (Providing for Health Network), Ilsa NELWAN (WHO), Sudha PANT (UNFPA), Frank PAULIN (WHO), Anne M. PENISTON (USAID), Jean Henri PERROT (WHO), Vikas RAWAL (KOICA), Arun RANA (Asian Development Bank), Geetha RANA (UNFPA), Priyanka SAKSENA (WHO), Binod Bindu SHARMA (Western Regional Health Training Centre, Pokhara), Bishnu Prasad SHARMA (Nepal Health Economics Association), Nastu SHARMA (AusAID), Gunasena Sunil SENANAYAKE (WHO), Joo SIN-YOU (KOICA), Sewa SINGH (KOICA), Amuda SHRESTHA (National Women's Commission), Jagan SHRESTHA (Sanchaya Multipurpose Cooperative Limited, Pokhara), Sundar SHRESTHA (Gajuri Primary Healthcare Centre, Dhading District), Paolo SPANTIGATI (Asian Development Bank), Viroj TANGCHAROENSATHIEN (International Health Policy Programme, Bangkok), Phylida TRAVIS (International Health Partnership), Bishnu Hari TIMILSINA (Western Regional Health Directorate, Pokhara), Phuldev TIMILSINA (Hemja Sub Health Post, Kaski District), Bhim Singh TINKARI (MoHP), Purna Bahadur THAPA (KOICA), Beth VERHEY (UNICEF), 16 Female Community Health VOLUNTEERS (Hemja Sub Health Post, Kaski District), and Ke XU (WHO).

Special thanks to

Kishori MAHAT, Silas RAI, Yugesh RAJBHANDARI, Shrawan K. RANJITKAR, Rudra Sirnet THAKURI, and Fidelma TULADHAR.

Abbreviations used

ALOS	Average Length Of Stay
ANC	Ante Natal care
CBHI	Community Based Health Insurance
DDC	District Development Committee
DHS	Demographic Health Survey
EDP	External Development Partner
EHCS	Essential Health Care Services
FCHV	Female Community Health Volunteer
GDP	Gross Domestic product
HRH	Human Resources for Health
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MCHW	Maternal and Child Health Worker
NGO	Non Governmental Organization
NHSP-2	The Nepal Health Sector Programme-2
NHSSP	The Nepal Health Sector Support Programme
NLSS	National Living Standard Survey
OOP	Household Out-Of-Pocket spending
OP	Out-Patient
PHC	Primary Health Centre
PPP	Public-Private Partnership
SHP	Social Health Protection
SWAp	Sector Wide Approach
SWOT	Strengths, Weaknesses, Opportunities and Threats
VAT	Value Added Tax
VHW	Voluntary Health Worker
WHA	World Health Assembly

Table of contents

Executive Summary

The World Health Report 2010 urges the Member States, particularly low- and middle-income countries, to further develop their national health financing systems so as to achieve universal coverage and social health protection. In Nepal, the Nepal Health Sector Programme 2010-2015 emphasises the need for developing a health financing strategy. The purpose of this background paper is to assist in the strategy development process by outlining key health financing issues, options available to address them and certain process elements relevant for strategy development. Observations provided here are based on desk review, expert/stakeholder consultations and field visits.

The need to transform Nepal's health financing system

Resource inadequacy: The health financing system in Nepal is essentially determined by three primary sources of revenue - households (50%), government (24%) and external development partners (20%); the shares of civil societies (4%) and the corporate sector (2%) appear to be limited. Total health spending in Nepal, from all sources, is estimated as US$ 24 per capita probably falling short by about 45% of resources needed to provide essential health services. As a result, over 60% of the national population lacks quality access to even basic essential care (e.g. maternal care). Nevertheless, as a result of an increased government emphasis on and efforts aiming at cashless (free) health care, health care access is steadily expanding. Critical gaps still persist, calling for additional resources for health.

On the other hand, those with some access don't have full coverage of services adequate enough to fulfil their health needs partly due to their inability to raise adequate financial resources. Some others, even while receiving partial care, get impoverished as they mobilise resources through unaffordable means.

Limited pooling: There is very little pooling of risks and resources, limiting the scope for cross-subsidization, which could mitigate the ill-effects of catastrophic health spending and impoverishment. In particular, household spending is completely exposed to financial risk with inadequate or not pooling.

Inefficient and inequitable resource use: Purchasing of services is carried out in an ineffective manner; there is considerable scope for efficiency gains in Nepal. Efficiency concerns persist at all levels and with respect to all sources of financing. Other issues of relevance are access inequities, due to which the financial burden of illness falls disproportionately on the poor, sub-optimal quality and utilization of care. As a result, there are significant regional, district-level and facility variations in the attainment of health outcomes and outputs in Nepal.

Insufficient financial risk protection: It is speculated that only about 50% of the illness episodes requiring outpatient care receive attention; 2003-04 National Living Standard Survey showed that about 43% of the poorest did not seek care for their previous episode compared to 27% among the richest. This, along with the more skewed distribution of out-of-pocket in favour of the rich, indicate the possibility of health care consumption according to people's ability to pay, not according to their needs; poorer households lack affordability and receive less-than-optimal care or no care due to financial barriers. On top of it, estimates from 2003-04 household data indicate a 2.5% point increase in poverty as a result of high levels of out-of-pocket spending on health.

The need to transform: The enormous nature of the problem, given that health financing issues and challenges are deeply and widely prevalent, justifies significant transformation of the current national health financing system in the country taking into account its current strengths, prevailing opportunities and future possibilities. The most important need is to strategically align health financing actions of households, government and external development partners. Since resources from all sources fall short of their desirable levels, it is all the more important to use the existing resources prudently so that the people are not deprived of essential health care services.

Existing opportunities to initiate the transformation

Current engagement of the government with the development of various national strategies (e.g. health financing and human resources) and the national health policy provides an opportunity for transforming the health financing system. In addition, there are similar initiatives emerging from other ministries (e.g. the Ministry of labour) with implications for health and health financing. The transformation process could take advantages of all these developments to re-position the health financing system in the desirable direction by providing a framework for resource prioritization and a plan of action which best meet the national values, expectations and societal preferences. It is important to align health policy and health financing strategy processes so that the key elements of the health financing strategy are included in the national health policy.

Questions to be answered through the national health financing strategy

The system transformation requires answers for certain critical health financing questions. Questions that require early answers, for example, are:

Resource mobilisation: How much more resources are required to provide at least essential health care services, particularly to the poor and the disadvantaged? How much unutilised potential for financing health (e.g. health resources from the Ministry of Local Development) exist? What can be done to tap it? How can the bargaining capacity of the Ministry of Health and Population within the government be enhanced? Has the financial potential of the households been fully utilised? What more needs to be done to increase the household investment in health?

Pooling: How to improve the predictability of resources? What actions are required to ensure better alignment of national resources to achieve the health and health care goals? How to align the national health financing with the decentralised political system? What are the existing mechanisms to pool resources? How best can they be integrated at the national level?

Allocation/Purchasing: How can the purchasing be made strategic? What is the optimal balance between the supply and the demand side initiatives? What services are to be included in the national essential health service package so as to address major health problems in Nepal? What services are to be newly included? What is the additional cost of providing these services free to the target population?

Financial risk protection: What additional measures are needed to extend the population coverage of the existing cashless (free) services? Which solidarity mechanisms are likely to work to involve the private sector in the delivery of the essential package, particularly to the poor? What additional measures are needed to bring the private sector closer to the

poor? How to address the affordability question? What is the affordable price for people who are excluded from cashless (free) care? Is it feasible to prepare a national (sub-national) price list of all services not provided free? What social protection measures are effective to reduce the ill-effect of and impoverishment due to health spending?

Efficiency: What measures are required to spend the existing resources wisely? What are the comparative advantages of the government and private sector? How to ensure that the comparative advantages are efficiently utilised? What are the ways to achieve optimal resource sharing between the government and private (for-profit and not-for-profit) sector?

Some additional questions could be added to make sure that answers are sought on all crucial areas of health financing. This is important to devise the national strategy.

Possible future health financing options for Nepal

The scope for raising additional resources from existing sources appears to be limited in Nepal; new (innovative) resource mobilisation options (e.g. health cess) need to be explored. Building public confidence in existing facilities and creation of additional facilities (as stated in the Nepal Health Sector Plan -2) could bring additional household resources for health. An improvement in the financial bargaining of the Minsitry of Health and Population (through capacity building) could expand the fiscal space for health to some extent. Budget preparation needs to be based on sound economic analysis of issues, evidences and options. Essential links between health priorities and the health budget need to be established to bridge the evidence-policy-budget gap. Efficiency gains also need to be seriously pursued so that available resources find their fullest value; efficiency gains are possible with respect to all the three major health financing sources.

There is a need to gradually work towards prepayment, pooling and strategic purchasing by developing and strengthening institutional mechanisms. Government at present mixes service provision, contracting and demand side financing to provide some sort of risk pooling through tax funding. A possible alternative way of integrating various financial risk protection measures is the formation of a social health protection centre to plan and gradually channel/coordinate resources meant for financial risk protection. It will make the system responsive to local needs.

Insurance is an option to pool risks and resources, but not to mobilize resources. Development of insurance requires clear purchasing mechanism, costing and packaging of services so that they can be linked with premiums and benefits, electronic smart cards, facility strengthening for financial management and electronic card reading, e-governance, etc. Some of these actions could be initiated immediately. Poorly developed insurance system will do more harm than good.

The government could find ways to strategically work with the private (for-profit and not-for-profit) sector in areas where it has adequate strength and comparative advantage. Private sector's role should be clearly defined so that it is not a self-evolving process; incentives to it should be strategically employed to produce desirable health and health system outcomes. In addition to public-private partnership, other means of solidarity could be explored to cross-subsidise the poor. Nepal would benefit from the establishment of a national purchasing mechanism/agency to effectively carry out the purchasing/allocation function linking government, external and household resources.

Capacity development requires long-term planning and development to allow for separate sub-plans for individuals, institutions, networks and the system. Personal capacities need to be developed in some core health system areas so that a larger pool of individual talents exists in Nepal for use when in need. Similarly, the capacity of the public sector and non-government institutions (e.g. hospitals) requires strengthening in some areas in order to effectively perform their role as a provider of care and producer/purchaser of services.

The suggested process for developing the health financing strategy

A national health financing strategy is a necessary but not a sufficient condition for universal coverage and social health protection. Although there is no single blueprint for its successful development, the process is more or less similar to the one that is often followed while drafting national policies. Conscious efforts are needed to develop a good, effective, informed, inclusive, nationally acceptable and workable health financing strategy. The strategic approach in health financing means a movement towards comprehensive, inclusive and sustainable approach juxtaposed to *ad hoc*, reactive and selective approaches.

The strategy architecture includes a few essential components. A strategic review of the existing health financing system - its basic features, strengths, weaknesses and constraints – providing a sound basis for the development of a strong strategy is a good starting point. This is followed by establishment of the national vision for the future, based on an understanding of the present. An investigation into options, experiments and choices based on domestic and international experience is the next step for the informed choice of appropriate strategies. The most important and probably time-consuming activity is the development of the strategy; it requires various consultations and discussions at the national and sub-national level. The strategy document could include aspects concerning the three functions – efficient and equitable mobilization, pooling and utilization of resources. Another strategy document could guide the implementation process; this helps to weave various actions towards achieving desirable goals and outcomes. An assessment of the current and future availability of resources from various sources forms an essential part of the strategy development.

The actual process usually starts with the establishment of the entities that will direct the process. Two committees are relevant here - to steer the political and bureaucratic processes and to execute the technical work. The steering committee could initiate the process by stating the national vision and goals through a high-level consultative process; wider political consultations will make the process stable and sustainable. The technical/expert committee, on the other hand, could carry out tasks given to it once the vision and goals are stated by the steering committee. Wider international, national and sub-national consultations are necessary to incorporate all relevant issues and options in the strategy. Domestic consultations, in particular, widen the ownership of the strategy and avoid any future controversies. They also help to arrive at acceptable approximations and estimates for variables for which actual figures are not easily available. In addition to national consultations, some feedback from the field through focus group discussions will be very useful.

Preparation of the strategy document is a part, not the sum-total, of the strategy. The document could include topics such as context, vision, mission and objectives, values guiding the strategy (e.g. equity, ethics and rights), system building for financing (relative roles and responsibilities of various mechanisms and actors), strategy for resource

mobilization, risk pooling mechanisms (how are they connected if there are multiple mechanisms), purchasing of services and products, efficiency and equity-enhancing options. It is important to carry out a SWOT analysis of choices outlined in the strategy from cultural, economic, geographic, political and social perspectives. Resource mobilization plan is also an essential component of the strategy; this requires detailed discussion with the Ministry of Finance, external development partners and domestic philanthropists, if any.

Finalization of the strategy requires another round of consultations with key stakeholders, particularly those who will be involved in the implementation, including financing, of the strategy. Political approval is an important step to be followed in the end so as to make the strategy a real one. Faster implementation also depends on how quickly resources are made available for this purpose; an official launch of the strategy will also speed up the implementation.

Actual implementation may require additional capacity development, system building, policy and regulatory measures and involvement of different health financing actors besides the need for mobilizing additional financial resources. Successful strategies require regular, coherent and consistent actions at different layers and levels of the health system.

Conclusion

Given the task ahead, prudent and strategic planning is necessary to generate adequate financial, human and material resources and pool, allocate and utilise them efficiently; it requires inter-ministerial and multi-stakeholder coordination and actions. A universally acceptable strategic plan developed now could place the national health financing system in an orbit capable of taking the country closer to universal coverage and social health protection in future.

1 Introduction

Nepal is a land-locked country with many hard-to-reach areas. The Human Development Index is low at 0.428 and the country is ranked 138 in the world (UNDP, 2010); about 30% of the population are poor (World Bank, 2010). However, there have been significant reductions in child and maternal mortalities in recent times and improvements in equity in health service provision and utilisation (Government of Nepal, 2010). Economic growth is moderate (an average 4.0% during 2006-2011); its average annual growth rate during 1960-2008 was about 3.6% (World Bank, 2011). But, the government revenue grew from 12.0% of GDP in 2007-08 to 14.8% in 2009-10 (World Bank, 2010); revenue target for 2011-12 is 22.4% (World Bank, 2011). Interest payment declined from 1.3% of GDP in 2003 to 0.8% in 2009, but it is still considerable taking away 5.4% of the government revenue every year almost equivalent to what health sector actually receives from the budget. By 2015, spending on pensions is also likely to be 7% of GDP up from 0.5% in 2006 and 1.1% in 2009; it will be equal to the salary by then. Capital expenditure is low at less than 40% of the total spending.

1.1 Policy context

Nepal's Interim Constitution (2007) stipulates health as a fundamental right for all citizens and accordingly, every citizen shall have the right to basic health services. A strong primary health care based health system with the emphasis on service availability at the lowest possible level is the commitment through the National Health Policy (1991). The Nepal Health Sector Programme 2010-2015 (NHSP-2) envisages free or affordable provision of quality health services for all (Government of Nepal, 20'10). It aims at increased access to and utilization of quality health care, reduced cultural and economic barriers to access and improved health system to achieve universal coverage; it is also committed to the provision of financial risk protection to those facing catastrophic expenditures associated with illness. Fulfilment of the NHSP-2 vision requires further development of the national health financing system (resource mobilization, pooling of risks and resources and effective funding/purchasing of services), which is currently structured around tax-based financing and free government provision of essential health care.

Several national initiatives are already in place. Essential health care is free for all at sub-health and health posts and primary healthcare centres; services at district hospitals are free for the poor and the disadvantaged (Government of Nepal, 2010). Institutional deliveries are free at all public health care institutions. All medicines (about 25 types of medicines are supplied) are free at peripheral facilities and 40 medicines are free at PHCs and district hospitals. Decentralised medicines purchasing was introduced in 2009. The Free Health Care Policy seems to have increased health care access of the poor (GTZ, 2009). Non-poor patients pay user fee for services not covered under the EHCS to the extent of 25% of the revenue in district hospitals financing salaries for contract staff, performance incentives, maintenance and additional medicines and supplies. User fee also absorbs any delays in receiving government resources. Recently, there has been an emphasis on shifting resources towards effective and productive programmes (World Bank, 2010). Cash transfers in favour of some targeted essential services (e.g. safe delivery) seem to have produced intended results.

1.2 What is a strategy?

The term 'strategy' refers to a commitment to a goal and a structured plan of action to achieve the goal (Morris *et al* 2006; Nollet *et al* 2005). More often, it is a dynamic concept involving a continuous process by which goals are determined, strategic analyses are carried out, strategies are formulated, choices are made, resources are allocated and cohesive actions are promoted and implemented. A strategy is likely to fail if it is confined only to analytical review and bureaucratic decision making without recognizing the influence of different stakeholders on its design, implementation and outcome.

Strategic approach helps to realize the intended effects of a policy by providing a framework to prioritize different medium-to-long-term goals, identify the main strategies for achieving them and draw up a plan of action to implement the strategy. It outlines what is to be achieved, how and by whom. If the intended effect of a national health policy is universal coverage, then the health financing strategy could draw up a plan of action towards achieving it taking into account the cultural, demographic, economic, Geographic, health, health system, political and social context.

1.3 Rationale and purpose of a health financing strategy

A health financing strategy provides a framework and process for a comprehensive and sustainable approach to health financing and systems development with a sound analytical basis, moving away from selective, *ad hoc* approaches. The purpose of a health financing strategy is to develop a medium-to-long-term plan of action, which best meets the values, expectations and societal preferences, to achieve universal coverage. It particularly guides the country's Ministry of Health in its efforts towards obtaining best possible health outcomes and outputs for the population by providing strategic guidance in crucial health financing areas.

An important feature of a health financing strategy is that it includes both, technical and political aspects. The technical dimension deals with guidance on adequate, equitable, efficient and sustainable resource generation, pooling of risks/resources and provision/purchasing of good quality health services. The political dimension deals with values such as the right to better health, social justice, solidarity and participation (WHO 2008) and equally important are the interests and preferences of the population through a process of social dialogue beyond the health sector boundaries.

1.4 Purpose of this paper

The health financing system in Nepal is going through a critical phase characterized by numerous experiments such as demand side financial incentives, community-based health insurance, user fee exemption, staff incentives and contracting. The natural next step would be to mould these experiments into a strong unified health financing system without loosing current strengths, capabilities and achievements. Development of the national health financing strategy is the essential first step in this regard and the Ministry of Health and Population has already initiated the process of developing one for Nepal.

Development of the strategy involves a series of actions including the preparation of various background documents, scenario analysis, national stakeholder consultations, strategy drafting, costing, financing, implementation, monitoring and evaluation. This background paper is drafted with a view to support the strategy development process; it

provides suggestions and options concerning the process and key elements of the national health financing strategy taking into account current strengths, challenges and future opportunities. In other words, the focus here is on the future. Its scope is limited to the strategy development process and possible key elements of the strategy.

The paper is based on the data and background information generated through a review of various documents (from the government, external development partners and academia), expert and stakeholder consultations and field visits[1] (covering sub-health post, health post, primary healthcare centre, district hospital, district health office, regional directorate, regional training centre and financial cooperative). The paper's tone is generally positive, forward-looking and solution-oriented; it provides some suggestions and options for bringing in reasonable and notable changes in the national health financing system, keeping universal coverage and social health protection as its main goals.

Wider consultations with various (national and sub-national) stakeholders are advocated to take the strategy development process forward. The process could include the following stages:

- Organization and logistics concerning the strategy development process (e.g. formation of committees)
- Launching the process (e.g. vision statement)
- Conduct of the technical work (e.g. drafting of the strategy)
- Consultations and finalization of the strategy
- Implementation and monitoring

Different types of technical and financial support are required during these various stages. Costing and financing of the strategy development as well as its implementation are crucial pillars of the process.

1.5 Organization of the paper

The paper has five sections. The next three sections discuss the main characteristics of the current health financing system, future health financing options for Nepal and the possible strategy development process. The last section provides concluding observations.

[1] *The list of institutions visited is provided in the Annex.*

2 Current health financing system in Nepal

Strengths and weaknesses

The national health financing system is analysed here under three heads viz., resource mobilization, risk pooling and financial risk protection and allocation/purchasing. In other words, this section describes resource availability, organization and use in Nepal.

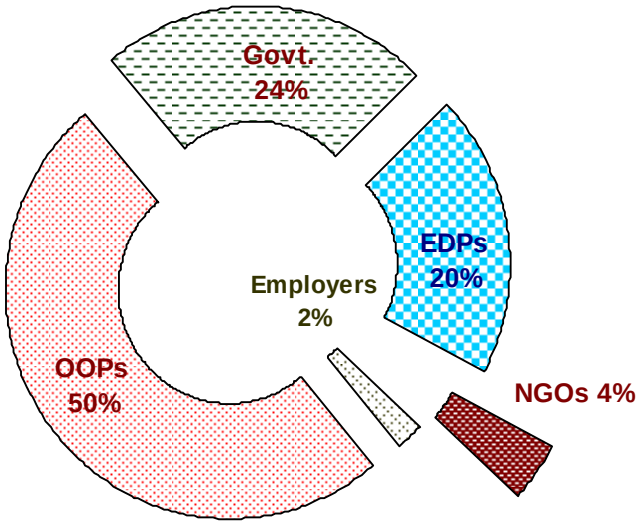
2.1 Resource mobilization

Currently, there are six distinguishable sources of health financing in Nepal viz., government revenue (tax and non-tax), external funding, household resources, NGO resources, employer or corporate resources, and domestic philanthropic resources. Total as well as per capita health expenditure has increased since 2000-01 (World Bank, 2011); per capita total health expenditure has increased from US$ 12.5 in 2000-01 to US$ 19 in 2005-06 (World Bank, 2010).

Household out-of-pocket spending (OOP) is the dominant health financing source in Nepal accounting for about half of the total health spending in the country (Figure-1); about 90% of the private spending comes from households. About two-third of OOP is spent on medicines, about 15% on outpatient consultation and the rest on others.

Figure-1

Sources of health financing in Nepal



Data source: Government of Nepal 2010

The government increased its health expenditure from NRs. 6.5 billion (US$ 88 million) in 2004-05 to NRs. 17.8 billion (US$ 228 million) in 2009-10 (Government of Nepal, 2010); health's share in total budget increased from 5.87% to 7.24% between 2004-05 and 2010-

11.[2] Actual spending, however, was 70% of the allocated budget in 2004-05 and increased to 85% in 2008-09 probably due to salary increases (Government of Nepal, 2010).

Contribution of donor funding to the total health expenditure has declined from about 20% during 2000-2006 to 11% in 2007-08 only to rise to 14% in 2008-09 (World Bank, 2011). In addition to its contribution to the government budget, there is also a portion flowing directly to NGOs.[3] The reason for this high off-budget spending is not clearly known. Philanthropic resources are involved in financing of some rehabilitation programmes (Government of Nepal, 2010); NGOs finance a few community-managed hospitals/clinics.

2.1.1 Strengths

Political desire to provide basic health services free at the time of delivery of services: The biggest strength of the existing health system in Nepal is the strong political desire to provide at least essential health services free at the time of delivery/receipt of health services. This commitment plays an important role in raising government resources for health to some extent.

Steady increase in foreign remittances: Foreign remittances play a major role in private (household) spending on health; their annual contribution to GDP in Nepal is estimated as 25% (World Bank, 2010). Due to a steady increase in foreign remittances, household spending on health is likely to increase further in future. It is rather important to smoothen it by removing the conditions for high spending during the time of illness and low spending otherwise.

Increasing government spending: Government health spending as the share of GDP increased from 0.9% in 2006 to 1.7% in 2010 (World Bank, 2010); this is in comparison to 4.1% for education. The annual rate of increase in government health spending (22.2%) is higher than the rate of increase (11.9%) in government revenue.

Significant external spending: Donor funding contributed 48% to the 2010 health budget (World Bank, 2010): there are some off-budget spending from donor resources as well. Its contribution to total health spending, however, is less than the low-income country average of 16.4% (WHO, 2011).

Wide-spreading banking services: In recent years, in Nepal, there has been a huge expansion of banking services, particularly by financial intermediaries like financial cooperatives. A survey in 2006 on access to financial services estimated that 79.9% of Nepalese households were served by a formal/semi-formal financial institution (Fernando, 2007); the reach of formal or semi-formal institutions alone was 52.3% and 16% of the rural households had a bank account. Given their spread, these cooperatives may be already covering about 80% of the non-poor (second, third and fourth quintiles) in Nepal. Their potential for financing health, however, is unknown. Some cooperatives offer health loans at a lower interest rate (say, 13% per annum).[4] The main advantage of these cooperatives is their population coverage and potential to include the middle-income group

---

[2] The aim is to reach 10% of the national budget

[3] It is estimated that about 47% of the aid (all sectors) is spent outside the budget. In 2010, foreign aid financed 28% of the Nepal budget and 74% of capital expenditure (World Bank, 2010). In 2008, for every one US dollar of aid flowing through the budget, an estimated US$ 0.60 or 37.5% flow outside the budget.

[4] As observed by an official from one of these cooperatives.

in development financing. However, they do not offer risk pooling and the advantage of group purchasing.

2.1.2 Weaknesses

Inequality: Utilisation of health care services[5], irrespective of providers, is not uniform across different income groups (Table-1); it is high among the rich and low among the poor.[6] Consultation with qualified physicians is the lowest among the poorest and vice versa. Lack of adequate and timely availability of services, financial barriers and location issues prevent people from receiving optimum care from government health care institutions (GTZ, 2009). Some people are more disadvantaged than others. The conditions have been exacerbated by the difficult political environment,[7] human resource issues (e.g. staff absenteeism, behaviour and competence, posting, transfers and retention and gender issues), Operational issues concerning availability (e.g. opening hours) and quality of services (lack of specialised services), inadequate supply of medicines and essential equipment, low demand due to cultural aspects (e.g. gender, caste and language in some areas), lack of information on free care and geographical location (GIZ, 2009).

Table-1

Health care utilisation by income quintile (in per cent)

Consumption Quintile	Physicians	Paramedics	Kabiraj/ Baidya	Traditional Medicine Practitioners	No consultation
Poorest	8.1	42.4	1.1	5.4	43.1
Second	16.6	40.1	0.2	2.9	40.3
Third	20.6	42.4	0.2	2.5	34.4
Fourth	30.9	34.3	1.2	4.3	29.3
Richest	45.7	25.2	1.4	1.0	26.8

Source: Adhikari, 2010

Reporting of illness is the lowest among the poorest quintile and vice versa (RTI International, 2010). The recent Nepal Multiple Indicator Cluster Survey in mid-Western and far-Western regions reveal that about 53% of the possible diarrhoea suspects and about 44% of the pneumonia suspects among children aged under-5 received appropriate treatment (Central Bureau of Statistics, 2011).[8] The percentage of mothers receiving 4 or more antenatal care consultations is also low (10.5% in 2006 [DHS]) among the poorest quintile compared to 60% among the richest. It is also low among Muslims (18.3%) and Dalits (21.4%). Similarly, **percentage of deliveries receiving skilled birth assistance is low (8.5% in 2009) among the poorest** in comparison to 57.7% among the richest (World Bank, 2010). About 20% of the people in the far-Western Region have to travel for over 2

[5] *Although it is a broader question than just limited to resource availability, resource adequacy plays a major role here.*
[6] *Of course, this is a broader question than just a resource availability issue.*
[7] *However, it should be mentioned here that health and education sectors have been doing relatively better than other sectors despite the political difficulties*
[8] *These numbers, however, are to be interpreted with caution because it is not known what proportion of the suspects are real cases requiring treatment.*

hours to reach a health care facility. However, time to travel is more or less uniform across wealth quintiles although the richest quintile appears to reside closer to a health care facility.[9]

Resource inadequacy: The biggest health financing weakness in Nepal is the lack of adequate resources to finance the growing demand (quantity and range) for good quality health services. While a low-income country such as Nepal would need to spend about US$ 44 per capita (2009 estimate) to provide key health services (WHO 2010), Nepal actually spends US$ 24 (2008) falling short by about 45% (WHO, 2011). The funding gap for HIV/AIDS alone is estimated as 54% (UNAIDS, 2010); that is, an additional funding of US$ 86.4 million is required to fully fund the national response to HIV/AIDS.A number of priorities (e.g. incentive package for human resource retention in remote areas) as identified by the government remain under-funded or unfunded due to lack of resources (Ministry of Health and Population and External Development Partners, 2009). Many people are not connected with the health care delivery system due to lack of finance to cover the cost of transport, health care and other related items. Although health service coverage increased during the NHSP-1, antenatal care coverage (4 visits to a doctor, nurse or MCHW/VHW) still remained at 48% and institutional deliveries at 27% in 2009; 45.6% of children suffering from ARI did not receive treatment (Government of Nepal, 2010). TB case finding rate was 71.4% in 2008.

On the other hand, household resources emerge from past savings, loans and distress measures. **Distress loans bearing exorbitantly higher interest rates and selling of hard-earned assets are not uncommon**[10] in Nepal; that is, a significantly high amount is spent on interests over and above the cost of care.

Uncoordinated resource mobilization efforts: Better coordination of health resources flowing from different Ministries under one health plan could facilitate their effective utilization (World Bank, 2010). Organization of the external resources also needs improvement. While the that flows through the budget is well coordinated, the off-budget support could be guided better. Government and a portion of external resources are fairly well-organized under a SWAp mechanism. It exists since 2004 with an increasing number of external development partners joining it. In 2005, the government and EDPs signed a joint statement of intent in health, envisaging joint planning, programming and performance reviews. However, the Pool Fund still accounts for less than 50% of the external resources.

Better coordination of health resources flowing from different Ministries under one health plan could facilitate their effective utilization (World Bank, 2010). Organization of the external resources also needs improvement; while their flow through the budget is well-defined, their direct flow to institutions and the community needs to be taken into account while devising government policies on resource allocation.

A portion of resources mobilized by the NGOs comes from external sources while another portion comes from their own economic activities and local philanthropy.[11] There is no account of how well NGO resources fit into the achievement of the national goals. In order to avoid duplication of efforts, it is necessary to take such efforts into account in national

[9] *The key issue, however, is that the poor would need to spend a greater share of their income than the rich to travel the same distance.*
[10] *As observed by the FCHVs*
[11] *The amount generated through local philanthropy, however, appears to be relatively small.*

planning. Local and international philanthropic resources exist, but their size and flow are unknown. What is known is that a portion of it flows through NGO channels while the rest goes straight to individual beneficiaries or institutions used by them. Corporate resources finance health care of the employees; some of it flows through insurance.

2.2 Risk pooling and financial risk protection

Government and a portion of external resources are fairly well-organized under a SWAp mechanism. It exists since 2004 with an increasing number of external development partners joining it. In 2005, the government and the EDPs signed a joint statement of intent in health, envisaging joint planning, programming and performance reviews. However, the Pool Fund still accounts for less than 50% of the external resources. Insurance and banking (saving and credit) methods are also used by some households. Of course, saving is a prepayment method but not a pooling method unless there is a solidarity payment from the rich/healthy to the poor/unhealthy. Similarly, credit is a form of post-payment and therefore, cannot be considered to be desirable.

2.2.1 Strengths

NHSP-2 measures to expand access and minimise financial risk: Free provision of health care to the poor is a form of financial risk protection. NHSP-2 desires to take free health care closer to the people, particularly the poor. Some options described in the NHSP-2 implementation plan and their possible impact on risk pooling and financial risk protection are given in Table-2. All these options are very important potential positive steps towards expansion of health care provision in the country; however, more clarity is required about their operation and practicability. This, along with recent efforts to expand the road network, will go a long way to extend health care coverage and financial risk protection to the disadvantaged populations.

Recently initiated demand side financial risk protection measures: Many measures targeting financial risk protection are either in place or in pipeline (Acharya 2011 and Adhikari 2010). Provision of free essential health services is the biggest financial risk protection measure in operation. This is shown to be achieving risk protection by the recent shift in service provision and budget in favour of rural and remote areas. Recently, there has been an emphasis on shifting resources towards effective and productive programmes (World Bank, 2010); cash transfers in favour of some targeted essential services (e.g. safe delivery) seem to have produced intended results. Examples of cash transfer programmes in particular to focus on the financial barriers to access that occur outside the health system (e.g. labour loss and transport costs) are the *Aama Suraksha Karyakram* (Safe Motherhood Programme), Social Inclusion Programme (Targeted Free Services for communicable diseases like Kala-azar, TB and HIV/AIDS), Safety Net against catastrophic illnesses such as Alzheimer's disease, cancer, heart ailments, Parkinson's disease, paraplegia due to spinal injury and renal failure, Free Treatment of Uterine Prolapse and special grant to community-based health insurance to include the poor.

The *Aama Suraksha Karyakram* is found to have contributed to an increased proportion of women giving birth in a health facility (GTZ, 2009 and GIZ, 2011). The average annual rate of increase has been 50% (from 6% to 21% in 5 years) in the low-HDI districts and 12.7% (from 33% to 54%) in the high-HDI districts (Powell-Jackson et al, 2010). However, it is not known whether these interventions have effectively protected the poor against the financial risks; although the household cost incurred at the health facility has fallen, there has been

no fall in expenditures on drugs and medical supplies bought outside of the health facility (Powell-Jackson et al, 2010).

Table-2

NHSP-2 options to enhance financial risk protection

Options	Possible financial risk protection
Supply side	
Establishment of new facilities, including *Ayurveda* facilities	▪ Future reduction of catastrophic spending through early case detection & treatment by moving health services closer to people. ▪ Reduction of OOP by minimizing/eliminating the transport cost & the need for raising loans.
Public-private partnership, including contracting for ancillary services	▪ Increased access to health services through increased effective resources for health ▪ Enhances the possibility for cross-subsidization, if differentiated pricing forms part of the partnership
Strengthening of district hospitals	▪ Minimizes/eliminates the cost of referral ▪ Prevents future catastrophic spending through early treatment
Enabling the private sector to operate facilities in rural areas	▪ Prevents shopping around (multiple visits) for good quality care ▪ If the price is effectively regulated, it is likely to minimize the cost of care and the need for resource mobilization through informal channels ▪ If the services are offered free of cost (through government subsidies), it is likely to reduce the future need for catastrophic spending
Demand side	
Support to meet transport and other access costs	▪ Reduces/eliminates the need for raising 'unsafe' loans ▪ Extends coverage to the poorest lacking affordability
▪ Knowledge improvement ▪ Empowerment to demand the services	▪ Reduces resource wastage from 'care shopping' ▪ Could enhance collective bargaining and reduce cost of care
Encouraging pregnant women to deliver in institutions	▪ Resource saving through early management of complications and emergencies

Source: Government of Nepal, 2010

Community strengthening efforts: Given the huge information symmetry, particularly in health, strengthening of the demand side or the community is an important aspect of health system development. Community strengthening prepares the demand side better for demanding appropriate services besides participating in financing and organization of health services. Empowering the community and offering it a wider choice could speed up human development, promote disease prevention and reduce health care exclusion (Varatharajan et al, 2010). Some community-based efforts in Nepal are women's group for health education, community-drug programme and community-based health insurance (CBHI). Although its population coverage is very limited so far (Adhikari, 2010), the potential of the CBHI is being currently reviewed by GIZ (GIZ, 2011b). Similarly, KOICA is involved in the spreading of the insurance concept, standardization of CBHI and experience sharing in the rural population.

2.2.2 Weaknesses

Insufficient financial risk protection: Financial risk protection is partial in Nepal with all those who incur out-of-pocket spending (OOP) are exposed to financial risk. Per capita outpatient care (OP) contact with public facilities is 0.9 (including contacts with volunteers) while it is 1.1 with private facilities (excluding pharmacies and traditional healers). It is speculated that only about 50% of episodes requiring OP care receive care; NLSS (2003-04) showed that about 43% of the poorest did not seek care for their previous episode compared to 27% among the richest (Government of Nepal, 2010). This, along with the more skewed distribution of OOP in favour of the rich (Adhikari, 2010), indicate the possibility of health care consumption according to people's ability to pay, not according to their needs; poorer households lack affordability and receive less-than-optimal care or no care due to financial barriers (Ensor et al, 2009). On top of it, estimates from 2003-04 household data indicate a 2.5% point increase in poverty as a result of high levels of OOP in health (RTI International, 2010a).

New mechanisms (e.g. demand side financing) are put in place by the government to address these issues and support the most disadvantaged. However, the design of some programmes is such that beneficiaries have to reach the facilities to avail benefits; in other words, they have to spend resources on transport to receive cash benefits and so, the demand side financing is not cashless.[12] Also, financial incentives are not meant to contribute to system building and if they are withdrawn at some stage, then access will be greatly affected. This may expose the affected to fresh financial risks. Free care policy seems to have affected certain institutions such as CBHI schemes and rendered them non-functional.[13]

The relevance and the scope of private (for-profit) health insurance need to be discussed in Nepal. In a number of countries, where it has developed and worked well, there is significant adverse selection that dumped the poor and the sick to the public sector. Private (for-profit) insurance works As observed in other countries like Uganda, health insurance is not a profitable business in a low-income country mainly because the administrative cost tends to be higher and benefit-premium ratio tends to be over 100%. Moreover, household willingness to pay for health insurance is not known. Also, health insurance requires certain minimum infrastructure to function well and it is not present in

---

[12] Other relevant aspects here are whether the target people are aware of these schemes, they are being administered properly and they are enough.

[13] A simple redesign of these schemes to accommodate services that are not already covered by the free care policy could have enhanced their functionality though.

Nepal.[14] Therefore, additional infrastructural requirements for health insurance to be successful could be identified and developed.

The growth of community-based health financing mechanisms, particularly in many low-income countries, can be viewed from two perspectives. They can be seen as a response to government and market failures in health in general and health financing in particular. In such cases, they may be viewed as transitory mechanisms, not permanent ones, as they may disappear once the distrust in government and market mechanisms are successfully addressed. On the other hand, community-based mechanisms can be viewed as a new development paradigm wherein they create new community dynamics and ownership. Community ownership by implementing these financing mechanisms may achieve a balance by empowering the demand side.

Community-based health insurance schemes, in particular, attempt to develop some understanding of the insurance concept and negotiation skill, but it is a different kind of insurance mechanism operating differently in comparison to formal insurance. For instance, their level of risk pooling and coverage of financial risk are very limited and localised. There are other questions about CBHI. For example, how is related to the free care model? What is its value addition in the context of free care in public facilities and absence of private facilities? Participation in CBHI seems to have declined after the introduction of free care policy.[15] Also, benefit packages under the CBHI are not well-defined. It may also be the case of high premium and low benefits due to its low scale.

About two-third of the beds in the country are in the private sector, which also owns about 80% of the laboratories (Government of Nepal, 2010). Therefore, financial risk protection measures are to be developed against the financial risk of accessing private health care. It is not enough to cover only the government sector when a bulk of OOP is incurred outside the public health care facilities. There is also a need to develop mechanisms to optimally utilize private sector facilities for better access to care.

Partial pooling of resources and health risks: More than physical control of all resources at one place, their coordinated spending is very important. At present, pooling of resources is limited to government resources even though resources flowing[16] from other Ministries do not form part of the MoHP planning at present. Inadequate attention is paid towards pooling of risks with respect to household spending; it is unclear whether the government spending (and policies) is directed at enhancing pooling of all resources (not only government resources) and risks. The last benefit-incidence analysis, however, showed progressive distribution of public resources. The planned fresh benefit-incidence analysis is likely to throw more light on it. A portion of the external resources and the entire household out-of-pocket spending are not pooled while community-based health insurance pools resources in a very small way. At the same time, CBHI is not the ideal mechanism to pool risks among larger populations as it often deals with small homogenous populations. Similarly, some resource pooling occurs at the level of village and district development committees (local taxes) and facilities (user fees).

Inadequate mechanisms to identify poor: One of the major weaknesses in Nepal, like in other low-income countries, is the lack of an appropriate mechanism to identify poor (GIZ,

---

[14] It should, however, be noted that motor vehicle or home insurance seems to work well in Nepal.
[15] Coverage under CBHI schemes was not very high in the first place.
[16] Their actual size is unknown though

2011). As a result, every programme finds its own mechanism to identify poor making the programme management very expensive besides the possibility of excluding poor from schemes meant for them. Geographical and service targeting are alternative forms of targeting; these are, of course, the main mechanisms used in Nepal at present. Absence of proper mechanism to target the poor induces under-the-table payments, exclusion of real poor (false negatives) and inclusion of non-poor (false positives).

2.3 Allocation/Purchasing

The main purchasing mechanism used in Nepal is passive purchasing by government;[17] households do purchase health services as they do other services. Government uses the line-item budget; the cash transfers from Government to users also complement other provider payment mechanisms. Where the government is the provider, the provider also acts as a purchaser.[18] Where the government is the contractor, it directly purchases services from the non-government sector. Roughly half of all outpatient care visits for acute illnesses among both children and adults are with non-government providers owning 66.4% of 20,196 beds and employing about two-third of health human resources in the country; they also own 78.3% of 1,277 laboratories (Government of Nepal, 2010). Two-third of the children taken to non-government providers receives care from pharmacies. Government facilities serve 45% of new contacts with a health facility (in 2007-08) - health posts, sub-health posts, outreach clinics (85%), PHCs (10%) and hospitals (5%).

2.3.1 Strengths

Well-defined rural health care infrastructure: The rural health care infrastructure of the government system is fairly well-defined and people can rely on these centres for essential care including normal deliveries. According to the NLSS 2003-04, about 60% of the poorest find a health post[19] within one hour of reach (Table-3); about 80% of the richest find a facility within 30 minutes of reach.[20] However, non-availability of human resources is a concern; two-year compulsory rural service and 18-month ANM training were introduced to overcome the human resources this problem. The growth in some of these cadres is a positive recent trend although their effectiveness is not yet documented.

Utilization of public facilities seems to be high in places where poverty is high and vice versa; it is high (70.3%) in the Mountain Region and low (39.2%) in the Tarai Region (RTI International, 2010). Similarly, utilization of government facilities is relatively high in mid-Western (51.3%) and far-Western (50.2%) regions where, ironically, the number of public facilities is low. However, government resources do not follow the level of utilization; they rather follow the infrastructure meaning the far-western region and mountain districts lesser share of government spending (World Bank, 2010).

---

[17] *Including the resource/budget allocation to various facilities*
[18] *How efficiency resources are allocated is important here.*
[19] *Its functional and quality aspects are important too.*
[20] *The mode of transport is unclear here. The poor may walk about 1 hour to reach a facility while the rich may use a vehicle to reach a facility in 30 minutes. This makes a qualitative difference to the access.*

Table-3

NLSS - Access to the nearest health post[21] by consumption quintile (in per cent)

Consumption Quintile	< 30 min.	30 min. - 1 hour	1 - 2 hours	2 - 3 hours	> 3 hrs
Poorest	48.9	18.9	22.5	6.3	3.3
Second	53.4	21.8	18.1	4	2.8
Third	58.9	20	13.7	4.8	2.7
Fourth	61.4	20	13.4	3	2.2
Richest	79.2	13.8	4.8	1.6	0.6

Source: Adhikari, 2010

Patients are not required to make any official payment up to the Primary Healthcare Centre level and free promotive, preventive and curative services are offered at Sub-health Posts, Health Posts and Primary Healthcare Centres.[22] Inpatient care and emergency services are provided free of cost by Primary Healthcare Centres and District Hospitals. Deliveries - normal, complicated and caesarean sections - are now conducted free of charge to all women at government facilities and at certain select autonomous, government aided and private institutions nationwide and in fact, financial incentives are offered to whose who deliver at government healthcare institutions. Up to 40 essential medicines are dispensed free of cost and these medicines cover a significant portion of the disease burden requiring immediate care and attention.[23]

Decentralized purchasing/allocation: The main features of the budgets during the NHSP-1 were decentralized (district and hospital autonomy) spending (49.5% of the health budget in 2009-10) and higher allocation (75% of the health budget) for essential services (Government of Nepal, 2010). Resource flow to communities for implementing local, need-based programmes went up from 1% of the budget to 8% in 2010-11. The expenditure on safety nets (not just health) also increased from 0.6% of GDP in 2008 to 3.0% in 2010 or 11% of the budget (World Bank, 2010). The health SWAp, contributing about 50% to the health budget, also focuses on expanding essential health care services, with a focus on reducing maternal and infant deaths.

In addition, district and village development committees, from their own locally generated revenues and funds such as the DFID-funded Community Support Programme,[24]provide additional financial support towards staff salaries and medicines. District development committees also provide per capita grant to Primary Healthcare Centres, Health Posts and Sub-health Posts; this is granted according to the number of registrations (NPR 5 per registration). Such grants are spent on day-to-day maintenance of these institutions.

---

[21] Health post is a specific type of health facility providing services to fulfil certain basic health care needs. and access to it does not mean access to comprehensive (full) health care. To this extent, the rich-poor comparison needs to be cautiously made.

[22] Target groups get free health care in district hospitals with 25 beds and below

[23] However, abortion services are not free; they are charged at all levels of institutions according to published rates (NPR. 500 per abortion).

[24] Of course, only a few of them have their own source of revenue while the rest use the grant received from the central government.

2.3.2 Weaknesses

Lack of provision-purchasing divide: The main weakness of the current system is lack of separation of purchasing from provision, which led to the problems associated with efficiency, governance and accountability. The dual provider-purchaser role of public facilities masks several weaknesses of the system and results in lack of accountability.

Efficiency issues - weak provision and purchasing of services: There are efficiency concerns with respect to both government and household resources spent on health. There are significant regional, district-level and facility variations in the attainment of health outcomes and outputs in Nepal (World Bank, 2011); some regions, districts and facilities appear to be more efficient than others.[25] Over 80% of the budget is channelled through line-item budgeting and a portion is allocated based on outputs. However, it is not able to strategically incentivize the service providers to deliver the desired outputs. For example, the government spends on grants to semi-autonomous health care institutions, mainly to provide subsidised care. But, the outcome of those grants is not fully known because the contracts by government are not well-defined and there is no contracting policy to guide this process. There is also a mismatch between government expenditures on provision of services and system building. Preparation of the budgets is not need-based; the process uses top-down approach (GIZ, 2011).

Similarly, allocation of government spending is biased in favour of certain regions (World Bank, 2010). For example, the Central Development Region, where about 40% of the population lives, receives over 90% of the spending on medicines and 75% of the capital fund. Variation in spending on essential services is also observed with the *Terai* (Plain) Region receiving 60% of it. There are also equity issues concerning health care access, quality and utilisation of health care. More importantly, the inequality in public spending across the development regions has not come down between 2001 and 2009. This is true for even the spending on essential heath care services.

Low budget absorption, lack of linkage among several financial risk protection programmes[26] and uncoordinated procurement of medicines at varied prices are other efficiency issues requiring attention. Less than 80% of the allocated budget is often spent and the shortage is more pronounced in the capital expenditure. Factors such as late budget release and poor financial management contribute to sub-optimal spending.

The newly introduced output-based allocation does not seem to have integrated well with money from line-item budgets at the facility level (GIZ, 2011); so, it is not clear whether there is any duplication of funding for similar activities. Spending on demand side on cash incentives to people is unlikely produce desirable results if it is not matched with supply increases so as to meet the additional demand created. Also, inflated outputs in response to the demand side spending are not uncommon. It must be noted here that there have been considerable investments on the supply side in areas like deliveries.

---

[25] The other issue here is that since most determinants of outcomes are outside the health system the health system is responding to them; therefore there needs to be better matching of resources to where the outcomes are bad.

[26] Aama, Cash incentives for ANC visits, referral services and Kalazar patients, Family Planning sterilization (Voluntary Surgical Contraception), Financial support to the poor and the endangered ethnic group for treating catastrophic ailments (kidney, heart, etc.), Free health care services, Free treatment to citizens aged below 15 years and above 75 years, Free treatment to the conflict/people movement victims, Nutrition Support to TB patients, Uterine prolepsis.

Efficiency issues are not well-understood with respect to household spending, which uses fee-for-service method to pay for services. Fee-for-service payment encourages over-provision for those who can pay (or are insured) and under-provision for those who cannot pay. Information asymmetry plays a role when patients enter into contract with providers through the fee-for-service mechanism and patients are unsure whether their money purchases the most appropriate care at the right price. Discussions with a few health care delivery staff (including FCHVs) in rural areas revealed that use of less-than-fully qualified practitioners and home remedies are common as well; significant number of home deliveries (particularly in rural areas) provide an example for this (Government of Nepal, 2010; Borghi et al, 2006). Moreover, what is purchased out of OOP is not clear, but sub-optimal. People may also possibly shop around to find the right provider and OOP may be wasted in the process because they may probably find the right provider only after third or fourth attempt. For the rich, it could be a case of shopping around for verifying earlier diagnoses. OOP could also be wasted on unnecessary tonics and medications.[27] Further, visit to private facilities is being equated with status symbol and not necessarily related to quality of service. This is a waste of OOP as well. While individual/household preferences need to be respected, government needs to intervene in areas where market failure (information asymmetry, quality of care, etc.) prevails.

Adequate supply and availability of crucial inputs (e.g. human resources and medicines) are the essential preconditions of a well-functioning health system; many of them are under-funded. For example, only 76% of the sanctioned posts in high mountain districts were filled in 2006; physician availability in public health institutions is particularly low in mid-Western Region where only about 60% of sanctioned physician positions are filled. As a result, ineffective and wasteful health spending persists particularly in rural areas as result of seeking care from less-than-fully qualified practitioners and home remedies. Two-year compulsory rural service (for newly qualified doctors who studied under government scholarship) and 18-month ANM training were recently introduced to overcome this problem.[28] Similarly, due to inadequate supply of medicines,[29] patients lacking resources to buy additional prescriptions go without care. In all the cases, shortages could be observed, but their size is not known so as to estimate the level of resource adequacy.

Similarly, the demand side financing is not well-defined and comprehensive enough. It is not linked with other financial risk protection measures and so, there is a possibility that some beneficiaries may receive dual benefits for the same service even while some others fail to receive it. There is also a possibility of statistical twisting (by local authorities) to indicate higher number of beneficiaries. Moreover, cash provided to beneficiaries does not buy services in real terms and it is compensatory in nature. Only beneficiaries for whom the cash incentive exceeds their access cost may use the service. That is, those who reside near health care facilities are likely to receive more services than those who reside far and therefore, more disadvantaged or, the incentive payment is more likely to cover their costs of accessing care than those who live far from health facilities. In addition, as mentioned before, beneficiaries have to make an invesment before claiming the benefit;

---

[27] There could also be an element of induced demand in the form of wasteful medications/tonics and unnecessary diagnostics.

[28] But, their effectiveness is not yet documented well. Moreover, there is a government waiver for those who paid NRs. 200,000. There are also gender concerns due to which parents of women doctors do not allow their daughters to go to rural areas.

[29] For example, about 225 medicines may be required for secondary care, but only 40 (for both primary and secondary care) are provided free of cost although some others are available on payment.

the extreme poor and migrant workers are particularly affected because they may not have any investible surplus or credit worthiness may be affected.

Defining and costing the essential health service package is a challenge: The NHSP-2 discusses about coverage of essential services. A residual approach seems to be advocated when it says that the focus will be on services currently not provided by the non-government sector or unaffordable (page-16). It could then mean (inadvertently though) that people would have to go to the non-government sector first to check whether the needed service is available and affordable. One preferred way may be to define absolute minimum services people must receive and work with the non-government sector to offer them free to the poor and make it affordable to the non-poor; this is in addition to the free provision by government facilities. The focus could also be on services that are cost-effective. The package cost and resource availability are yet to be estimated.[30]

At the same time, there is a trade-off between expansion and extension of available services. If new services are added to the existing ones to expand the package, then extension of services to rural, remote and marginalized areas is likely to suffer. Hence, the opportunity cost of the expanded services is the possible exclusion of some areas and population groups, unless resources are available to do both.

[30] *However, the cost and resource availability (from the budget) of immunization are clearly mentioned in the NHSP-2 implementation plan.*

3 Towards universal coverage and social health protection in Nepal

Future options

This section discusses universal coverage and social health protection concepts as applicable to Nepal. It also describes the role of health financing and possible future health financing options for Nepal.

3.1 Universal coverage - what does it mean to Nepal?

It may be argued that health system re-positioning for universal coverage is a non-issue in tax-funded NHS-based systems because public health care centres already exist everywhere and their population reach is near universal (Wagstaff 2010). The real issue, for some, is quality of care, not universalism.[31] It is also about equity - that everyone everywhere has some coverage; but there are huge inequalities in coverage. So the issue is not to cover or not, but rather how to bridge the gap. Some others argue that universal coverage is all about addressing the demand side, not the supply side (Mayes 2004). For them, it is not enough to put facilities in place; they should rather be utilised by people effectively when in need. They tend to suggest that insurance-based systems relate well to the demand side and the level of insurance coverage could explain the level of universal coverage. Yet another group argues that universal coverage is not achieved so long as people are made to pay for health services directly out-of-pocket at the time of delivery of services (GTZ-ILO-WHO 2007; ILO 2007).

The World Health Report 2010 urges the Member States, particularly low- and middle-income countries, to further develop their national health financing systems so as to achieve universal coverage and social health protection. It argues that universal coverage can be said to be achieved only when every one, irrespective of their financial position, receives the required amount and quality of health services when in need without having to pay at the time of delivery of service.[32] This definition brings in three different sides of health system viz., population coverage, health service coverage (quantity and quality) and financial risk protection. As shown in Figure-2, universalism requires all the three to be accomplished, not just one or two.[33] Shortfall in any one side would simply mean that universal coverage is not yet achieved. Social health protection, on the other hand, extends beyond health services and includes other aspects such as economic, gender and social empowerment, poverty reduction, maternity benefits and wage loss due to ill-health.[34] In this report, both universal coverage and social health protection are used synonymously and the term 'universal coverage' is employed to reflect both. It is important that universal coverage and social health protection responsibilities are shared appropriately between MoHP and other relevant Ministries based on their comparative strengths.

---

[31] Of course, universalism is an aspiration whereas quality of care is an aspect of it.

[32] Affordability is an essential component of this approach

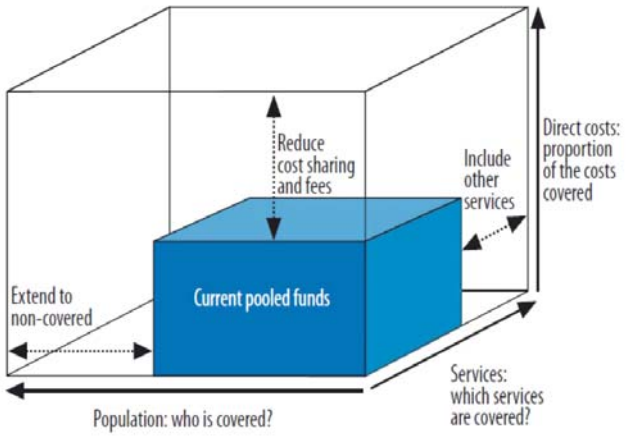
[33] However, measures are yet to be developed to measure the distance travelled with respect to each dimension.

[34] Universal coverage and social health protection principles are not against the use of household resources to finance health, but they are against their non-risk pooled use. Both require resources to be prepaid so that the financial distress on account of illness is minimised.

Currently, there are gaps with respect to all three areas (population coverage, health service coverage and financial risk protection) of universal coverage. Population coverage is patchy with some areas and services performing better than others. For example, only 18% of the poorest quintile receives antenatal care services (4 visits) compared to 84% among the richest (Government of Nepal, 2010). Service coverage (availability, accessibility and acceptability) is inadequate and a vast majority of people receive less-than-optimal care (low quality and partial course of treatment). It is good in some areas, for some services and for people with higher ability to pay. For example, 81.5% of the women from the lowest quintile receive delivery care from unskilled/semi-skilled personnel. Financial risk protection is weak with household out-of-pocket spending, the most regressive and unfair way of health care financing, meeting 54.8% of the total health expenditure (WHO, 2010a). Moreover, the current health system does not provide sufficient safeguards to the citizens against catastrophic health expenditure. Out-of-pocket spending is still a black box in Nepal and its complete facts are still unknown. It is a double-edged sword imposing financial burden on its users and impoverishing them on the one hand and preventing non-users from utilizing health care services because the fear of incurring heavy out-of-pocket spending keeps people away from health care on the other. Therefore, the immediate challenge in Nepal is to extend population, health service and financial risk protection coverage beyond the current levels. The path to universal coverage would be expensive and time-consuming, particularly in Nepal because of its many hard-to-reach areas.

Figure-2

Towards Universal Coverage - The three dimensions



Source: The World Health Report 2010

Attainment of universal coverage in Nepal (as explained using Annex Figure-1) would mean that every Nepali citizen is entitled to receive appropriate quality and quantity of health services (prevention, promotion, treatment and rehabilitation) when needed without having to incur any out-of-pocket spending at the time of receiving care. Keeping people in the centre, it requires efficient and adequate availability of appropriate and quality health services and products, equitable access (accessibility, affordability and acceptability or preferences), sufficient resource mobilisation, resource/risk pooling and strategic purchasing. As a first step, it is necessary to ensure that households are not prevented from seeking care owing to financial constraints or impoverished as a result of accessing

and/or using health services. At the same time, service provision and financing are necessary but not sufficient to ensure the movement towards universal coverage. The key element here would be that people receive appropriate services and products as and when needed. Universal coverage cannot be achieved if there are other access barriers (cultural, geographical, social, etc.) due to which people are not able to utilise health services. Therefore, it is important that provision and financing are effectively coordinated.

3.2 Role of health financing in the attainment of universal coverage and social health protection

Health financing is a key instrument in the process of achieving the ultimate goals of universal coverage and social health protection. The way health financing operates to assist in the process of attaining universal coverage is explained in Figure-3. Progressive resource mobilization, pooling of resources and health risks, and enhancing institutional capacity to purchase equitable and quality health care services are the key elements of health financing. Of course, efficient provision and accessibility of health services are essential preconditions for the health financing system to produce desirable results.

3.2.1 Key objectives

A crucial component of the health financing system is the health sector's ability to raise sufficient resources that are predictable in a manner to deliver desirable health services. Two performance attributes are relevant here for follow-up:

- Level of funding
- Sustainability/predictability of funding

Domestic resources are a preferred option to make health financing sustainable/predictable.[35]

Next important objective of a health financing system is to provide equitable financial access. It aims to separate the use, and financing of services, and is based on the premise that access and use are determined by need while payment is based on the financial ability. Four performance attributes could be used for follow up:

- Extent of population coverage
- Level of solidarity, i.e. the degree of cross-subsidization[36]
- Financial risk protection
- Fairness in financing

As a first step, it is necessary to bring the entire population under a prepaid, predictable and sustainable health financing mechanism. At the same time, the healthy and the rich need to cross- subsidize the sick, the poor and other disadvantaged populations; the level of such cross-subsidization indicates the level of solidarity. At the same time, those who seek care when needed must receive optimal, not partial care and must not get impoverished or spend disproportionate to their income. Fairness in financing requires that resources are spent without discrimination or differences in how people are treated.

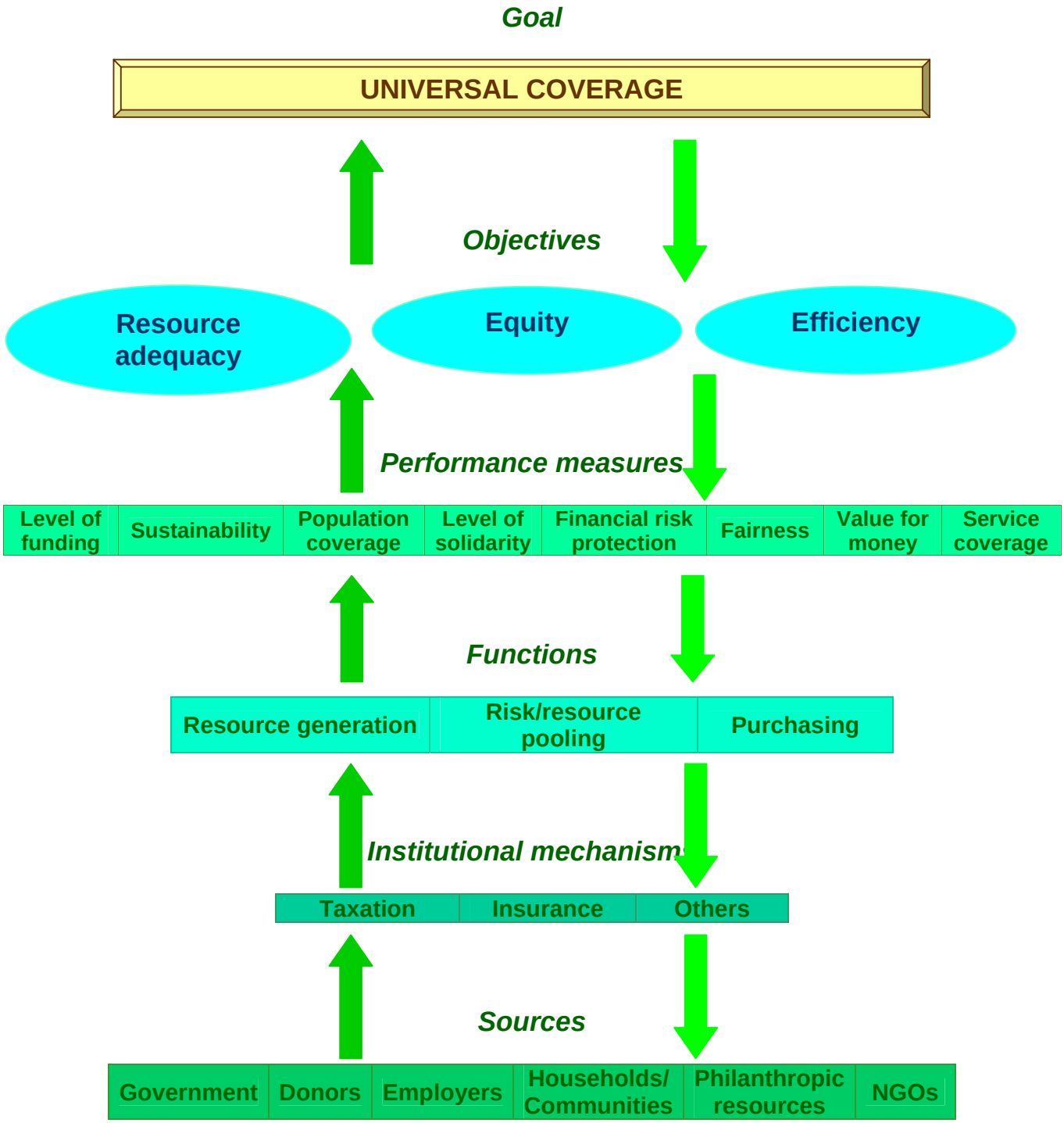
---

[35] *In reality, this is a long-term goal.*

[36] *This is a driver of success in risk and revenue pooling but we must admit that there are practical challenges in measuring it as a performance measure for a health financing system*

Figure-3

Health Financing Pathway for Universal Coverage



Source: Government of Uganda and WHO, 2011.

The third objective is to use resources efficiently so as to obtain value for money. That is, available resources should be used in a manner that ensures the highest possible benefits to the users. Two performance attributes could be used for follow up:

- Value for money
- Service coverage

Value for money is achieved when services are provided in a cost-effective manner. Service coverage here means provision of maximum range, quantum and choice of services using available resources.

3.2.2 Health financing functions

The health financing system performs three critical functions; they are

- Mobilization of sufficient resources for health (resource mobilization)
- Removal of financial barriers to access and reduce financial risks of illness (prepayment and risk pooling)
- Making better use of the available resources (efficient purchasing)

While resource mobilization often receives more attention, pooling and purchasing receive lesser attention. Resources need to be raised from a sufficiently large pool of individuals so that the financial risk of each individual can be reduced. In general, the bigger the pool, the better able it is to cope with financial risks (WHO, 2010). Prepayment simply means that people pay before they are sick, then draw on the pooled funds when they fall ill. Countries can make faster progress towards universal coverage by introducing forms of prepayment and pooling to take advantage of the strength in numbers. Taxes, insurance contributions and resources from other sources can be combined to cover the population as a whole, rather than being kept in separate funds. The most efficient health systems avoid fragmentation in pooling but also in channelling funds and distributing resources.

On the other hand, strategic purchasing can improve quality and efficiency by matching health services with population health needs and community expectations, given the available resources and by optimizing the mix of promotion, prevention, treatment and rehabilitation. It also finds ways to efficiently provide or purchase these services, including contractual mechanisms and provider payment systems.

3.2.3 Sources of financing and their institutional mechanisms

In order to plan for the optimal utilization of available resources, it is important to understand how different health financing sources operate at present. As stated earlier, there are possibly six distinguishable sources of health financing in Nepal. Figure-4 explains the flow of funds from various sources in Nepal (GIZ, 2011). In addition to the four main sources indicated in the figure, NGOs also generate their own domestic resources; similarly, local philanthropy exists. Some local bodies also mobilize their own resources in addition to the central transfers.

Each source follows a different institutional mechanism to mobilize and pool resources and purchase services; of course, some sources (e.g. OOP) do not pool resources. The major institutional mechanism used in Nepal is direct purchasing[37]; this is used by government as well as households. Insurance and banking methods (saving and credit) are also used

[37] *Of course, the purchasing function is not clearly distinguishable when services are directly provided by public providers although conceptually it is clear that the providers also perform the purchasing function.*

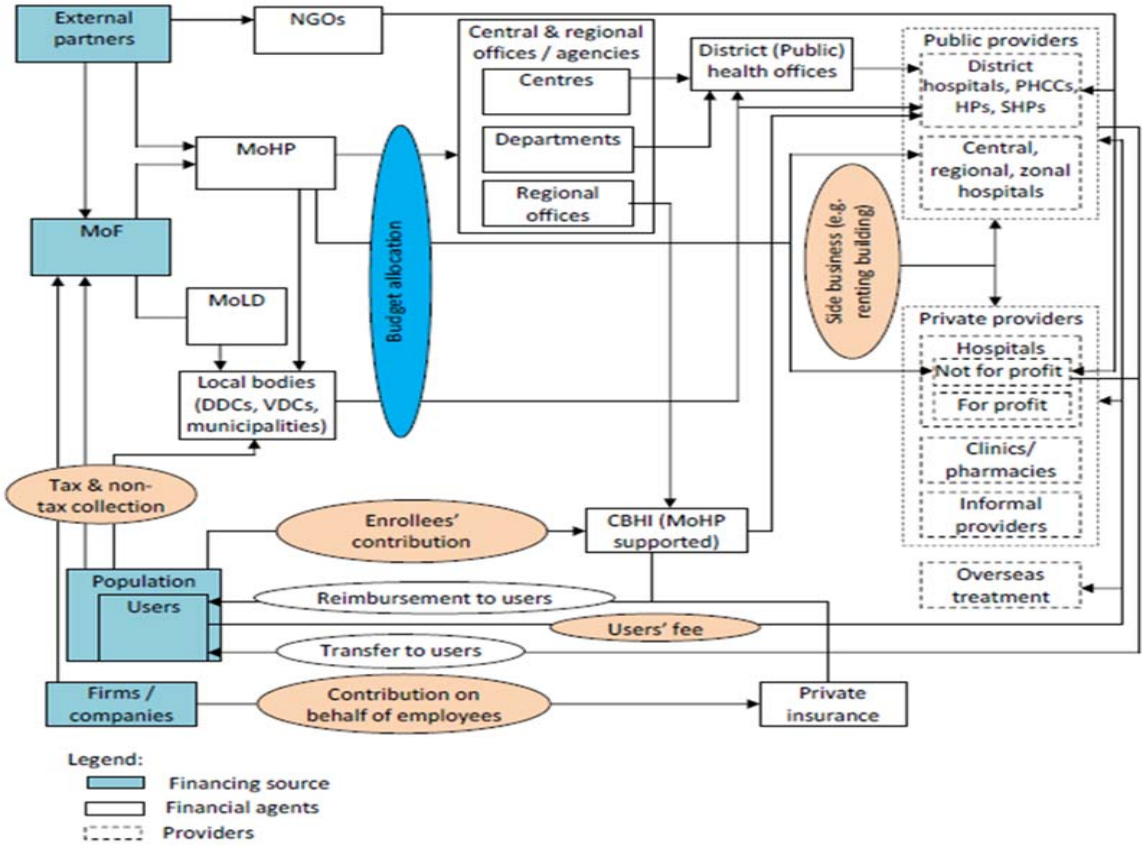
by some households. Direct purchasing by households produces many harmful repercussions (WHO, 2010). Payment at the point and time of delivery of health service discourages them from using services (particularly health promotion and prevention), and encourages them to postpone health checks, disease diagnoses and treatments. This is especially true for poorer people, who must often choose between paying for health and paying for other necessities such as food. In Nepal, health financing could be potentially organized through three institutional mechanisms viz.

- Taxation
- Insurance
- Others (e.g. saving)

Resources could flow through one of the three channels in order to be prepaid, efficient and pooled. All these need to be combined under a single pool and the purchasing function could be performed in an integrated manner through an independent mechanism. For instance, saving is only a resource mobilisation tool, not useful for risk pooling. However, if it is linked with insurance (like in Singapore, for example), then it can result in risk pooling.

Figure-4

Broad description of the health financing system in Nepal



Source: GIZ, 2011

At the same time, credit (formal or micro credit) is not the preferred option of reducing the financial risks associated with ill health for many reasons (Varatharajan et al, 2010). For example, credit used to pay health expenses could result in the need to sell assets subsequently to repay the loan. But, formal or micro credit is preferred to informal lending by local money lenders bearing exorbitant interest rates and the government could use the newly created institutional mechanisms such as micro-saving and micro-credit as a vehicle to move towards prepayment and pooling across large population groups.

3.3 Future options for Nepal

The major health financing challenge in Nepal is to develop the national health financing system to achieve universal coverage and social health protection. No country in the world has achieved universal coverage and full social health protection; countries, rich or poor, struggle to meet the entire demand for health services. Nepal is doing relatively well by many criteria for a country of its income level (World Bank, 2011). Therefore, it is necessary to build the system on the positive features found in Nepal. Improvements are possible with respect to the strategic direction for the national health system to work better, size and progressiveness of resource mobilization, risk and resource pooling, resource use efficiency, capacity development (e.g. analytical work), financial risk protection (minimization of OOP without reducing access) and effective balancing of funding between supply and demand sides.

At present, the health financing system is highly fragmented in terms of resource mobilization, risk pooling and purchasing. Efforts with respect to each health function are not linked and do not follow any specific pattern. This needs to be changed so that resource flow could be well-targeted and efficient.

3.3.1 Including universal coverage and social health protection in the national development paradigm

Attainment of universal coverage and social health protection require inter-sectoral, inter-ministerial and inter-agency approach because there are multiple inequities and barriers requiring an integrated approach involving complex processes; targeting any single inequity or barrier may not produce desirable outcomes. The National Planning Commission is in a better position to lead this integrated process/forum of effectively utilizing the comparative advantages of different Ministries, keeping the MoHP as the catalyst. It needs active support from civil societies, the non-government sector, academia and local governments. Aspects of universal coverage and social health protection could be discussed and solutions arrived at in this forum. Roles and responsibilities of each Ministry and External Development Partner in implementing actions outlined by the Commission could be clearly drawn through mutual understanding and agreements. This Commission, through a technical agency under the MoHP,[38] could steer resource mobilization, investment, pooling and purchasing/allocation towards the achievement of universal coverage and social health protection; it could also identify investment needs, priorities and monitor the impact of new investments.

[38] *The MoHP could avail make or buy option here, meaning it could set up or strengthen an unit under it or groom an institution outside the MoHP to work autonomously and provide technical support to the MoHP as and when needed.*

3.3.2 Finding a suitable health financing framework for Nepal

The present health financing system in Nepal is a mixed one using resources from a variety of six sources (of course, only three - household spending, government budget and external resources - are prominent ones). There is very little pooling of non-government resources. In order to make better use of the available resources (equity, efficiency and solidarity) and generate additional resources, it is advisable to have a health financing framework to guide the three functions of resource mobilization, risk pooling and purchasing. A fragile system, on the other hand, produces enormous wastages and prevents people from contributing resources to health. It is not easy to define the framework for Nepal upfront.[39] In short, there is a need to take a system-wide view[40] on health financing, not just government financing of health.

The framework could provide options for making better use of the existing capacity; it could include a plan for utilizing idle/excess capacity in both government and non-government facilities so as to serve the population better. Effective utilization of the idle/excess capacity will not only expand service coverage, but also reduce price and enhance solidarity between the rich and the poor clients. Choice of location and service delivery options of non-government providers could be guided by national goals and the service provision gap. The role of non-government insurers in financial risk protection needs to be debated and shaped.

3.3.3 Resource mobilization options

The main challenge before Nepal is to mobilize adequate resources sufficiently enough to keep pace with large unmet needs, epidemiological transition (dual disease burden), population growth and technological progress in medicine. Expensive options are made available by new technologies even while conditions requiring simple technologies remain untreated. At the same time, given the moderate economic growth, the scope for raising domestic resources for health from all sources of health financing is limited. In fact, no country, rich or poor, is able to provide its population with the entire range of technologies or interventions that are available to improve health or extend life (WHO, 2010). Government, with its current tax resources, funds less than one-third of the total health expenditure while household resources contribute over 50%. Some additional options for raising domestic resources could be explored.

At the same time, the most important aspect of domestic health financing in Nepal is to find ways to streamline household resources through some prepayment mechanisms so as to make them equitable, sustainable, predictable and accountable.[41] Of course, individual/household preferences need to be taken into account although health spending may have certain characteristics of a merit good. If household resources are organized poorly and spent on unnecessary care, this causes waste and the responsibility of absorbing the financial burden caused through wrong household financial actions may ultimately fall on the government. Therefore, government could guide the use of non-government resources by designing appropriate policy. Government could also use its

---

[39] It needs to be done through wider consultations with different stakeholders.

[40] This is nothing but taking the SWAp a step forward towards the alignment of resources from all health financing to achieve the national goals.

[41] This could be done in such a way that household/individual preferences are respected. Nevertheless, household OOP has characteristics similar to 'merit goods' and so, some amount of pro-active government intervention to streamline it cannot be entirely avoided.

licensing and regulatory channels to prevent unnecessary catastrophic payments emerging from private (formal and informal) providers.

Tax alternatives

Finding additional source of tax to finance health may not be easy, as all possible options for tax may already have been exploited. Since health is already a high-priority sector in Nepal attracting 7.24% of the government budget, any increase in public spending on health will depend on further expansion of the tax-base. Raising additional resources for health through earmarking is an option though. Earmarking a portion (say, 15%) of the value added tax (VAT), as in Ghana, is an option to allocate more and sustainable tax resources for health. If this is not feasible in Nepal due to fiscal rigidity, an additional VAT (say, 1%) to exclusively finance health, as in Chile, could be considered as another option. However, VAT could be regressive if not carefully planned to cover purchases of the rich. Moreover, these taxes are fungible – if health gets money from VAT, the MoF can adjust its allocations, as happened in Ghana where the overall public funding remained the same, but switched from general tax to VAT tax funding for health care. Solidarity tax or health cess could be levied on items such as air tickets, mobile phones, foreign exchange transactions, financial transactions and items produced by large profitable enterprises.[42]

Sin tax

Sin tax could be considered as an alternative source of health financing; it could even attract broad political and population support. Experience in 12 low-income countries indicates that there would rather be a decline in the consumption of these products as a result of an increase in tax (WHO, 2010). One advantage of sin tax is that it raises funds besides improving health at the same time by reducing consumption of harmful products such as tobacco or alcohol (WHO, 2010). The scope for it could be considerable, given the prevalence of tobacco or alcohol use in Nepal, as advocated by the WHO Framework Convention on Tobacco Control (Prakongsai *et al, 2008*). An analysis of excise taxes in 22 low-income countries revealed that excise taxes on the most popular brand of cigarettes fetched US$ 0.03 - 0.51 per pack of 20 (Stenberg et al, 2010). The extra revenue thus generated may represent a 10% increase or more in total health expenditure (WHO, 2010). Of course, price and tax scenarios of harmful substances need to be analyzed to estimate the potential to generate additional resources through tax on harmful substances. Nepal has the history of sin tax; sin tax was imposed on cigarettes and alcohol in the early 1990s, with revenues used for treating cancer (Prakongsai et al, 2008; World Bank, 2011).

An argument against the application of sin tax is that it is regressive, disproportionately affecting the poor since it takes away more of poor people's income than that of the rich. There were also instances elsewhere when earmarking was not particularly successful (World Bank, 2011); actual challenge lies in ensuring that resources generated out of sin tax are channelled to health.

However, both VAT (if the rate is not increased for health purpose) and sin tax are not new taxes and proposing these two as an option for financing health could simply mean their earmarking for health. Therefore, they don't guarantee an increase in overall government

[42] *Of course, the political feasibility of imposing new taxes or enhancing the tax rates will have to be taken into account.*

health spending because the increase in health funding from these taxes may be offset by a reduction in flows from the rest of the budget.

Possible avenues for non-tax revenue

*There could also be some non-tax options to r*aise revenue for health. Efficiency frontier analysis in Nepal indicates the existence of excess (or idle) capacity in public sector facilities, as outputs vary across facilities and regions (The World Bank, 2011). One option for generating non-tax revenue is allowing the non-government sector to utilize a portion of the excess/idle capacity in public sector facilities.[43] For this, government could strategically plan for the involvement of the non-government sector in the provision of health care. Similarly, private corporate sector could be asked to boost the functioning of some under-utilized government facilities through a solidarity mechanism. Modalities could be worked out by the respective district and regional health offices.

Currently, commercial banks in Nepal are required to provide at least 3% of their total loan portfolio to deprived sectors, which primarily refers to microfinance, at a subsidized interest rate. However, concerns have been raised by development partners on the usefulness and efficiency of such provision. External development partners involved in financial sector reform in Nepal, particularly in the rural finance sector, believe - rightly so - that the deprived sector lending is distortive for various reasons. Primary among these reasons is the high transaction cost for banks in administering these small size loans, because of which they prefer to lend to other wholesale lending institutions in larger amounts. The wholesale financial institutions in turn may deposit the amount back in other banks at a higher interest rate - essentially making a profit. This amount could be used for financing health costs instead, with clearer guidelines on how they should be administered. One administration modality that can be employed is pooling a share of the amount intended for deprived sector lending from commercial banks by the government - as it was envisioned recently for the Youth Self-Employment Program. Other types of innovative mechanisms to attract non-tax revenues could also be explored.

External resources

Mobilization of additional resources from external funding does not seem to be an attractive option for Nepal. First, the share of external resources in total health expenditure is reasonably higher (about 13%) than the average for the WHO south-east Asia region (1.8% in 2008) although it is lower than the average for low-income countries (16.4% in 2008). It will be challenging for Nepal to push the share of external resources beyond the current level. Second, external funding comes with some uncertainties and sustainability issues (World Bank, 2011 and WHO, 2010).

---

[43] It may be possible in the case of operation theatres, beds, consultation rooms, laboratories, medicines supply and training. The non-government sector may require additional financial incentives to operate the excess capacity in government facilities. In such case, the relative cost-effectiveness of the options of providing additional investment for expanding direct service provision (Option-A) and providing incentives to non-government institutions to operate the idle capacity (Option-B) needs to be assessed. If, however, re-activation of the idle capacity requires additional investment or incentives, then resource mobilization will only be a long-term option.

Efficiency gains

There is scope for efficiency gains in the health sector by reallocating of resources to priority areas, choosing cost-effective interventions, improving quality and governance, and reducing corruption and waste (World Bank, 2011). Performance-based financing is an option available to Nepal to extract efficiency gains and enhance service coverage, quality and health outcomes (WHO, 2010; World Bank, 2011); the design of existing grants and incentives could be refined so that payments are directly linked to performance. Significant amount of resources could be made available by addressing problems of health worker absenteeism, medicines stock-outs, procurement and distribution of medicines, and procurement and maintenance of equipment (World Bank, 2011). Similarly, improved governance, reduced corruption and waste, re-allocation of resources to priority areas, improved quality and choice of cost-effective interventions will contribute to efficiency gains. Efficiency differences exist across regions, districts and facilities.

Efficiency gains are also possible with respect to household spending, the single dominant source of financing in Nepal. However, in order to apply efficiency principles to it, there is a need to understand its dynamics well. Streamlining of OOP through a well-developed prepayment mechanism will considerably maximize efficiency gains.

Health insurance is NOT an option for mobilizing additional resources

Health insurance contributions and coverage could play a role in terms of raising public resources for health to the extent that the premium-paying proportion of the population is large enough to subsidize coverage for those who cannot afford to pay. However, given the large extent of the self employed and casual labourers – available estimates for 2004 indicate that 73% in urban and 95% in rural Nepal are self-employed or casual labourers – this remains a challenging option. Moreover, the primary purpose of health insurance is risk pooling, not resource mobilization. In a low-income setting with huge informal sector (and very small formal sector), it is not possible for health insurance schemes to survive on their own resources. Moreover, given the backlog unmet health care needs of the population in countries like Nepal, the initial (say, first 5 years) demand (or claims) for health insurance resources will far exceed the insurance revenue generated. So, additional resources will be required from government to meet this initial excess demand. Government funding is also needed to subsidize insurance for the poor. In fact, establishment of an insurance system requires considerable initial investment on technology and physical and human resources. Even in the case of private for-profit insurance, value of claims often exceeds the premium collection (IRDA, 2010).[44]

3.3.4 Financial risk protection and risk pooling

Enhancement of appropriate access to health care by mitigating the financial barriers is the most important health financing challenge in Nepal. For those who are incurring OOP, reducing it without affecting their health care access will be the key. The only way out here is to make OOP predictable, sustainable and accountable through prepayment and pooling. Therefore, there is a need to gradually work towards prepayment and pooling by developing and strengthening institutional mechanisms to pool risk and resources and

[44] *In such contexts, health insurance is simply employed as a door opener for selling other insurance products (e.g. fire, flood and motor vehicles).*

efficient use of resources through effective purchasing.[45] All the existing financial risk protection measures, therefore, need to be coordinated and streamlined as part of the purchasing mechanism to be developed. The institutional mechanism required for this purpose needs to be discussed and developed.

General tax revenue financed health system is the best risk pooling mechanism as it involves the broadest risk pooling. However, as in many developing countries, Nepal is unable to use this instrument to provide financial protection against health shocks. On the other hand, the insurance fabric of the country is very weak and a very small proportion of the labour force is in formal employment, making revenue collection very expensive and difficult. The insurance mechanism needs to be freshly developed in Nepal; even the private sector is not active in health insurance. Currently, the risk pooling function is carried out through tax funding. Government at present mixes service provision, contracting and demand side financing to provide some sort of risk pooling through tax funding. Development of insurance requires clear purchasing mechanism, costing and packaging of services so that they can be linked with premiums and benefits, electronic smart cards, facility strengthening for financial management and electronic card reading, e-governance, etc. Some of these actions (e.g. establishment of a purchasing mechanism and smart cards) could be initiated immediately. Poorly developed insurance system will do more harm than good.

Government needs to find ways to work with the private (for-profit and not-for-profit) sector in different areas where it has adequate strength and comparative advantage. Private sector's role should be clearly defined and it should not be a self-evolving process. For instance, incentives to the private sector should be strategically employed to produce desirable health and health system outcomes.

Social health protection centre

One of the drawbacks of the prevailing approach to financial risk protection is fragmentation and possible duplication of resource allocation and activities. A possible way of integrating various financial risk protection measures is the formation of a social health protection centre which could plan and gradually channel and coordinate resources meant for financial risk protection coming from various ministries and other agencies. Such an arrangement, besides making the system effective and minimising administrative costs, will make it responsive to local needs. The rationale and possible institutional mechanism for it are provided in the GIZ review of the government health financing system in Nepal (GIZ, 2011).

3.3.5 Resource pooling, allocation and purchasing

In Nepal, resources flow into health from different government Ministries as well as from households. Various options are available to improve resource pooling and purchasing (World Bank 2010, GIZ 2011 and WHO 2010). Linking financing to performance will improve efficiency, MoHP's bargaining position (by demonstrating results) and enable tackling of access and utilization inequalities directly (Acharya 2011); it is also likely to promote transparency and accountability in the system. Nepal would benefit from the establishment of a national purchasing entity to effectively carry out the purchasing/allocation function linking all resources from the government, external sources

[45] *Of course, quality assurance is an important aspect that needs to be considered here.*

and households. The seed for a national purchasing entity could start within the MoHP under the proposed social protection centre. This entity may eventually spin-off as a separate entity or under the National Planning Commission set up to carry out the function of resource pooling and purchasing.

Purchasing is an important component of financing not only to buy additional services for the poor from the non-government sector but also to address long standing governance issues and improve efficiency. Also, purchasing is the first essential step for the establishment of any insurance mechanism. A few purchasing models can be advanced so that a clear purchasing mechanism could evolve in a reasonably quick time. However, there is a need and plan for capacity development in this area; the present purchasing mechanism appears to operate based on 'the rule of the thumb'.

Changes in the provider payment system

A gradual change in the provider payment system could be utilized to incentivize hospitals to improve efficiency. Different types of provider payments have different effects on the hospitals with varying level of efficiency. Changing the payment from the current to a per diem system, for instance, would incentivize increases in bed occupancy rate. This is desirable as the bed occupancy rate is rather low in most of the hospitals in Nepal. It is important to understand that the change to a per diem system will incentivize increases in average length of stay (ALOS) because the cost of inputs per day is higher in early days of hospital stay and decreases with stay. The drive to reduce cost by the hospital means that hospitals tend to increase ALOS more than they increase admission. However, the fact that most of the hospitals have low bed occupancy as well as low ALOS may make per diem an appropriate initial option. The per diem system has an added advantage of administratively requiring less information to implement.

Given the current performance of hospitals, Nepal could start with a per diem system with an eventual move to a case-based approach. A per diem system is ideal for implementation as it is simple to administer and is less information intensive. The risk is that providers quickly learn the system and can start changing behavior in order to maximize revenues. The best option may be a mix of per diem and case based rate which will take advantage of the per diem system while at the same time addresses its downside, by correcting for expected length of stay based upon the type of illness being treated. However, a case-based payment system is complex to administer and requires information that is not readily available today. By starting with per diem system, data that are necessary to design a case-based rate can be collected for eventual move towards case-based approach.

Grants to hospitals and districts

Refining the current practice of providing grants to hospitals would enable the government make the most out of existing expenditures. Instead of unconditional grants, hospitals could be provided payments that encourage better performance. Such payment could be in the form of lump sum so that the hospital retains the flexibility of spending without the need to report on budget lines. However, the payment can be based on performance so that the hospital is incentivized to do better. There are extensive international experiences in reforming provider payments systems that Nepal can learn from (Cashin et al, 2010; Moreno-Serra & Wagstaff, 2010). Moreover, such practices can improve the transparency

of the budget process and allocation which otherwise remains highly compromised with further expansion of the use of making grants to facilities/providers within the budget.

Putting free care in the hands of the users

Provide users the choice among health facilities by letting the money follow the user. There is some evidence that a number of facilities implementing free care are unable to provide the full range of services and drugs they are supposed to provide. The free care program entitles users the right to receive services with no payment. The Ministry allocates budget to participating facilities to enable them provide services free of charge. In effect, this means that it is up to providers to provide the services for free with little consequences for failing to do so. The alternative to allocating budgets to facilities to provide services is to put the budgetary decision on the hands of users by allowing them to choose among health facilities. That is – instead of providing money to facilities – money be given to potential users (in the form of explicit entitlements) so that they can make payment to facilities when using services. This way, users will have the right to choose which facility to go to and pay only for services provided and facilities will have incentives to attract users. For instance, when facilities are out of drugs, they could lose revenues if users choose to go elsewhere.

Output-based budgeting

The first best outcome the Ministry should strive for is separating financing from provision, through purchasing. As an intermediate solution, however, the Ministry can start refining the budget preparation such that the proposed budget is directly linked to the NHSP-2 output/outcome it is expected to achieve. The current practice of budget preparation is largely based on historical input use with no clear link with the expected output. This year the exercise is expected to start with teh aim to produce an output based budget for FY 12/13.

3.3.6 Regulation and monitoring

Once the desirable national health financing framework is arrived at, appropriate guidelines (including performance indicators and roles and responsibilities of various stakeholders), monitoring and regulation mechanisms need to be developed. A set of performance and regulatory indicators are to be developed to guide the monitoring, evaluation and regulatory processes. Service contracts, intervention packages, prices and consulting practices need to be streamlined and monitored so as to reduce undesirable OOP caused by induced demand, excess pricing and other wastages.

3.3.7 Capacity building

Capacity building is one area that requires long-term planning and development. The capacity building plan could include separate sub-plans for individuals, institutions, networks and the system (European Commission, 2005 and GTZ, 2003). Individual capacity needs to be developed in some core health system areas so that a larger pool of individual talents exists in Nepal for use when in need.

MoHP capacity

Among the institutions, strengthening of the MoHP capacity is crucial for efficient policy and strategy development, financial and contractual negotiations, regulation, monitoring and evaluation. Such core capacity needs to be developed at key units/centres of the MoHP. Budget preparation needs to be based on sound economic analysis[46] of issues, evidences and options. Economic analysis and evidence creation are important to feed into the budget and policy processes. It is necessary that the MoHP unit or institution responsible for this activity works closely with various departments under the MoHP or other Ministries responsible for priority setting and purchasing/allocation and actively provides inputs for policy development.

Translating evidence into policy and budgetary allocation requires specific skills.[47] It is necessary for the MoHP unit to work closely with the Ministry of Finance and other Ministries to bring in essential linkages between health priorities and the health budget so as to bridge the evidence-policy-budget gap. The unit also needs to ensure that budget line items are properly aligned with the national health plan and the health financing policy/strategy. Resource planning, financial analysis, budgeting, risk pooling mechanisms and policy making for financing are the basic skills required for personnel staffing this unit/section of the MoHP. This year's policy is translated into next year's budget allocation and so, strategic use of the policy pronouncements under the budget is very important. All these mechanisms will also help to advance the budget process within the MoHP.

Capacity of health care providers

Similarly, the capacity of the public sector and non-government (NGO) institutions (e.g. hospitals) requires strengthening in the following areas in order to effectively perform their role as a provider of care and producer/purchaser of services:

- Contracting capacity, so that contracts between MoHP and semi-autonomous bodies can be improved
- Effective planning and delivery of free essential health care to the poor and the disadvantaged
- Effectively dealing with various health financing schemes such as the demand side financing schemes
- Designing and managing contracts between government and non-government providers in order to efficiently deliver care to the poor and disadvantaged at all levels
- Development of primary, secondary and tertiary care packages (e.g. services to be included)

Each one requires different kind of skill and organization. The MoHP unit (e.g. HEFU) could coordinate these activities; it could include the above sub-functions under its responsibilities. The unit should, however, function as a technical body rather than a bureaucratic unit.

---

[46] This could be undertaken by an institution or professional association (e.g. the Nepal Health Economics Association) outside the MoHP. Capacity of that institution could be developed or supported for this purpose. This will require inter-ministerial coordination, particularly involving the MoHP and the Ministry of Education.

[47] It would be ideal if this work is carried out by MoHP (e.g. HEFU) in close cooperation with the institution or network helping to carry out economic analyses.

Possible training avenues

Training of people could be carried out through various mechanisms; possible avenues for developing people to take up these roles are

- Training mechanisms in different Ministries (e.g. Ministry of Finance) and Regional Training Centres
- Programmes such as the World Bank Flagship Course and WHO internship
- Technical support from academic institutions (e.g. Tribhuvan university) and networks (e.g. the Nepal Health Economics Association)

Short term training can be provided or coordinated by the training division of the Ministry of Finance. The World Bank flagship and WHO internship programmes offer other opportunities for short-term training. These could also be topped up by the Nepal Health Economics Association, which could get involved in long-term training as well. Special tied scholarship, financial support for Masters Dissertations and Ph.D. theses and promotion of special curriculum within the existing Masters courses in economics are some other options to be considered (for developing in-country capacity and a critical mass of experts).

4 National health financing strategy

Suggested process

A national health financing strategy is a necessary but not a sufficient condition for universal coverage and social health protection. Its design and implementation involve continuous adaptation rather than linear progress towards some notional perfection (WHO, 2010). Conscious efforts are needed to develop a good, nationally acceptable and workable health financing strategy. In practice, strategy-making ranges from the simplest form of intuitive, informal and implicit decision-making to a comprehensive process involving formal, systematic, complex, sophisticated, rational and explicit strategy formation; sometimes, strategies are also driven by best practices.

4.1 The architecture of a strategy

As described in Figure-5, the basic strategy architecture includes nine essential components (Box-1) constituting the 'UNIVERSAL' framework (WHO, 2011a). This architecture is a modified version of the pathway outlined in the World Health Report 2010 (WHO, 2010).

Box-1

Essential components of the strategy architecture

Understanding the health financing system

National vision and goals

Investigation of various options, choices and experiments

Valid strategy formation

Execution plan

Resource planning and mobilization

Strategic implementation

All-round monitoring and evaluation

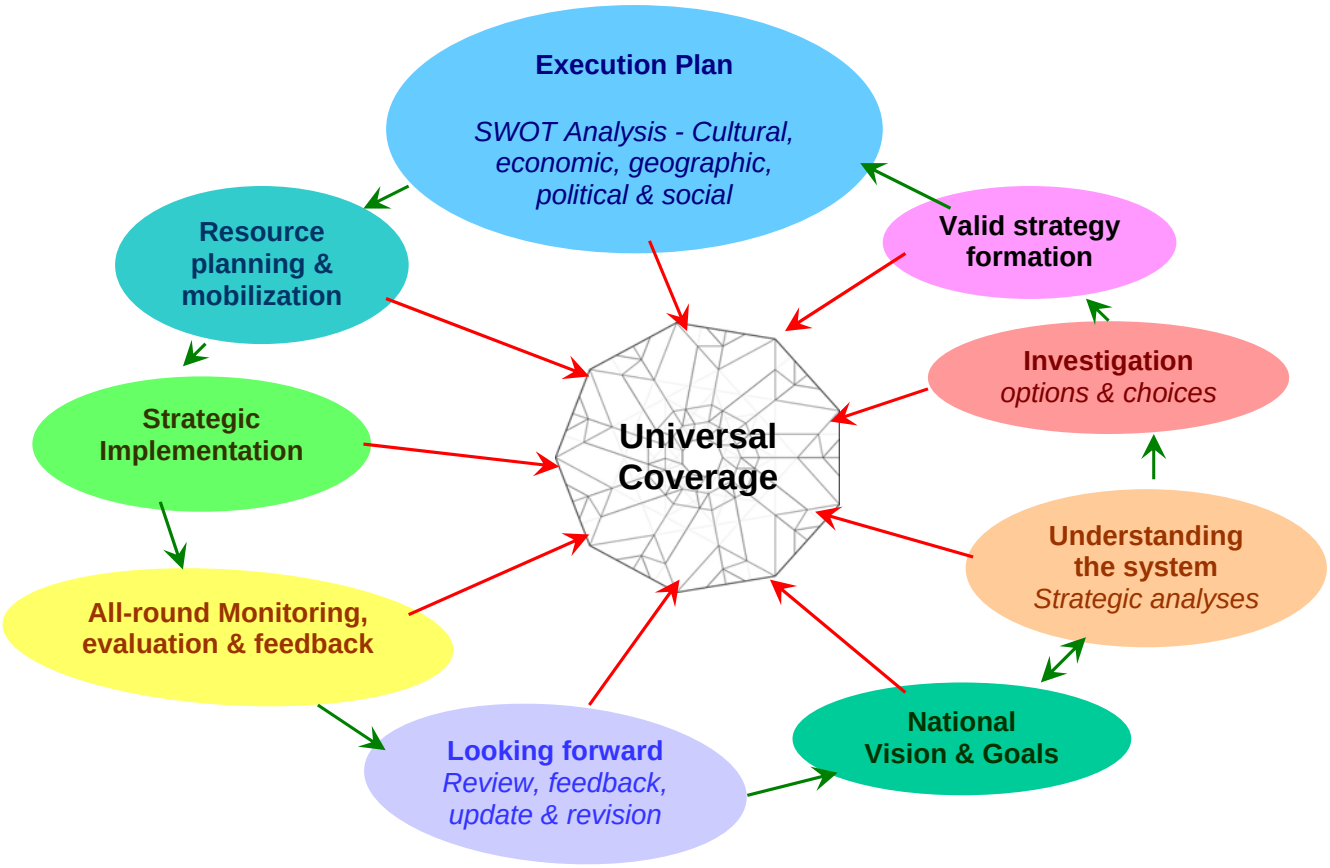
Looking forward - review, feedback, update and revision

Strategic review of the existing health financing system - its basic features, strengths, weaknesses and constraints - provides a sound basis for the development of a strong strategy. Establishment of the national vision and goals suiting the health financing context

is crucial in order to establish the future road map for achieving universal coverage. An investigation into many different options, experiments and choices based on domestic and international experience is necessary for the informed choice of appropriate strategies. The most important and probably time-consuming activity is the development of the strategy; it requires various consultations and discussions at the national and sub-national level. The strategy document could include all aspects concerning the three functions: raising funds; pooling them; and using them efficiently and equitably. An implementation strategy could guide the implementation process; this helps to weave various actions towards achieving desirable goals and outcomes; some countries may only require minor changes while a few others may need major reforms. An assessment of the current and future availability of resources from various sources forms an essential part of the strategy development.

Figure-5

The UNIVERSAL architecture for national health financing strategy



Source: WHO, 2011a

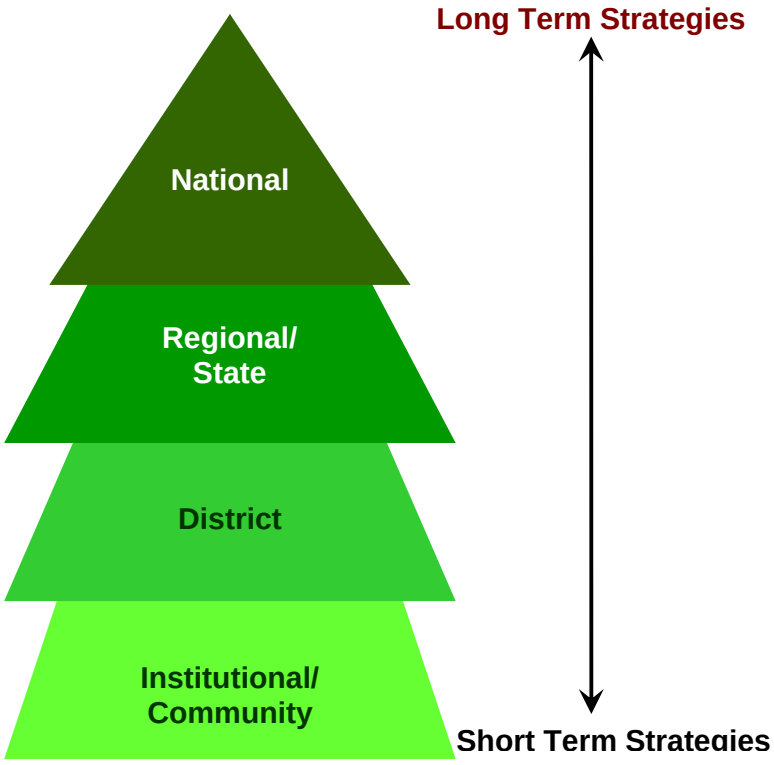
Actual implementation may require additional capacity development, system building, policy and regulatory measures and involvement of different health financing actors besides the need for mobilizing additional financial resources. Successful strategies require regular, coherent and consistent actions at different layers and levels of the health system. Systematic monitoring and evaluation helps to assess the progress vis-à-vis

objectives and goals that were set. The system may not adequately respond to the strategies and changes; persistent reviews and feedbacks support constant update and revision of the strategy. Countries differ in their starting points and need not necessarily go through the entire process; they could focus on tasks not completed or planned.

Designing and implementing a comprehensive health financing strategy involves continuous adaption rather than linear progress towards some notional perfection.[48] It is a process based on a series of steps (short-term strategies), continuous learning and re-adjustment. National strategies often serve longer time period than those developed by smaller communities or institutions (as in Figure-6). More often, successful implementation of a national strategy requires development of a series of short-term, regional and institutional strategies appropriately aligned to the national strategy.

Figure-6

The Strategy Tower



Source: WHO, 2011a

4.2 The guiding principles of a health financing strategy

The immediate need in Nepal is to provide adequate health services to all and protect people against the financial risks of obtaining health care - i.e., to allow them to seek needed care without the risks of financial catastrophe and impoverishment. Hence, the main guiding principle here is to strengthen the national health financing system so as to

[48] *The World Health Report 2010*

provide required health services (promotive, preventive, curative and rehabilitative) and financial risk protection to an increasing proportion of the population, particularly the disadvantaged, till the universal coverage is attained. This principle is consistent with the World Health Assembly resolutions WHA 58.33 (2005) on *Sustainable health financing, universal coverage and social health insurance* and WHA 64.9 (2011) on *Sustainable health financing structures and universal coverage*. A well-developed health financing strategy is expected to initiate or accelerate the transition process towards universal coverage.

Operationally, the strategic approach in health financing means a movement towards comprehensive, inclusive and sustainable approach juxtaposed to *ad hoc*, reactive and selective approaches. It could also mean coherence of health financing strategy with other sector and sub-sector strategies having relevance to health and health financing.

4.2.1 Suitability

Suitability deals with the overall rationale of the strategy - i.e. whether the strategy would address the key issues underlined in the national health policy and the situation analysis. Questions to be considered here are - Does it make cultural, economic, epidemiological, political and social sense? Would it suit the existing skills and capabilities? Tools that can be used to evaluate suitability include ranking of strategic options and decision tree.

4.2.2 Feasibility

Feasibility is concerned with whether the resources (funding and people) required to implement the strategy are available, can be developed or obtained. Tools that can be used to evaluate feasibility include resource tracking, forecasting, resource deployment analysis and break-even analysis.

4.2.3 Acceptability

Acceptability is concerned with the satisfaction of the key stakeholders about the expected outcomes viz., the risk or probability of failure and the impact or consequences of the strategy on their health, health care access and financial risk protection. Tools that can be used to evaluate acceptability include what-if analysis and stakeholder mapping.

4.2.4 Links with other policies and strategies

Health financing is one of the essential building blocks of a national health system. A health financing strategy should be geared towards the development and strengthening of the entire health system and the attainment of its goals and objectives. Ideally, the design and implementation of a health financing strategy should be part of and link with the broader health sector strategy and fully integrated in the health reform process.

It is also important to link the development of a health financing strategy to a country's social protection policies and strategies. Such an approach could provide a platform for initiating an inclusive social dialogue with various stakeholders and for the harmonization of social and economic policies on health.

4.3 Common dilemmas concerning its scope

While initiating the process for the development of the national health financing strategy, several questions and dilemmas crop up concerning its scope. Some of the possible dilemmas are discussed here.

4.3.1 Wide or narrow view

The strategy could take a system wide view with an intersectoral dimension with an understanding that some health financing issues lie, at least partially, outside MoHP's purview but that it will need a proactive role in pushing through this agenda.

These issues include for example human resources, infrastructure development, etc. When taking this wide approach MoHP needs to include in the health financing strategy an action plan on how to tackle these issues - for example for HRH there needs to be a strategy for working with the other government ministries and departments (education, management of civil servants, etc) so that there is a strategy for financing the training for the right amount of people with the right skills to provide the needed services in the right places. This could involve also discussions on how the different government budget streams are used for financing the HRH effort and what is the part of the direct MoHP budget.

This wide approach would in a way be a "sector" approach where the health financing strategy covers all the issues related to the "health sector" but which sometimes are out of the MoHP's direct reach. From the strategy point of view this would mean that the strategy will become more comprehensive and it would need a larger contribution from other stakeholders (e.g. private and NGO sectors) for its effective implementation.

On the other hand, the "narrow" approach looks at things that could be managed within and by the MoHP. It could be that HRH for example is not absent here, but it would maybe be more focused on issues like costing the need for HRH (and not an actual plan on how to finance HRH development) or using HRH more efficiently. Conceptually this "narrow" view would be focused on health financing as a building block. In practice this would mean that the NHFS would be focused on the issues of how to provide accessible and affordable services in a framework where some of the determinants are given and not in (direct) reach of health financing as it can be approached by the MoHP.

The two approaches presented here, of course, do not have clear-cut boundaries. The "wide" approach is where all ministries of health should be aiming: a coherent financing plan that includes all the different building blocks. However, it is not at all sure that a health financing strategy that takes the larger view would have a bigger impact since it might actually create more blockage. In fact even though a MoHP general strategy and plan(s) would necessarily involve a sectoral view, a Health Financing Strategy could have a narrower view.

4.3.2 Operational document for the Ministry of Health?

It is ideal that the health financing strategy is developed by the MoHP jointly with the other relevant Ministries (e.g. Ministries of Finance, General Administration and Labour) and the National Planning Commission. However, it is possible that the MoHP may want to development a health financing strategy covering programmes and activities planned

under this Ministry. In such a case, the strategy could have a limited purpose of guiding the MoHP policies and activities. In the process, it helps governments analyze their health financing situations and identify specific actions to achieve universal coverage.

4.3.3 Short- or long-term strategy

Setting the optimal time limit for the strategy is crucial; it could be short or long. The time limit could coincide with the planning cycle and could include 2-3 plans. Alternatively, if it is designed to be altered during every plan, it needs to be appropriately aligned to the long-term national vision and goals.

4.3.4 Supply, demand or both?

Health sector is comprised of both supply and demand sides. The strategy could aim at addressing issues in the supply side, demand side or both depending on the national context and issues. Supply side strategies often focus on aspects such as resource mobilization and allocation, financial management, governance, efficiency, quality, purchasing, effectiveness and sustainability while demand side strategies address equity, ethics, service utilisation, financial risk protection and risk pooling aspects.

4.4 Strategy development stages

The UNIVERSAL architecture needs to be carefully employed in Nepal. The strategy will be effective if it is developed through a systematic consultative process involving key or all stakeholders as it brings all stakeholders together and tries to achieve some sort of a collective ownership for the effective implementation of the strategy. Such a process could be used to define the vision, goals and objectives, set priorities, develop strategies and build commitment.

There is no single blueprint for the successful strategy development. However, it is important to follow certain stages, based on the architecture, in order to come out with an effective, informed and inclusive strategy. The process is more or less similar to the one that is often followed while drafting the national policies. Development of an acceptable, inclusive, informed and implementable strategy consumes considerable time because strategic analyses, technical consultations, strategy drafting, and political approval take time. While it is usually the Ministry of Health, which is responsible for the development of the health financing strategy, participation of other relevant Ministries such as the Ministry of Finance is crucial. Also, the national dialogue needs to include other relevant actors. For this reason, temporary consultants hired for this purpose may not be the right persons to carry out this task although they could provide valuable technical inputs.

4.4.1 Stage-1: Organization and logistics

The essential first step is the establishment of the entities that will direct the process. The Ministry of Health and Population needs to set up two committees to steer the political and bureaucratic processes as well as to execute the technical work. The committees must be officially set up through the most appropriate channels - ministerial order, internal memorandum, etc. The official order must both designate the members of the committees and define, as clearly as possible, their mandate.

The steering committee, to be chaired by the Minister of Health and coordinated by the Health Secretary, could oversee the work and hold wider consultations to ensure collective ownership and state the national vision and goals for the technical/expert committee to follow; this committee could also be responsible for resource mobilization for the successful execution of the strategy. An indicative list of members is provided here. The steering committee could have the following composition:

Chair: Minister of Health and Population

Convener: Secretary, MoHP

Members: National Planning Commission, Ministries of Finance, General Administration, Labour and Gender and Social Welfare, NGO Representative or a national philanthropist,[49] DDC, Private health care provider, Insurance company, Public health care provider, Auditor General, External Development Partner and a Bank

The main function of this committee to state the national vision, set up and draw the terms of reference for the technical committee, supervision and monitoring of it and final approval of the draft strategy.

The technical/Expert committee, to be chaired by the Health Secretary, could lead the technical process covering the following tasks:

- Strategic analyses[50] including the situation analysis and the analytical work concerning the investigation of various health financing options, experiments and choices
- Organization of guided national consultations
    - Development of lead questions for this purpose
- Drafting and finalization of the strategy
- Development of the implementation plan - pathways, milestones and resource planning
- Implementation of various strategy elements
- Monitoring and evaluation of the implementation
- Strategic review, feedback, update and revision of the strategy (if needed)

In addition to national consultations, some feedback from the field through focus group discussions will be very useful. The committee could have the following composition:

Chair: Secretary, Ministry of Health and Population

Convener: MoHP (e.g. Planning and Budget making)

Members: Ministry of Finance (one each from Budget, Foreign Aid and Training), National Planning Commission, External Development Partner, Academic expert, Regional Health Director, Head of a Regional Health

---

[49] *If there is any big domestic donor who has concerns for the poor and the disadvantaged*

[50] *These could be undertaken by other agencies or institutions. But, it is necessary that this committee or its members coordinates and gets closely associated with the work.*

Training Centre, PHC Revitalisation Unit, Purchasing section, NGO, DDC and NHSSP

Of course, it is important to take into account their availability and suitability for the task. The members of the committee must be able to devote the necessary time to this task throughout the strategy development process. It should be borne in mind that the process will be very time-consuming and that they will have to carry out this task in addition to their normal duties. This also means that their supervisors are to be informed of the tasks assigned to their staffs, who are the members of the group.

4.4.2 Stage-2: Launching the process

Once the logistics are worked out, the steering committee could initiate the process of stating the national vision and goals through a high-level consultative process. Wider political consultations will make the process stable and sustainable.

The technical/expert committee, on the other hand, could carry out tasks given to it once the vision and goals are stated by the steering committee. The committee may require a brainstorming and training, if necessary, to make sure that every member is on the same page. It is quite possible that not all the members will be equally familiar with issues and challenges concerning health financing and the strategy development process. An orientation towards technical issues and the process could be a good starting point for the technical group; such a gathering could also be used to restate the vision and goals. The orientation could be provided by some political leaders and resource persons; it is important to understand the political priorities in addition to technical issues so as to design an appropriate strategy suiting the context. The next task for the technical group will be the preparation of a detailed work plan clearly outlining the roles and responsibilities with timeline. Consultants, development partners and domestic institutions could be involved to carry out a portion of the technical work. However, it is ideal if the actual drafting of the strategy is undertaken by the group. Strategic analyses and wider consultations are very important to arrive at a workable and sustainable strategy. It is also important to arrive at a consensus on 'what constitutes the core of the national health financing strategy in the country'.

Preparation of a technical note at the end of the brainstorming exercise outlining all actions, roles and responsibilities will be very useful in order to carry out the task smoothly. The note could be discussed and approved by the steering group so as to mobilize the highest level of support at the earliest. This is a worthwhile precaution to guard the group against any possible misconceptions and miscommunications in future; it also keeps the steering group informed. Some clarifications on the proposed actions and necessary funding could be sought from the steering group. Once it is approved, the technical note will become the terms of reference for the technical group.

4.4.3 Stage-3: Conduct of the technical work

The technical committee will then start the technical work as outlined in the terms of reference. Under the technical work, some fresh short-term studies may have to be undertaken if there are gaps in knowledge. Given the evidence and information gap in Nepal, it will not be possible to gather all the information and evidence required for designing the strategy in the short run and so, the committee may have to work with estimates and approximations wherever it is not possible to quickly gather actual data.

These approximations and estimates could be replaced by actual data as and when they are made available and the revised figures could be used while updating the strategy. Collection and analysis of background information and evidence help to appropriately contextualize the strategy.

Wider international, national and sub-national consultations are necessary to incorporate all relevant issues and options in the strategy. Domestic consultations, in particular, widen the ownership of the strategy and avoid any future controversies. They also help to arrive at acceptable approximations and estimates for variables for which actual figures are not easily available. The group could decide whom and how long to consult. Learning from domestic and international experience is important. Quick assessments of domestic options and experiments and international visits by the technical group will be useful to gather as much evidence as possible on various options so as to arrive at near-optimal choices; the visits could focus on technical aspects of different successful options and strategies followed in some comparable countries as well as the processes concerning the strategy development. Field visits are to be included in the agenda concerning the domestic and international trips. Presentations of the findings of these assessments and visits to a wider group of stakeholders and resource persons will be useful to sharpen the understanding of the group members and validate and triangulate the findings.

Preparation of the strategy document is a part, not the sum-total, of the strategy. While drafting the strategy, particularly when each member develops a specific part, it is necessary to maintain and verify internal consistency and alignment between different parts of the document. It is also important to carry out a SWOT analysis of choices outlined in the strategy from cultural, economic, geographic, political and social perspectives. Resource mobilization plan is also an essential component of the strategy; this requires detailed discussion with the Ministry of Finance, external development partners and domestic philanthropists, if any.

4.4.4 Stage-4: Finalization and approval

Finalization of the strategy requires another round of consultations with key stakeholders, particularly those who will be involved in the implementation, including financing, of the strategy. A retreat (say, for a week) outside the usual workplace of the stakeholders will go a long way in effectively finalizing the strategy. It is crucial to involve all the relevant stakeholders in this process. At the end of the retreat, it is expected that all the key stakeholders including the technical group members will be on the same page and in agreement with the strategy (process and content). Wider distribution of the strategy document to those persons and institutions (particularly those who were not invited to the retreat) seeking their comments and suggestions within a time limit will add value to the document. Separate workshops could be conducted to enhance the value. However, care should be taken not to re-draft the entire document at this stage, as it would nullify earlier consultations and efforts. At the same time, in the unlikely event of severe reservations and objections, re-drafting and redoing the process could be considered. Usually, it should not take too much time for the technical group to carry out changes in the document and the process based on suggestions during these rounds of consultations.

Political approval is an important step to be followed in the end so as to make the strategy a real one. The political approval could come in the form of a bill, presidential decree, parliament approval or cabinet approval. The initial move in this regard comes from the chair-person of the steering group once the group discusses and approves it. More often,

the steering group or technical group will have very little control over timeline beyond this point; in some cases, it may be a mere formality while in the case of some others it may take considerable time before it is finally approved. Wider consultations during the strategy development process may reduce the time delay at this stage, as it would have already generated wider ownership and acceptance. The steering group could consider a preface or foreword from the highest possible political head of the government (e.g. Prime Minister or President) after the strategy receives the final political approval.

4.4.5 Stage-5: Implementation and monitoring

Once the strategy receives political approval, it is ready for implementation. Preparation of an implementation strategy along with the strategy itself is a good strategy to be followed in order to reduce difficulties and delays in translating the strategy into a reality. The official nature and ownership of the strategy need to be clearly stated while implementing it. Faster implementation also depends on how quickly resources are made available for this purpose; an official launch of the strategy will also speed up the implementation. A campaign may also be organized to inform the general public; posting it in the web also announces it to wider public and to all those who are concerned with its implementation.

The implementation needs to be carefully planned so as to extract the desired outcomes. Constant monitoring, review and update are essential components of successful implementation. Separate monitoring bodies could be established for this purpose because successful monitoring requires responsibility to be fixed; it is not enough to make provision in the document and non one is made responsible for it. The technical committee could remain in place till the monitoring body is established and it could be dissolved once such a body is established. It is also possible that some or many technical group members get nominated to the monitoring body.

4.5 Relevant activities already carried out by the MoHP

The MoHP has already embarked on strategic and policy level discourses to further the effort in health financing and social health protection. Within the spirit of the Sector Wide Approach (SWAp), the External Development Partners (EDPs) are committed to support the government's endeavour to draft a comprehensive health financing strategy and to design a fairly-financed social health protection system. A number of workshops during 2009-2011 set the climate to move forward with the social health protection agenda and provided initial thoughts on the health financing policy reform. Several policy options ranging from improving the current system by efficiency gains to establishing a national insurance scheme have been developed and discussed (MoHP and GIZ, 2010). A workshop in 2009 in Dhulikel and Pokhara introduced the concept of social health protection. The National Planning Commission, with the active participation of MoHP, developed a social health protection framework in 2010 followed by a joint MoHP-GIZ mission for the development of social health protection options. The World Bank Regional Workshop in 2010 developed the terms of reference for the health financing strategy development. The workshop on health financing and social health protection held in March 2011 by the Technical Working Group on Health Care Financing highlighted key health financing challenges and provided some guidelines for the development of the national health financing system to achieve social health protection. It also came out with the following recommendations:

- Setup a core team to draft the health financing strategy and implementation plan for social health protection
- Assess information gaps through further studies in areas such as fiscal space, costing of benefit packages, household survey to study the distribution and purpose of out-of-pocket payments among the population, and assessment of community based health insurances in Nepal.
- Improve the current system and work towards establishing Social Health Protection Centre under MoHP to progressively:

    - Consolidate existing social health protection programmes under a single management and administration
    - Let the proposed Social Health Protection Centre work as a fund holder and introduce strategic purchasing
    - Develop capacities and ascertain continuous capacity enhancement in the areas of health financing, financial management, actuarial, auditing, etc.

This background paper builds on the works already carried out in this area.

4.6 Situation analysis

The situation analysis should focus on the two components of universal coverage from a financing perspective: access to needed services and financial risk protection. It would identify who is covered from pooled funds, for what services and for what proportion of cost, showing the gap between what is currently being achieved and what the country would like to achieve. In planning for the future, the situation analysis needs to consider factors inside and outside the health system that may affect progress on the path to universal coverage and social health protection.

Although broader health financing issues and challenges are fairly known in Nepal, their deeper understanding needs to be established. Situation analysis needs to be structured well so that it could adequately inform the strategy development process. Following components could be included in the situation analysis:

- Status of health financing in Nepal – e.g. distance to travel to reach universal coverage and social health protection
- Issues and challenges – e.g. access and utilisation gap, resource gap, efficiency issues, system development
- Functioning of different health financing sources – government, community and household resources
- Alternative health financing mechanisms - existing and future options
- Possible future financing scenarios - expected increase in coverage and associated costs, potential constraints, risks and strategies to overcome them

The key point is the inclusion of all health financing sources, not only government sources, in the analysis. For example, efficiency analysis is equally applicable to out-of-pocket spending as well as the government spending. Similarly, if philanthropic resources are spent inefficiently, it is a loss to the health economy, particularly when resources are scarce. Government needs to streamline all resources, not only government resources.

Similarly, it is necessary to take into account alternative financing mechanisms such as the cooperatives, which finance health to a very limited extent. It is necessary to take stock of all these developments and devise an appropriate strategy to effectively use them for the betterment of health.

4.6.1 Completed analytical works

In Nepal, although there still gaps, some analytical works have already been completed in the following areas:

- Access barriers to health services (GIZ)
- An evaluation of the Aama programme (NHSSP)
- Fiscal space (The World Bank)
- Public expenditure review (The World Bank)
- Review of the Government Health Financing System (GIZ)

This paper synthesizes their main results to some extent besides outlining the process and content of the national health financing strategy.

4.6.2 Ongoing studies

In addition to the above completed analytical works, some others are ongoing; the following are some of the relevant ongoing studies:

- Review of Community Based Health Insurance schemes (GIZ)
- Benefit Incidence Analysis (NHSSP)
- Facility survey (NHSSP) and
- Service provision survey (USAID)

These studies will be completed soon and their results could be used in the strategy development process. There are also numerous other documents relevant fort his purpose and could be used as well. In short, there are evidence gaps, but there already exist some analytical works that could guide the strategy development process.

4.7 Development of the vision and framework

The enormous nature of the problem and the combination of lack of access, out-of-pocket payments, especially by the poor, inefficiency and inequity in spending and inadequate funding levels for the public sector justifies a revisit of the national health financing system in the country. The Health Sector Programme 2010-2015 (NHSP-2) recognized this when it placed greater emphasis on development of the national health financing strategy (by 2012). The strategy prepared now should be able to re-position the national health system so as to take Nepal closer to the achievement of universal coverage.

Establishing a health financing vision for the future, based on an understanding of the present, is crucial because the path to universal coverage and social health protection to be chosen by Nepal will depend on the vision. The commitment to universal coverage and social health protection recognizes the objectives of reducing financial barriers to access and increasing and maintaining financial risk protection. While it may be argued that developing a vision during the time of uncertainty and instability may be faulty, it may be difficult to get a 'normal year' in a low-income country context. Moreover, the country could

plan for a 'constrained optimum', not an unconstrained one. Whatever may be the context, setting the vision is very important to drive the strategy development process in a desired direction.

The period of vision could be longer (say, 20 years) while the period of the strategy could be shorter (say, 8-10 years) with a clear plan to have another strategy during the vision period. Millennium Development Goals are the best example for such a visionary approach. Another example for a vision is the Abuja Declaration when the African countries joined together to declare that 15% of the national budgets will be devoted for health. It helped many countries to raise the level of budgetary allocation for health. Due to this reason, average budgetary allocation to health is higher in African countries than the south Asian countries. Even if targets set are not achieved in time, setting of such goals help brining out more efforts and resources in that direction. Under the vision, a set of questions[51] as given in Box-2 could be asked to set the goals right.

Experience elsewhere shows that decentralization may suit provision of private goods, but not for providing services with externalities and information asymmetry (Varghese et al, 2007). At the same time, planning, budget making, some level of monitoring and sub-pooling of resources could happen at the decentralized level.

Putting the vision into a framework helps the fulfilment of the vision in a more organized manner. Thinking about a framework also helps in streamlining of actions in a desired way with specific direction. The framework also needs to be supported by clear operational guidelines so that the spirit behind the vision and the framework can be fully achieved. One important element of a framework is the assignment of roles and responsibilities of different institutions and actors.

4.8 Drafting the strategy

The strategy, based on scenario analyses and wider national consultations, is described in a document, which could include the following topics:

- Context, vision, mission and objectives
- Values guiding the strategy – equity, gender, ethics and rights
- System building for financing – relative roles and responsibilities of various mechanisms and actors
- Strategy for resource mobilization
- Arrangement for risk pooling
- Plan for resource allocation and purchasing of services and products
- Strategies for enhancing equity and efficiency

Strategy formation is context-specific and therefore, statement of the context is very important. Similarly, health financing strategy should be guided by certain value principles stated through national consultation. Resource mobilization strategy will be a key sub-component of the strategy. For instance, there could be newer types of resources, which were not in the radar of the policy making. The best example in the Nepal context is cooperatives. There are numerous cooperatives spreading across the country probably

[51] *These are only examples. The group drafting the strategy could come out with the relevant set of questions for Nepal.*

Box-2

Guiding questions for setting the health financing vision

- Where does Nepal want to be in 20 years in terms of the health financing system?
- What could be the optimal level of total health spending in Nepal from all sources? What is the optimal share of GDP to be spent on health?
- What is the right public-private mix for health spending in Nepal?
- How to link different sources of health financing to produce an unified plan? How to prepare an integrated programme budget linking all sources of financing including budget flows from different Ministries? What purchasing mechanism suits Nepal best to efficiently utilise all health care resources available from different sources?
- What could be the optimal budgetary share for health in Nepal? Is Abuja target (15% budgetary share for health) achievable in Nepal? How to get there?
- What could be the mechanisms for pooling risks and resources - insurance, tax and other non-insurance mechanisms?
- What is the acceptable level of out-of-pocket spending - 0%, 10%, 20%, 30% or 40%? How to achieve the number - i.e. how to convert at least 60%, 70%, 80% or 90% of OOP into prepaid resources? What are the prepayment mechanisms to be considered to make OOP predictable, accountable and sustainable?
- CBHI and free care - how are they linked? Does CBHI add value? Or does it duplicate free care?
- How to achieve equity in health financing so that contributions are made according to ability to pay and service utilization is according to health care needs?
- How much care will be directly provided by the public sector? How much will be purchased from the (for-profit or not-for-profit) private sector? What are the financing options to purchase care from the private sector? Will there be any set of services (e.g. cosmetic surgery except in the case of accidents) that will be left to the private sector?
- How to link the poor with the private sector - through purchasing/contracting, philanthropy or both?
- How decentralized will be the management and control of government and private resources? What is the optimal (geographical) level of decentralization? How much decision should be allowed under decentralization?

might have already reached 70-80% of the population. But, their health contribution is neither accounted nor planned. It is also true for philanthropic resources; their size, distribution and nature are unknown. Purchasing is a crucial activity for the government,

particularly when it cannot reach government services to the entire sub-set of the population that is poor. It is an important activity both under insurance and tax-based systems; it is important under the banking-based activity too. Some options to be considered by the strategy for regular/routine actions are given in Box-3.

Box-3

Some strategic options for routine actions

- Work towards an optimal budget share (say, 15%).
  - Efforts should be made to achieve its 100% utilization.
- Starting the budget process one year in advance
- Policy dialogue - consultation (between government bureaucrats, health care managers and providers, NGOs, private investors, providers and philanthropists) on priorities and policy measures
- Budget allocation - clear plan of action with probable outcome, costing and financing
- Release of budget based on previous year's allocations.
  - Salary and other recurrent items could be released based on the previous year's budget.
- Offering policy suggestions every year.
  - The government may wish to include fresh policy pronouncements in the budget every year. They are likely to be converted into budget allocations the following year.
- Advice from external development partners could be structured well.
- Better communication with other Ministries and across various MoHP bodies
- Better utilization of in-country technical expertise (e.g. Nepal Health Economics Association) in evidence creation and policy making
- Performance appraisal
  - Benefit incidence
  - Fiscal space review
  - Efficiency analyses of both government and non-government health spending

It is difficult to say what would be an optimal budget share for Nepal. Internationally, the Abuja target suggests 15%; world average or low-income country average could be used as an yardstick as well. Alternatively, the Ministry of Finance could be provided with a 'menu card' of options matching different budgetary allocations. Outputs under each budget allocation option could be clearly specified so that the Ministry of Finance could immediately consider and provide a budgetary allocation matching the option that best describes national priorities. Similarly, national budgetary process follows a routine timeline and the MoHP cannot deviate from it. The suggestion to start the budget process early is applicable to the MoHP. Even while discussing the current year's budget, the

MoHP could keep an eye on the next year's budget and reflect those (future) desires in the policy pronouncements section of the current year.

4.8.1 Activities requiring immediate attention

The strategy could use a phased approach to gradually achieve the health financing vision, objectives and goals over a period of time. Of course, all these need to be reflected in the consecutive policy and budget pronouncements in a systematic manner. In this sense, some of the key health financing actions that are to be considered for immediate attention are given in Box-4.

Box-4

Health financing actions requiring immediate attention

- Setting short-term goals - What can be achieved in the short run (say, before the completion of the NHSP-2)?
- Clear definition of the basic health service package(s) and prioritization for its gradual implementation
  - Costing or actuarial analysis of the package(s)
  - A discussion and decision on who will provide what and how to provide medicines outside the essential list
- Plan for an inter-ministerial approach to social health protection
  - Consolidation/linking of various MoHP measures on SHP
- Development of a contracting policy
- Assessment of the investment needs for establishing an appropriate health insurance system.
  - How to make use of the wide spread banking/financial institutions? CBHIs could be linked with them.
  - Discussion and decision on issuance of multi-purpose smart cards to establish electronic data base (for health planning, disaster management and health financing)
- Capacity development
  - Further strengthening of HEFU
  - Small grants for student research on health economics, health systems and health policy
- Setting up of a Purchasing division for resource allocation and purchasing
  - Organigram and Human resource planning for this division
- Exploratory studies to find the potential of philanthropic and other hidden resources

Definition of basic minimum services requires immediate attention. This should be equally applicable to private provision of health care as well and modalities to make it happen need to be worked out. The list existing now is not well-defined and tends to include majority of health services; however, there is clarity in the number of medicines to be

provided at various levels of government health care institutions. Clear ranking of priorities in terms of diseases, services and social/economic/demographic groups needs to be developed and top priority items financed. Simultaneously, it is necessary to work towards financing and provision of other crucial services.

Taking advantage of the declaration of 2011-12 as the year of women and health, a national seminar could be organized to highlight health financing issues concerning women's health in Nepal. Few slogans could also be developed to draw attention of the media and the public about (financial) access barriers faced by women.

4.8.2 Activities requiring medium-to-long-term attention

Community strengthening is important for strengthening the demand side and to get communities involved in the decentralized management of financing and health service provision. Some efforts are in progress, but they need to be gradually scaled up. If there is an inclination towards starting health insurance through a bottom-up approach (using the consortium model) through the CBHI, community strengthening is all the more relevant. Development of the second national health policy is a timely move given the changed health system context and future possibilities. There is a need to work on the procurement efficiency concerning various health products (e.g. medicines) and equipments.

Partnership with non-state actors is a priority under the NHSP-2. It, however, requires clear planning. Guidelines need to be developed for partnership or contracting negotiations between the government, private/NGO providers, philanthropists (e.g. rotary club) and communities for effective purchasing of care for the poor and disadvantaged. The non-state sector could be involved in the following areas:

- Establishment of facilities in rural and under-served areas (with government incentives, where required)
- Adoption of government healthcare institutions to expand the services
- Providing philanthropic funding to under-performing public healthcare institutions (e.g. medicines bills of a centre could be paid up)
- Earmark a portion of facilities (e.g. staff time, diagnostics and medicines) and infrastructure (e.g. beds) to serve the poor
- Actively engaging it in policy dialogue to serve the poor better
- Contribution to minimize OOP and impoverishment through fair pricing and need-based treatment (e.g. arrive at a fair price list)

Solidarity mechanisms could be developed as a third option (in addition to increased government spending and public-private partnership) to promote cross-subsidy favouring the poor. Per capita health spending is low in Nepal and efforts should be made to enhance it to reach an optimal level. A human resource strategy to improve the MoHP capacity (quantity and quality) could be included within the health financing strategy.

External development partners could work towards providing the MoHP with a 3-5 year forward information on their planned support (Accra Commitment). Actual flow of external resources in 2007-08 was only 58% of the expected external funding in Nepal, with the proportion being higher for pool fund resources (Government of Nepal, 2010).

5 Concluding observations

Given the enormous task ahead of expanding and extending health services and financial risk protection for all, prudent and strategic planning is necessary to generate adequate financial, human and material resources and pool, allocate and utilise them efficiently; it requires inter-ministerial and multi-stakeholder coordination and actions. A universally acceptable strategic plan developed now could place the national health financing system in an orbit capable of taking the country closer to universal coverage and social health protection in future. For this to happen, it is important to prioritise national goals and line them up for gradual accomplishment over a period of time. This would be the main outcome of the national health financing strategy development process. This paper outlined major health financing issues, a few possible future health financing options and the process of developing a good and acceptable strategy.

6 Reference

Acharya SP. 2011. *Health financing and social health protection in Nepal: Status and next steps.* Kathmandu: Ministry of Health and Population, 12th June.

Adhikari SR. 2010. *Social health protection in Nepal: Progress and challenges*. Kathmandu: World Health Organization.

Borghi J, Ensor T, Neupane BD, Tiwari S. 2006. Financial implications of skilled attendance at delivery in Nepal. *Trop Med Int Health* **11**(2): 228-37.

Cashin C, Koettl J, Schnieder P. (2010), *Setting Incentives for Health Care Providers in Serbia*. Washington DC: World Bank.

Central Bureau of Statistics. (2011). Monitoring the situation of children and women: findings from the multiple indicator cluster survey 2010 in the mid- and far-western regions, Nepal. Kathmandu: Central Bureau of Statistics, Government of Nepal.

Moreno-Serra R, Wagstaff A. (2010), System-Wide Impacts of Hospital Payment Reform: Evidence from Central and Eastern Europe and Central Asia, *Journal of Health Economics* **29**: 585-602.

Ensor T, Clapham S, Prasai DP. 2009. What drives health policy formulation: insights from the Nepal maternity incentive scheme? *Health Policy* **90**(2-3): 247-53.

European Commission. 2005. *Institutional assessment and capacity development. Why, what and how?* Brussels: European Commission, Aid Delivery Methods Concept Paper.

External Development partners. 2011. *Health Financing and Social Health Protection: Options for Improvement in Nepal.* Kathmandu: Workshop on health financing and social health protection, Consolidated presentation by external development partners, 22 March.

Fernando NA. Low-income households' access to financial services: international experience, measures for improvement, and the future. Manila: Asian Development Bank.

GIZ. 2011. *Review of government health financing system in Nepal: Analysis and recommendations.* Kathmandu: German International Cooperation, Health Sector Support Programme.

GIZ. 2011a. *Update Nepal: Extending social health protection by improving health financing*. Kathmandu: German International Cooperation, Health Sector Support Programme.

GIZ. 2011b. *Review of Community based health insurance (CBHI) initiatives in Nepal.* Draft terms of reference. Kathmandu: German International Cooperation, Health Sector Support Programme.

GTZ. 2009. *Access barriers to health services in Nepal: **c**urrent thinking of policy planners*. Kathmandu: German Technical Cooperation, Health Sector Support Programme.

GTZ-ILO-WHO. 2008. *GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries*. Geneva: World Health Organization, Conference on "Assuring Quality Health Care through Social Health Protection: The role of strategic purchasing and quality management", Kigali, Rwanda, Synthesis report.

GTZ. 2003. *Capacity development.* GTZ Policy Paper No.1.

Government of Nepal. 2010. *Nepal health sector programme - implementation plan II (NHSP - IP2): 2010-2015*. Kathmandu: Government of Nepal, Ministry of Health and Population.

Government of Nepal and UNAIDS. 2008. *Nepal: National AIDS spending assessment report 2007.* Kathmandu: Government of Nepal, HIV/AIDS and STI Control Board and UNAIDS.

Government of Nepal and WHO. 2002. *National seminar on health and poverty reduction in Nepal*. Kathmandu: Ministry of Health and WHO Regional Office for South East Asia, 14-15 February.

Government of Nepal and WHO. 2000. *Elements of essential health care services: main interventions or programme components.* Kathmandu: Ministry of Health and WHO.

Government of Uganda and WHO. 2011. *Uganda health financing review 2009-2010*. Kampala: Ministry of Health.

Hanvoravongchai P. 2002. *Medical Savings Accounts: Lessons Learned from Limited International Experience.* Geneva: World Health Organization, Department of Health Systems Financing, Discussion Paper No. 3.

HSRSP and RTI. 2010. *Health care financing in Nepal.* Kathmandu: Government of Nepal, Ministry of Health and Population.

Hsu J. 2010. *Medical Savings Accounts: What is at risk?* Geneva: World Health Organization, Background Paper to the World Health Report 2010, No.17.

ILO. 2007. *Social health protection: an ILO strategy towards universal access to health care.* Geneva: Social Security Department, Global campaign on social security and coverage for all, A consultation.

Institute of Policy Studies. 2004. *Better reproductive health for poor women in south Asia: review of costs and financing of reproductive health services.* Colombo: Institute of Policy Studies, Report prepared for the South Asia Health, Nutrition and Population Unit of the World Bank.

IRDA. 2010. *Annual report 2009-10*. Hyderabad: Insurance Regulatory and Development Authority.

Kutzin J. 2000. A descriptive framework for country-level analysis of health care financing. *Health Policy* **56**: 171-204

Mayes R. 2004. *Universal coverage: the elusive quest for national health insurance*. Ann Arbor: The University of Michigan Press.

Ministry of Health and Population and External Development Partners. 2009. *Nepal health development partnership.* Kathmandu: Government of Nepal, Ministry of Health and Population and External Development Partners, International Health Partnership National 'Compact'.

Ministry of Health and Population and GIZ. 2010. *Nepal at the Crossroads: Setting the Stage for Improved Social Health Protection.* Kathmandu: Ministry of Health and Population and GIZ Health Sector Support Programme.

MITRA Samaj. 2010. *Study to track the inflow of resources for the HIV/AIDS programme in Nepal.* Kathmandu: MITRA Samaj, HIV/AIDS and STI Control Board.

Morris GP, Beck SA, Hanlon P, Robertson R. 2006. Getting strategic about the environment and health. *Public Health* **120:** 889–907.

National Steering Committee on Social Protection. 2011. *National framework for social protection (2067-2077).* Kathmandu: Government of Nepal, National Planning Commission.

Nepal Health Economics Association. 2009. *Health financing and expenditure review (Based on a WHO template).* Kathmandu: Nepal Health Economics Association.

Nepal Health Economics Association. 2009a. *Monitoring the health impact of the financial crises: A study on the impact of the crises on the health budget, particularly from remittance.* Kathmandu: Nepal Health Economics Association.

Nollet J, Ponce S, Campbell M. 2005. About ‘‘strategy’’ and ‘‘strategies’’ in supply management. *Journal of Purchasing & Supply Management* **11**: 129–140.

Pande BR. 2005. *Nepal: Government doctors' survey 2005.* Kathmandu: Nepal Health Economics Association.

Pande BR, Shrestha BR. 2010. *Improving comparability and availability of private health expenditure data in health accounts in the Asia-Pacific Region - Country case study: Nepal.* Kathmandu: Nepal Health Economics Association.

Pande BR, Shrestha BR. 2007. *Financing health promotion in Nepal: A case study.* Kathmandu: Nepal Health Economics Association.

Prakongsai P, Patcharanarumol W, Tangcharoensathien V. 2008. Can earmarking mobilize and sustain resources to the health sector? *Bulletin of the World Health Organization*, **86(11)**: 898-901.

PCDRC. *Public opinion survey on health care services and health inequalities in Nepal.* Kathmandu: People-Centered Development and Research Centre (PCDRC),

Report submitted to Nepal Health Economics and Association, Kathmandu and Institute for Policy Studies, Colombo.

Powell-Jackson T, Tiwari S, Neupane BD, Singh M. 2010. *An early evaluation of the Aama 'free delivery care' programme.* A study report submitted to the Department for International Development (DFID).

RTI International. 2010*. Assessment of health system performance in Nepal.* Kathmandu: RTI International and Health Sector Reform Support Programme. HSRSP Report No. 2.20-5-10.

RTI International. 2010a*. Health care financing in Nepal.* Kathmandu: RTI International and Health Sector Reform Support Programme, HSRSP Report No. 2.21-5-10.

Stenberg K, Elovainio R, Chisholm D, Fuhr D, Perucic AM, Rekve D, Yurekli A. 2010. *Responding to the challenge of resource mobilization mechanisms for raising additional domestic resources for health.* Geneva: World Health Organization, World Health Report 2010 Background Paper No. 13.

Technical Working Group on Health Financing. 2011. *Summary of the workshop on health financing and social health protection.* Kathmandu, 22 March.

Torres LV. *Government health financing review - Developing the purchasing function of the government as cornerstone of the reform: some proposals.* Kathmandu: German International Cooperation (GIZ).

UNAIDS. 2010. *Joint UN programme of support on AIDS - Nepal: 2010-2012*. Kathmandu: UNAIDS.

UNDP. 2010. *Human development report 2010: the real wealth of nations – pathways to human development.* New York: United Nations Development Programme.

UNDP. 2009. *Nepal human development report 2009: state transformation and human development.* Kathmandu: United Nations Development Programme.

United Nations Country Team. 2009. *United Nations development assistance framework for Nepal (2008-2012).* Kathmandu: United Nations Country Team.

Varatharajan D, Sinha SR, Evans DB, Carrin G. 2010. *Shaping national health financing systems: can micro-banking contribute?* Geneva: World Health Organization, Background Paper to the World Health Report 2010, No. 22.

Varatharajan D, Muralikannan M, Gopalan SS, Jayalakshmi S, Clare SA, Shivalingiah M, Sarma PS. 2010a. *Lessons learned from a community-based medisave experiment among rural women in the Indian state of Karnataka*. Geneva: World Health Organization, Background Paper to the World Health Report 2010a, No.1.

Varghese J, Varatharajan D, Thankappan KR. 2007. Local factors influencing resource allocation to health under the Decentralised Planning Process in Kerala. *Journal of Health and Development*; **3 (1 & 2):** 217-26.

Verhey B. 2010. *Towards developing a national framework on social protection in Nepal.* Kathmandu: UNICEF

Wagstaff A. 2010. *What's the "universal health coverage" push really about?* Washington DC: Let's Talk Development, blog.worlgbank.org

WHO. 2011. *World Health Statistics 2011*. Geneva: World Health Organization.

WHO. 2011a. *National health financing strategy for universal coverage: principles, process and content.* Geneva: Department of Health Systems Financing, a draft guide for national policy makers (draft dated 25th August 2011).

WHO. 2010. *World Health Report 2010: Health systems financing - the path to universal coverage*. Geneva: World Health Organization.

WHO. 2008. *The World Health Report: Primary health care - Now more than ever*. Geneva: World Health Organization.

WHO. 2007. WHO Country cooperation strategy 2006-2011: Nepal. Kathmandu: WHO Country Office for Nepal.

WHO. 2004. *Regional macroeconomics and health framework*. New Delhi: WHO Regional Office for South East Asia,

WHO. 2003. *Macroeconomics and health*, New Delhi: WHO Regional Office for South East Asia, Report of a Regional Consultation, 18-19 August.

World Bank. 2011. *Assessing fiscal space for health in Nepal.* Washington DC: The World Bank, South Asia Region, Health, Nutrition and Population Unit

World Bank. 2010. *Nepal public expenditure review.* Washington DC: The World Bank, South Asia Region, Poverty Reduction and Management Unit, Report No. 55388-NP

7 Annex

Institutions visited

1. Dhading District Hospital
2. Dhading District Health Office
3. Gajuri Primary Healthcare Centre
4. Hemja Sub-Health Post
5. Kaski District Public Health Office
6. Naubise Health post
7. Regional Health Training Centre, Western Region
8. Regional Directorate, Western Region
9. Sanchaya Multipurpose Cooperative Limited (Pokhara)

Annex Figure-1

Attainment of universal coverage in Nepal