



Universal Health Coverage Assessment

Nepal

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Global Network for Health Equity (GNHE)

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Introduction

This document provides a preliminary assessment of the Nepalese health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Nepal.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Nepal and identifies the main sources of health financing (Table 1).² In 2012, total health expenditure accounted for 5.5% of the country's Gross Domestic Product (GDP), an amount that was close to the average of 5% for other low-income countries but well below the global average of 9.2%.

Public allocations to fund the health sector were around 10% of total government expenditure. This was higher than the average of 8.7% for other low-income countries and demonstrates government commitment to funding the health sector. However, it was still well below the 15% target set by the Organisation for African Unity's 2001

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Nepal (2012)

| Indicators of the level of health care expenditure | |
|--|-------|
| 1. Total expenditure on health as % of GDP | 5.5% |
| 2. General government expenditure on health as % of GDP | 2.2% |
| 3. General government expenditure on health as % of total government expenditure | 10.4% |
| 4a. Per capita government expenditure on health at average exchange rate (US\$) | 14.2 |
| 4b. Per capita government expenditure on health (PPP \$) | 31.6 |
| Indicators of the source of funds for health care | |
| 5. General government expenditure on health as % of total expenditure on health* | 39.5% |
| 6. Private expenditure on health as % of total expenditure on health** | 60.5% |
| 7. External resources for health as % of total expenditure on health# | 18.5% |
| 8. Out-of-pocket expenditure on health as % of total expenditure on health | 49.2% |
| 9. Out-of-pocket expenditure on health as % of GDP | 2.7% |
| 10. Private prepaid plans on health as % of total expenditure on health | 0.0% |

*This includes external resources that flow through government.

**This includes external resources that flow through NGOs.

Some external resources flow through government and some through NGOs. Indicators 5 and 6 therefore add up to 100% whereas indicator 7 in this Table is a separate indicator altogether. This is different from Figure 1 where donor funds are distinguished from tax-based financing.

Source: Data drawn from World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en)

²The data quoted in this section all derive from the World Health Organisation's Global Health Expenditure Database (<http://apps.who.int/nha/database/Home/Index/en>). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country's income category is determined from the World Bank's classification for the same year (<http://data.worldbank.org/about/country-and-lending-groups>).

Abuja Declaration (which, coincidentally, was the same as the global average for 2012).

In fact, government health expenditure translated into only 2.2% of GDP. While this amount was slightly higher than the low-income country average for that year of 1.9%, it was low for what is essentially the mandatory pre-paid component of a health financing system. The global average, for example, was 5.3%. A good sign, though, is that the 2012 percentage was considerably higher than a decade ago, when the figure was around 1.5% (Ministry of Health and Population 2011).

In 2012, per capita government expenditure on health was around \$32 (in terms of purchasing power parity), higher than the low-income country average of \$25 but twenty times less than the global average of \$652.

Nepal was reliant on donor financing which accounted for almost a fifth (19%) of total health sector expenditure in 2012. This was lower than the low-income country average of 28%. However, the country remains vulnerable to fluctuations in donor financing.

Out-of-pocket payments were the principal source of financing for health care (at almost half of total financing in 2012). This was around the low-income average but high in global terms (where the average was 21%). It was also well above the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010). Private health insurance was negligible in Nepal in 2012.

Structure of the health system according to health financing functions

Figure 1 provides a summary of the structure of the Nepalese health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.³

Revenue collection

The largest source of financing for health care in Nepal is out-of-pocket payments. Most private services are paid for out-of-pocket and a large portion of total out-of-pocket payments is made to private providers, which are utilised by both wealthier and poorer groups (Adhikari 2010).

In the public sector, essential health care services are now provided for free to everyone at primary health care centres, health posts and sub-health posts. Fees for hospital services are heavily subsidised by government for everyone. In fact, outpatient, inpatient, emergency services and listed essential medicines at district hospitals are provided free to priority population groups (namely, the poor, elderly, children, and other vulnerable people).

Figure 1: A function summary chart for Nepal (2012)

| | | | |
|--------------------|-----------------------------------|--------|-----------------------|
| Revenue collection | General taxation | Donors | Out-of-pocket |
| Pooling | Ministry of Health and Population | | No pooling |
| Purchasing | Other government | | Individual purchasing |
| Provision | Ministry of Health and Population | | Private providers |

Source: Created by the author using data from Table 1

³ The data quoted in this section are slightly different from the previous section because they are based on more detailed disaggregation by the authors of Nepal's 2012 National Health Accounts.

People targeted for fee exemptions are identified using various methods, such as identification cards, membership of specific caste and minority groups, or self-reported poverty. The government also provides a defined amount of money (or 'demand-side financing') to cover the cost of transportation to access certain services. This is intended to change consumers' behaviour and therefore increase utilisation of these services, specifically maternal care or treatment for communicable diseases, such as visceral leishmaniasis (Kala Azar).

With respect to general taxation, this is comprised of direct and indirect taxes. Direct taxes contributed 28 per cent of total general tax in 2012 (Ministry of Finance 2014). There is no mandatory health insurance in Nepal.

As mentioned earlier, almost a fifth of health financing in Nepal is provided by donors. Currently there are five major partners: the World Bank, the United Kingdom's Department for International Development (DFID), Australia's AusAID, the Health Systems Strengthening initiative of the Global Alliance for Vaccines and Immunisation (GAVI-HSS) and the German Development Bank (KfW). These make up almost two-thirds of total donor contributions to the health sector (Tiwari et al. 2011).

Pooling

Half of financing in Nepal is not pooled because it derives from out-of-pocket payments.

All publicly collected funds for health care are pooled nationally. These funds are allocated to geographic areas and different facilities on the basis of priority programmes identified by the National Planning Commission.

Since 2004, the health sector coordinates external resources via a sector-wide approach (SWAp). Nepal is also a member of the International Health Partnerships (IHP+) initiative, whereby donors commit to strengthening national health systems to achieve better health results around a single, country-led national health strategy. The Nepalese Ministry of Health and Population works closely and effectively with the donor community. All stakeholders plan and implement the single national health strategy, resulting in a single national work plan, a single set of targets and indicators that are entered into a single Health Management and Information System. This monitors health care from village level up to central government. Thus donor funds can be considered to be part of the public risk pool.

Purchasing

A package of essential health care services is provided at primary care level. This package includes preventive care, clinical services, basic inpatient services, delivery services, and listed essential medicines.

Both tax-funded and pooled donor financing is allocated through a documented process to the district level, where it is used to fund health programmes, especially those related to the Millennium Development Goals. Non-pooled donor funding is purchased directly by donors through contracts with NGOs and external consultants.

In general, Nepal does not practise strategic purchasing, whereby providers are incentivised to perform effectively and efficiently through reimbursement mechanisms such as capitation. Public services are generally funded on an historical basis, while private services are generally funded on a fee-for-service basis. This means there are few incentives for providers to perform efficiently. However, the Ministry of Health and Population is beginning to consider cost-effectiveness and impact evaluation methods that can inform the more efficient purchasing of essential services from providers.

Provision

Nepal has a plural provision system. Under the Ministry of Health and Population, the Department of Health Services is responsible for delivering preventive, promotive and curative health services throughout the country. The health system is structured as a network of hospitals, primary health care centres, health posts, sub-health posts and offices at different levels from the community up to central government.

The intention is that the majority of the population receive public health and minor treatment in places accessible to them and at a price they can afford. However, the distribution and quality of services is not adequate in all areas. The number of physicians, and nurses and midwives, per 1,000 population is very low, at 0.17 and 0.51 respectively in 2012 (Ministry of Finance 2014).

The private health sector is booming in Nepal, consuming around 60% of total health expenditure in 2012, and provides similar or complementary products and services (RTI International 2010). The private sector consists of private enterprises such as for-profit hospitals, nursing homes, clinics and medical suppliers, as well as non-governmental organizations. The private for-profit sector

dominates in providing curative care while most of the private not-for-profit sector provides preventive services. Government financing is not used to fund private provision, with the exception of some limited assistance to a few non-profit institutions and for some specific services. Some hospitals are engaged in public-private partnerships.

The public health system has adapted to the presence of the private sector and now acknowledges that private health care providers are complements to, rather than substitutes for, the public sector (Adhikari 2010). For example, the public sector focuses on providing health care services in rural areas whereas the private sector concentrates on urban areas. Public facilities provide outpatient care during the daytime whereas private clinics are open in the morning and evening.

Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights

into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Nepal and then moves on to assess the overall equity of the health financing system.

Catastrophic payment indicators

Using the 40% threshold of non-food consumption for assessing catastrophic payments, Table 2 shows that as much as 6.5% of the population incurred catastrophic spending in Nepal in 2003/04 as a result of accessing health care. However, it should be remembered that these figures are a decade old and levels of catastrophic expenditure may have diminished since the introduction of the government's free health care policy in 2006. Moreover, as Table 2 shows, catastrophic payments in Nepal affected wealthier households more, as revealed by a lower proportion for the weighted headcount compared to the un-weighted headcount. This suggests that some households that use private services are impoverished by the level of fees they have to pay.

Table 2: Catastrophic payment indicators for Nepal (2003/04)*

| | |
|--|--------|
| Catastrophic payment headcount index (the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold) | 6.49% |
| Weighted headcount index** | 5.93% |
| Catastrophic payment gap index (the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold) | 0.013% |
| Weighted catastrophic gap index** | 0.010% |

Notes:

* Financial catastrophe is defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food consumption.

** The weighted headcount and gap indicate whether it is the rich or poor households who mostly bear the burden of catastrophic payments. If the weighted index exceeds the un-weighted index, the burden of catastrophic payments falls more on poorer households.

Source: Adhikari (2011)

Table 3: Impoverishment indicators for Nepal (using \$1.25 poverty line (in terms of 2005 purchasing power parity)) (2003/04)

| | |
|---|-------|
| Pre-payment poverty headcount | 33% |
| Post-payment poverty headcount | 36% |
| Percentage point change in poverty headcount (pre- to post-payment) | 3% |
| Pre-payment normalised poverty gap | 8.63% |
| Post-payment normalised poverty gap | 9.67% |
| Percentage point change in poverty gap (pre- to post-payment) | 1.02% |

Source: Adhikari (2011)

However, a limitation of this method for estimating the level of financial protection is that it can understate the actual problem. This is because it may not capture the reality that there are people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003). This does appear to be the case in Nepal, as suggested by the utilisation patterns discussed below.

Impoverishment indicators

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Nepal, about 33% of the population lived below \$1.25 per day in 2003/04 (see Table 3). An extra 3% dropped into poverty as a result of paying out-of-pocket when accessing health services. This translated into as many as 800,000 people per year falling into poverty because of out-of-pocket expenditure on health care. Again, these data reflect the situation a decade ago.

Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A 'progressive' health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity is measured by the Kakwani index: a positive value for the index means that the mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive. Table 4 provides an overview of the distribution of the burden of financing in the Nepalese health system.

The Kakwani index for direct taxes in Nepal was strongly positive in 2003/04 (at 0.34), although direct taxes only make up a small proportion of total health financing.

Table 4: Incidence of different domestic financing mechanisms in Nepal (2003/04)

| Financing mechanism | Percentage share | Kakwani index |
|--|------------------|---------------|
| Direct taxes | 3.61 | 0.3433 |
| Personal income taxes | - | - |
| Corporate profit taxes | - | - |
| Total direct taxes | - | - |
| Indirect taxes | 13.39 | -0.0006 |
| VAT | - | - |
| Excise tax | - | - |
| Import tax | - | - |
| Total indirect taxes | - | - |
| Other taxes | - | - |
| Total public financing sources | - | - |
| Commercial voluntary health insurance | - | - |
| Out-of-pocket payments | 62.00 | 0.1141 |
| Total private financing sources | - | - |
| TOTAL FINANCING SOURCES | - | - |

Note: Estimates are based on per adult equivalent expenditures; - = data not available.
Source: Adhikari (2011)

Out-of-pocket payments in Nepal were positive (0.11), indicating that the rich spent proportionately more of their income paying out-of-pocket for health care. As out-of-pocket payments made up such a large proportion of total financing, this suggests that the Nepalese health financing system was progressive overall.

Equitable use of health services and access to needed care

This section considers how benefits from using different types of health services are distributed across socio-economic groups. The data in Figure 2 show clearly that poor people had worse access to doctors in 2003/04 than rich people. The data also show that more poor people consulted no health professional at all.

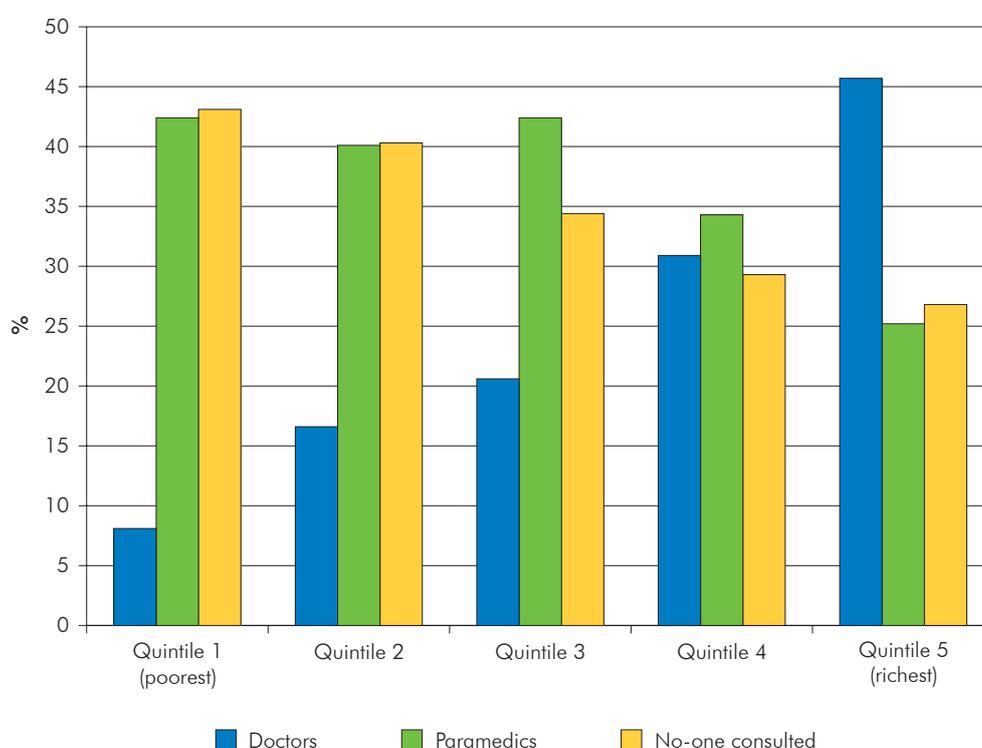
Another measure of utilisation by socioeconomic status is a concentration index, which shows the magnitude of socioeconomic-related inequality in the distribution of a variable. In Figure 3, if the concentration index has a positive (or negative) value, the distribution of the use of the health service is considered to benefit the richest (or poorest)

respectively. Figure 3 shows that the concentration index for non-hospital care in 2003/04 was close to zero, indicating that access was almost proportional. This was an improvement over the situation a decade earlier (in 1995/96), when both hospital and non-hospital care were more strongly pro-rich. Again, these data are quite old and it is not known whether, since then, the trend has improved further.

It is generally agreed that individuals' use of health services should be in line with their need for care. The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. The benefit incidence results discussed above do not allow one to draw a categorical conclusion about whether the distribution is equitable or not: the distribution of benefits first needs to be compared to the distribution of need for health care.

Such data on general need and utilisation are unfortunately not available for Nepal. However, Figure 4 shows that the lowest consumption quintile in Nepal accessed far fewer than the recommended four antenatal care visits than did the highest quintile, with six times as many women benefiting

Figure 2: Health care utilisation by consumption quintile in Nepal (2003/04)



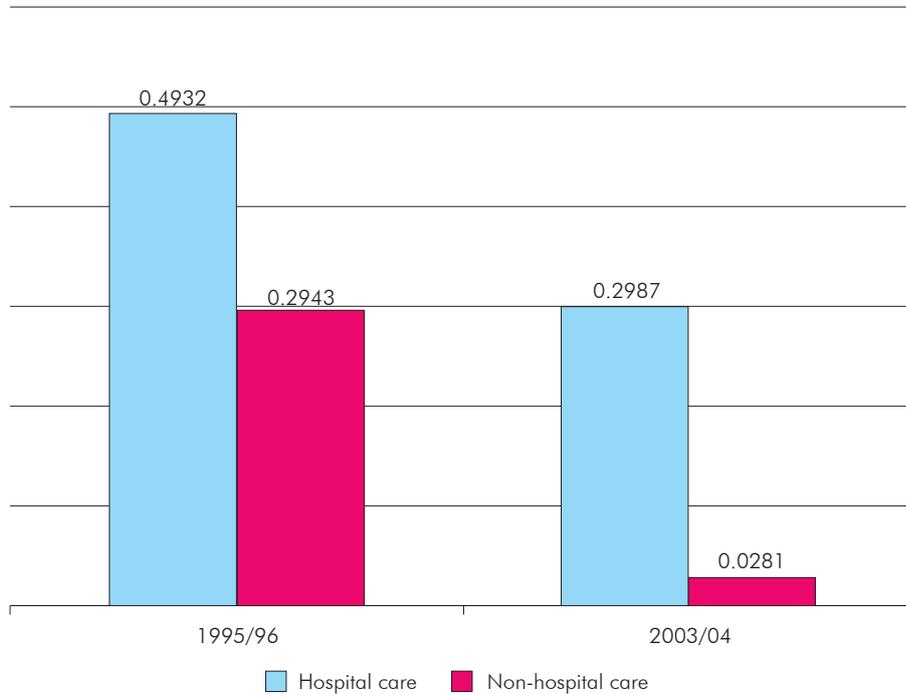
Source: Adhikari (2011)

in the highest quintile than the lowest. Poorer women would have been expected to have had a greater need for antenatal care, given the difficulties they face in meeting their daily basic requirements, such as food availability.

Conclusion

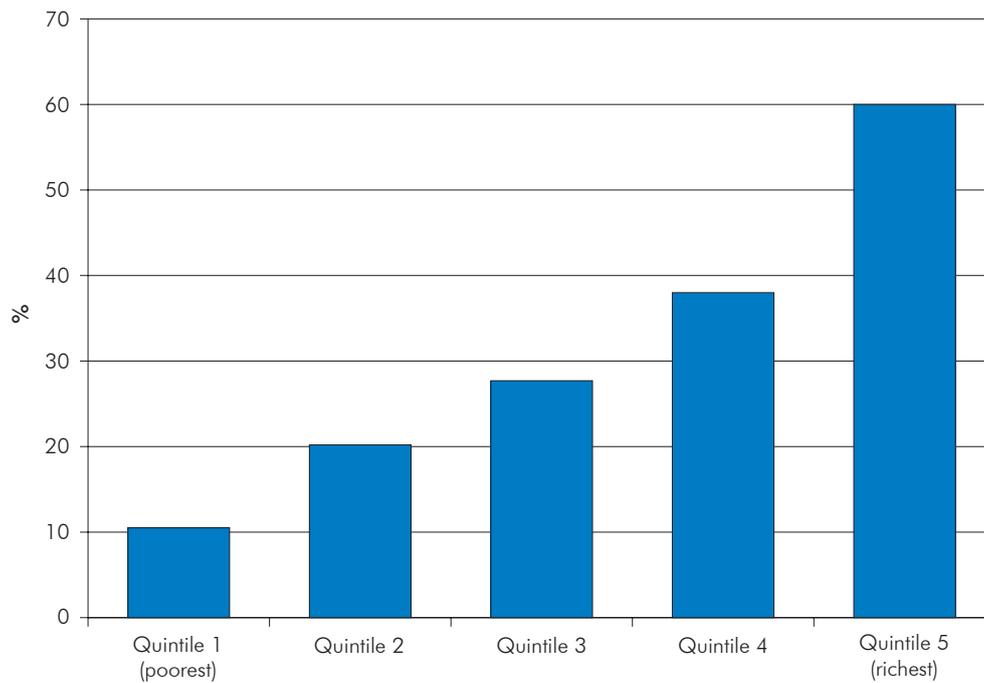
Nepal's health financing and expenditure indicators are slightly better than those of the average low-income

Figure 3: Concentration indexes for benefit incidence of health service use in Nepal (1995/96 and 2003/04)



Source: Adhikari (2011)

Figure 4: Percentage of mothers making 4 or more antenatal care visits, by wealth quintile, in Nepal (2006)



Source: RTI International (2008)

country, but out-of-pocket expenditure is still extremely high. This means that financial protection is not adequate for large numbers of people. Despite the provision of free essential services to the poor, geographic access to quality services is still pro-rich.

There is growing pressure on the government of Nepal to expand the benefits covered under the free essential health package, as well as to expand coverage to all Nepalese. There is also growing pressure to increase government expenditure on health and improve the efficiency of the health system. Proposals for new financing mechanisms, such as health insurance, are being debated.

Meeting these demands will be difficult for Nepal, given its low-income status. In relation to expanding the fiscal space for health, a first consideration is economic growth, as higher growth rates would broaden the tax base and increase government revenue, especially if tax administration could be improved as well. Unfortunately, in recent years real GDP growth has been quite low, at less than 5 per cent (World Bank 2011).

Another option for government is to expand its domestic borrowing although there are arguments that this could affect the economy. Increasing donor funding, or international loans, also does not seem a very viable option, given that Nepal already receives considerable funding from these sources.

From a macro-fiscal perspective, therefore, the prospects of finding additional public resources for health are relatively low, unless health can increase its share of the government budget. This could be difficult to argue for, as some consider that Nepal already spends a relatively large share of its budget on the health sector.

After analysing all these potential sources, a report produced by the World Bank suggested that the only realistic option for Nepal is improving the efficiency of existing health expenditure (World Bank 2011). However, more thinking may need to be done on how to increase tax-based financing – through widening the tax base, improving tax administration and earmarking certain taxes – given the remaining problems with financial protection and inequities in access in Nepal.

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GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

GNHE is coordinated by three institutions collaborating in this project, namely: the Mexican Health Foundation (FUNSALUD); the Health Economics Unit of the University of Cape Town in South Africa; and the Institute for Health Policy based in Sri Lanka.

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