Health Sector Support Programme Nepal
Social Inclusion and Fair Financing

gtz

GFA Consulting Group

A knowledge collage on social health protection in Nepal

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Introduction

German Development Cooperation commissioned the author of this report to contribute to social health protection in Nepal. One of the most self-evident first steps of such an endeavour is to screen

- the own (virtual) library compiled during long years of dedicated (re)search on areas like health protection, health financing, health systems research, etc.

- the internet according to various combinations of affiliated key words like “health financing”, “health insurance”, “social protection” in Nepal and

- the harvest of papers, presentations and publications available in the hands of partners in Nepal.

More than 470 electronic copies of such sources were compiled and looked into. A few of them contain interesting information in the context of social health protection in Nepal.

To benefit the whole team of partners dealing with social health protection the most interesting texts, graphs, tables are brought together in this volume. It is hoped that this volume will grow in the near future. More interesting articles could be discovered and their essences shared with all partners. Everybody is invited to contribute to this growing knowledge data bank which we dedicate to our very committed partners in Nepal.

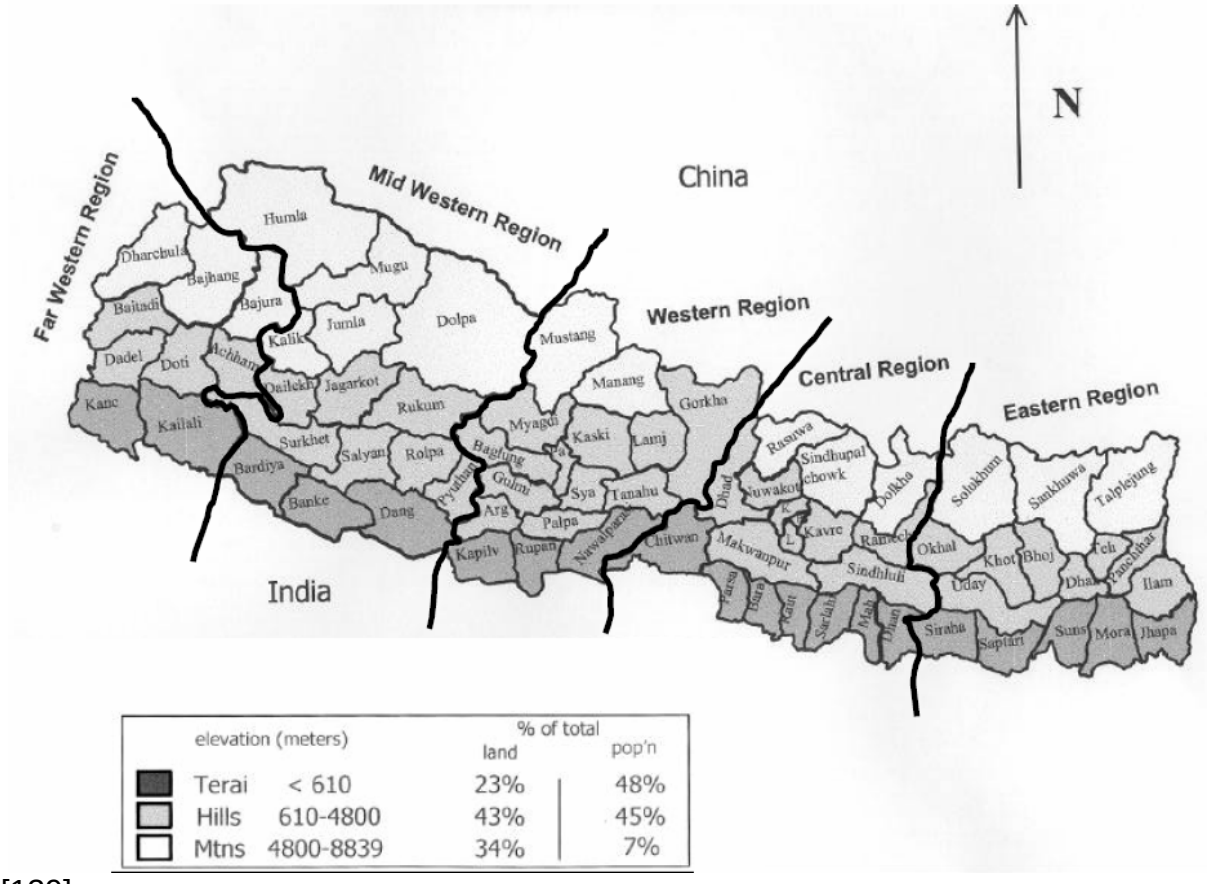
A “collage” is “an artistic composition made of various materials …, a creative work that resembles a composition in incorporating various materials or elements …, a hodgepodge <a collage of ideas>”.[1]

[1] Merriam Webster’s online dictionary at http://www.merriam-webster.com/dictionary/collage (19.05.09)

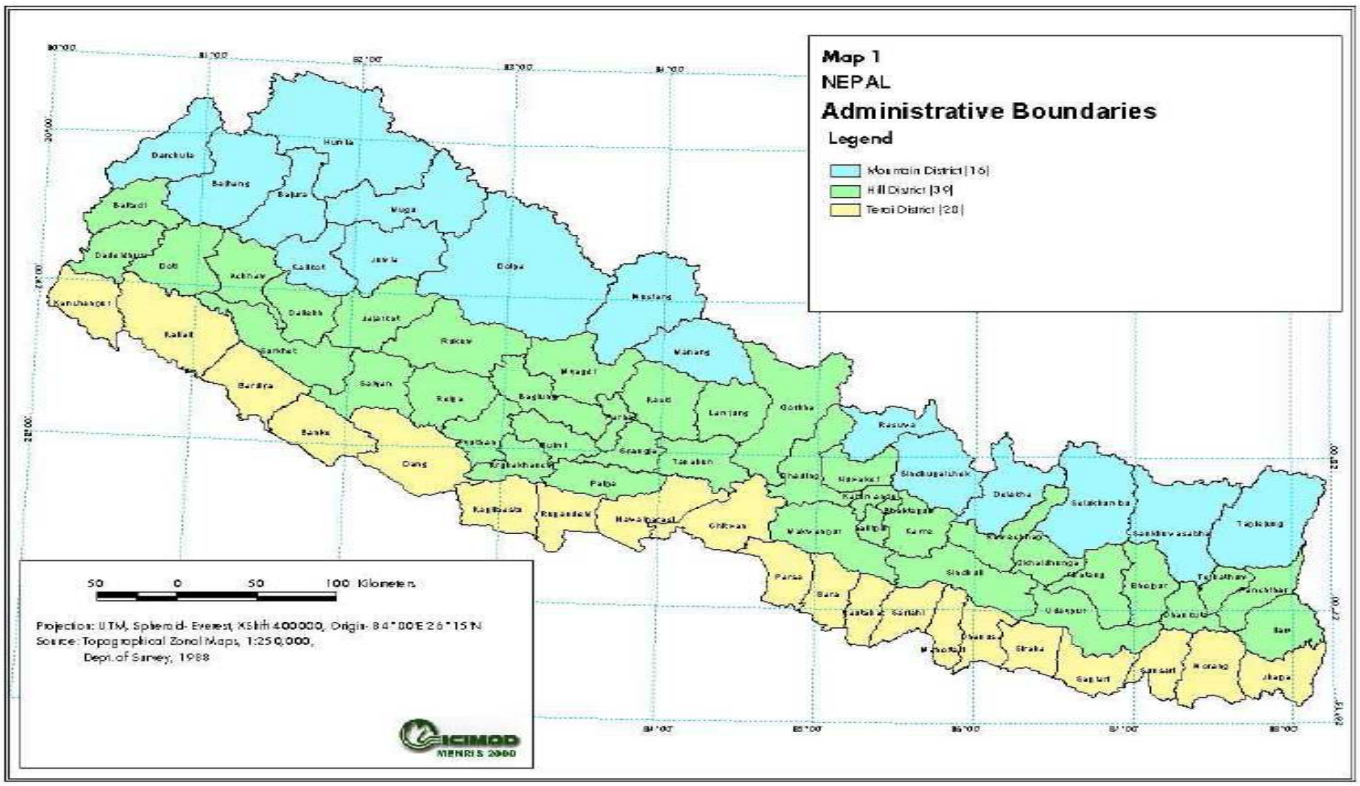
1 Background

1.1 Maps

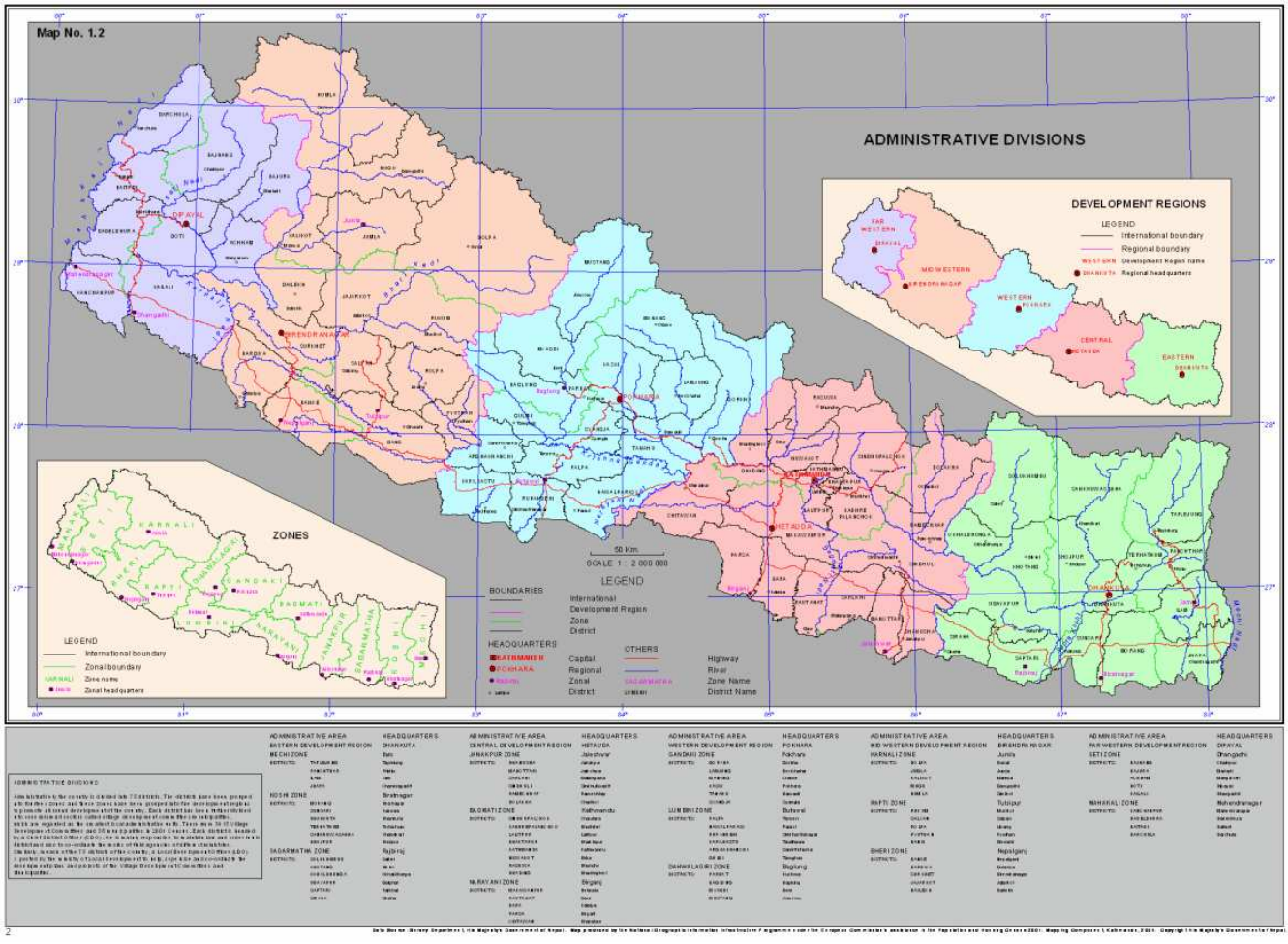
Source [101]



Source [139]



Source [105]



Source [CBS website]

1.2

Generalities

Table 1 Country background indicators, ranked by HDI rank, 2007

Indicators	Thailand	Sri Lanka	Indonesia	India	Nepal
HDI rank	78	99	107	128	142
Population 2015, million	66.8	20	251.6	1,302.50	32.8
TFR, birth per women 2000-05	1.8	2	2.4	3.1	3.7
GDP per capita US$	2,750	1,196	1,302	736	272
Adult literacy rate, % age >15	7.4	9.3	9.6	39	51.4
Underweight for age, % under age 5	18	29	28	47	48
Population living below $1 a day, %	<2	5.6	7.5	34.3	24.1
Health spending per capita, PPPUS$	293	163	118	91	71
Measles coverage, % children >1 year old	96	99	72	58	74
Birth attended by skilled health personnel, %	99	96	72	43	11
Physicians, per 100,000 population	37	55	13	60	21

Source: UNDP 2007 Human Development Report.

Source [9]

Table 3 Prevalence of selected risk factors in five selected countries

Risk factors	Gender	India	Indonesia	Nepal	Sri Lanka	Thailand
Smoking	Male	29.4	69	31.4	38	40.2
	Female	2.5	3		2	2.4
Adult (>15yr) per capita alcohol consumption, litres		0.29	0.09	0.19	0.28	5.59
high BMI (BW kg/ height m^2)	Male	16.8	9.7	8.8	8.9	27.9
	Female	15.2	22.7	8	5.9	35.2
Mean blood pressure(mm Hg)	Male	124.4	123.3	123.8	123.3	119.3
	Female	122.1	123.3	121.5	121.9	117.3
Mean blood cholesterol (mmol/l)	Male	5.1	4.5	4.7	5.5	5.1
	Female	5.2	4.5	4.7	5.4	5.3
Physical inactivity	Male	9.3	24.4	6.7	7.3	6.8
	Female	15.2	17.8	9.7	13.8	11.8

Data sources:

1) High BMI(($\geq$ 25 kg/m2), mean blood pressure(mm Hg), mean blood cholesterol (mmol/l) from: Ono T, Guthold R, Strong K. (2005). WHO Global Comparable Estimates. http://www.who.int/infobase : population age 15+
2) Physical inactivity
   India: 2003, subnational, age 18-69
   Indonesia: 2003, less than moderate physical activity, age 25-64
   Nepal: 2003, national, age 18-69
   Thailand: 2003, national, age15+
   Sri Lanka: 2003, national, age 18-69
3) Tobacco consumption
   India: 1999, national, all tobacco, age 15+
   Indonesia: 2001, all tobacco, age 15+
   Nepal: 2006, national, 15-49
   Sri Lanka: 2003, national, 18+
   Thailand: 2004, national, 11+
4) Alcohol consumption
   Source: Query online database retrieved from http://www.who.int/whosis/database/core/core_select_process.cfm, year 2003

Source [9]

Population distribution by religion, 2001	
Hindu	18.330.121
Bouddha	2.442.520
Islam	954.023
Kirat	818.106
Christian	101.976
Jain	4.108
Sikha	5.890
Bahai	1.211
Not stated	78.979
Sum	22.736.934
Source: Population Census 2001, Central Bureau of Statistics	

Source [CBS website]

Variable	Unit	Bangladesh	Indonesia	Mongolia	Nepal	Pakistan	Vietnam
Population	Million	134	214	2.5	23	149	80
Annual growth rate	% pa	1.6%	1.5%	1.8%	2.3%	2.5%	1.7%
Urbanisation	% population	23%	42%	58%	14%	34%	24%
Age Structure	% aged 0-14 years	39%	30%	23%	53%	44%	30%
GDP per capita *	$PPP	$1,720	$2,990	$1,650	$1,350	$1,940	$2,240
Government Expenditure	% of GDP	13%	15%	38%	19%	18%	38%
Agriculture	% of GDP	23%	15%	21%	39%	23%	23%
Employment Rate	Empl. as % of pop. Aged 15+	70%	60%	61%	84%	47%*	71%
Agricultural Employment	% of total employment	45%	na	47%	74%	42%	69%
Infant Mortality Rate	Per 1,000 live births	65	47	23	71	82	18
Life Expectancy at birth	Years	62	66	63.6	59%	61	na
Primary Schooling *	Completion Rate	70%	91%	82%	65%	59%	100%
Literacy	% 15 +years	48%	94%	98%	49%	42%	90%
Poverty (headcount)	% poor	34%	18%	36%	42%	32%	29%
Human Development Index **	Rank (out 0f 175 countries0	139	112	117	143	144	109
	Va;ue	0.502	0.682	0.661	0.499	0.499	0.688

Source: Country Reports except:

* World Bank, 2004, *World Development Report 2004 – Making Services Work for Poor People*, World Bank/ Oxford University Press, Washington

** United Nations Development Program, 2003, *Human Development Report 2003 – Millennium Development Goals: A Compact among Nations to End Human Poverty*, Oxford University Press.

Source [2]

1.3 Poverty

30,85% of population falls under poverty line according to the Nepal Living Standard Survey 2003/04. 1995/96: 41,76%

Source [428]

Table 23. Private consumption per capita and poverty rates in LDCs

Country	Year of latest household survey	Per capita consumption expenditure			Poverty rate			
					$1-a-day poverty line		$2-a-day poverty line	
		Survey	National accounts	Calibrated survey mean	New	World Bank	New	World Bank
		(1993 PPP dollars a day)			(Per cent of population)			
Bangladesh	2000	1.54	2.19	1.89	26.4	41.3	74.8	84.2
Benin	2003	1.96	2.76	2.21	24.0	30.8	65.8	73.0
Burkina Faso	2003	2.06	1.75	1.65	42.3	28.7	81.1	71.3
Burundi	1998	1.32	..	..	..	54.6	..	87.6
Cambodia	2004	1.19	..	..	..	66.0	..	89.8
Cape Verde	2001	7.29	7.84	5.16	8.6	1.9	32.3	19.0
Central African Republic	1993	1.35	2.45	2.04	52.7	66.6	73.9	84.0
Ethiopia	2000	1.83	0.86	1.14	60.6	21.6	94.0	76.6
Gambia	1998	3.04	2.98	2.33	38.6	27.9	65.6	55.9
Lao People's Dem. Republic	2002	1.90	..	..	..	27.4	..	74.2
Lesotho	1995	3.96	2.84	2.26	51.1	36.4	70.5	56.0
Madagascar	2001	1.32	2.44	2.03	41.6	61.0	71.4	85.1
Malawi	2004	2.36	2.00	1.79	36.8	20.8	77.6	63.0
Mali	2001	1.87	1.59	1.56	46.0	36.4	80.2	72.7
Mauritania	2000	2.23	1.26	1.37	51.5	25.9	85.1	63.1
Mozambique	2002	2.10	2.06	1.82	44.5	36.2	79.9	74.1
Nepal	2003	2.65	2.45	2.04	40.1	24.7	76.3	64.8

Source [86]

Table 30. Indicators of food security in LDCs

	Undernourished population	Food consumption	Change in per capita	Agricultural Production	Food aid	Food imports as % of:		
	%	Calories per capita/day	food consumption %	Instability Index[3]	% of total food imports	Total merchandise imports	Total merchandise exports	Food consumption
	2004	2002–2004	1995–1997 to 2002–2004	2004	2006	2006	2006	1996–2001
Net food importers and net importers of agricultural raw materials								
Angola	40	2 120	1.01	4.68	0.8	18.9	3.9	11.4
Bangladesh	30	2 200	0.97	3.47	2.2	14.3	18.3	7.8
Cape Verde	2.5	..	..	15.96	5.3	29.2	> 100	32.7
Comoros	62	1 770	-0.35	2.87	0.0	33.0	> 100	12.7
Djibouti	27	2 270	1.18	8.81	2.0	21.6	> 100	43.9
Eritrea	73	1 500	..	18.76	3.3	24.0	> 100	11.8
Gambia	27	2 240	0.23	18.42	7.2	31.2	> 100	38.1
Haiti	47	2 110	1.12	2.73	10.3	26.2	82.1	19.6
Kiribati	6	2 800	0.03	12.55	0.0	33.7	> 100	26.5
Maldives	11	2 600	0.64	4.00	1.1	16.0	> 100	31.0
Nepal	17	2 430	0.88	3.95	3.7	14.9	41.1	2.7

Source [86]

TABLE 4.2.1 POVERTY DISTRIBUTION

Ecological Zone	% Below the Poverty	% Intensity of Poverty	% Severity of Poverty
Mountain	56	18.5	8.2
Hill	41	13.6	6.1
Terai	42	9.9	3.4
Rural/urban			
Rural	23	7	2.8
Urban	44	12.5	5.1
Nepal	42	12.1	5

SOURCE: Poverty in South Asia, 2003

TABLE 4.2.2 POVERTY GAP

Health Status	Poorest	Richest
IMRU	96.3	63.9
5MR	156.3	82.7
Underweight<2z score	59	31.8
Health services:		
Immunization (all)	32.4	71.1
Medical treatment		
Diarrhea prevalence	32.2	20.7
Seen medically	9.5	18.3
Antenatal care (2+)	16.6	57.4
Delivery by HW	2.9	33.7

SOURCE: World Bank Analysis from 1996 Data

TABLE 4.2.3 THE URBAN-RURAL GAP

Item	Urban Rich	Rural Poorest	Rural Richest
Health status		96.5	71.7
IMRU5MR		156.8	90.5
Underweight <2z score	19.8	53.3	31.2
HNP services			
Immunization (all)	75.8	32.3	69
Medical treatment			
Diarrhea prevalence	20	32.3	21
Medically seen	14.2	9.6	20
Delivery by HW	71.7	16.6	51.2

SOURCE: World Bank Analysis from 1996 Data

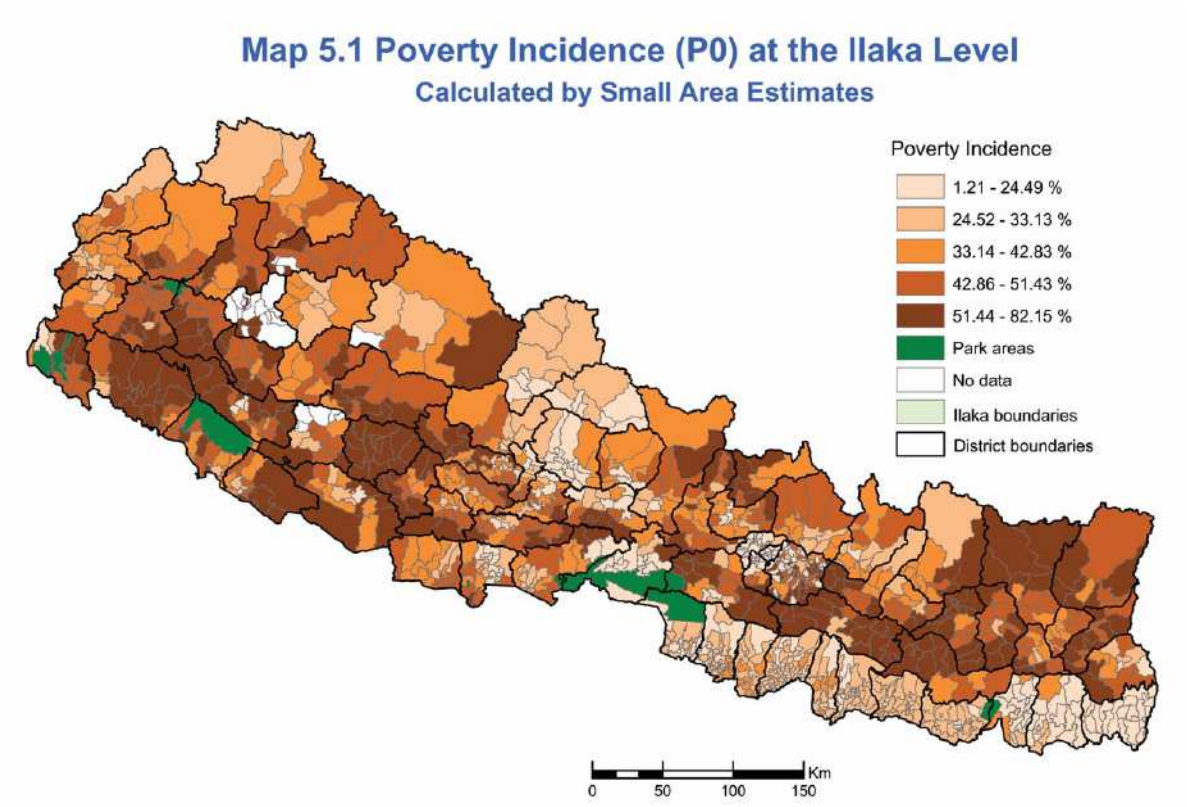
TABLE 4.2.4 THE GENDER GAP

No	Item	Male		Female	
		Poorest	Richest	Poorest	Richest
1	**Health status**				
	IMR	105	71.8	87.5	55.5
	Underweight <2z score	59.3	28.2	58.8	35.9
2	**Health services**				
	Immunization (all)	37.2	78.1	27.4	64.4
3	**Medical treatment**				
	Diarrhea (prevalence)	30.8	23.3	33.7	17.8
	Seen medically	9.7	11.6	5.6	12.9

SOURCE: World Bank Analysis from 1996 Data

Source [132]

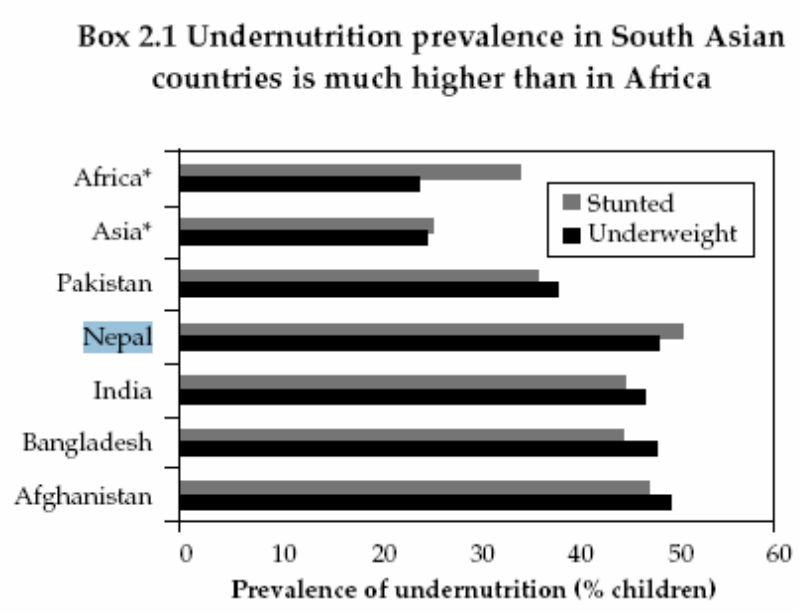
Poverty distribution in Nepal



Source [346]

1.4

Undernutrition



Source: De Onis and others (2004a); SCN (2004).
*Estimates are based on WHO regions.
Note: India, Bangladesh, Nepal, and Afghanistan have underweight rates that are similar to that of Ethiopia (see figure 2.12).

Source [196]

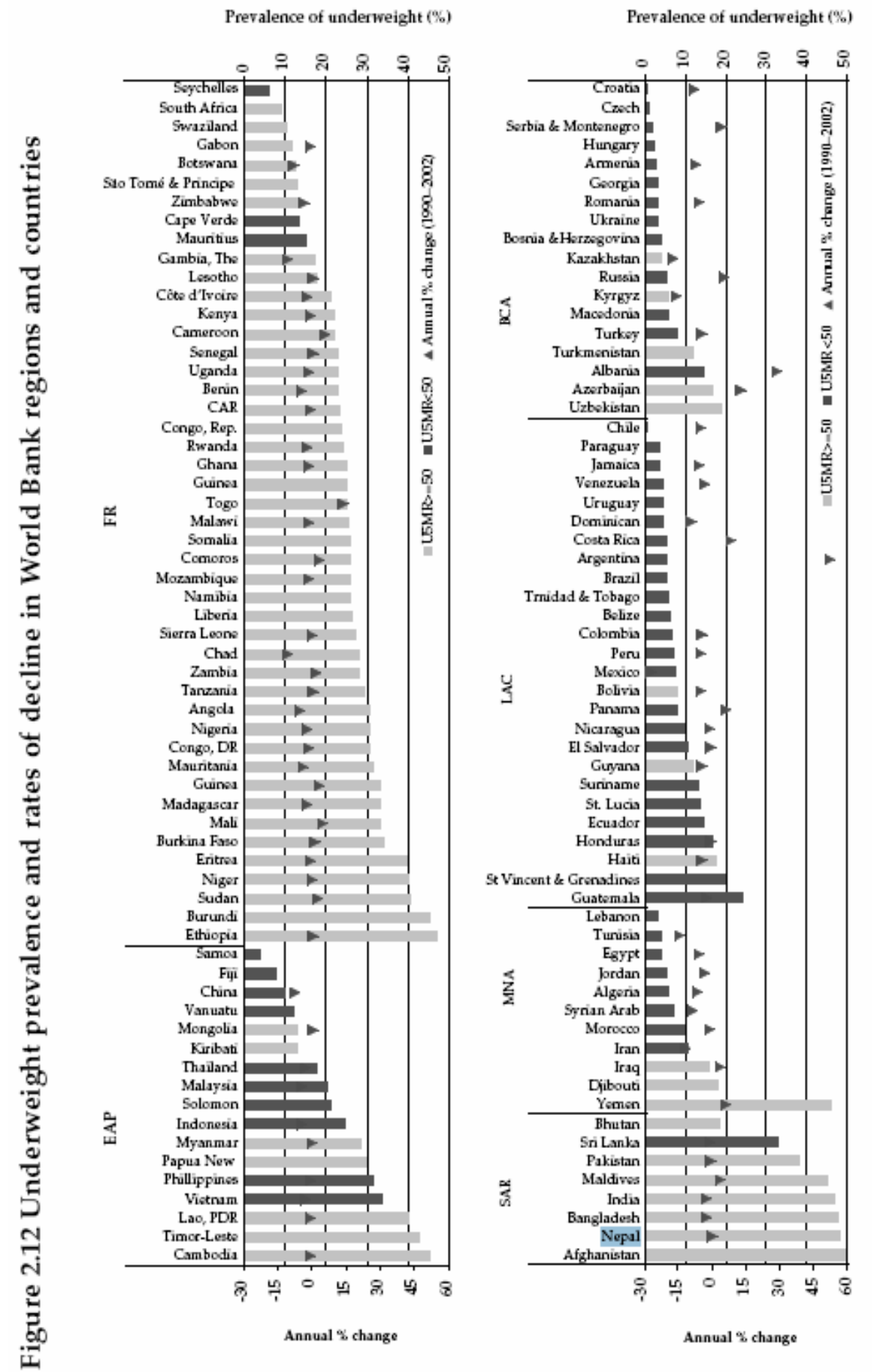


Figure 2.12 Underweight prevalence and rates of decline in World Bank regions and countries

Source [196]

1.5 Inequality

Table 28. Income inequality in LDCs, 2005
(Gini index)

Low inequality (Gini index < 30)		Medium inequality (40 < Gini index < 50)		High inequality (Gini index > 50)	
Burkina Faso	39.5	Madagascar	47.5	Sierra Leone	62.9
Mauritania	39.0	Mozambique	47.3	Central African Rep.	61.3
Malawi	39.0	Nepal	47.2	Lesotho	60.0
Benin[a]	36.5	Rwanda	46.8	Haiti	59.2
Chad	35.0	Uganda	45.7	Zambia	50.8
Lao People's Dem. Rep.[b]	34.6	Burundi	42.4	Cape Verde	50.5
United Rep. of Tanzania	34.6	Cambodia	41.7	Gambia	50.2
Togo	33.8	Niger	41.5		
Bangladesh	33.4	Senegal	41.3		
Yemen	33.4	Guinea	40.4		
Ethiopia	30.0	Angola	40.2		
		Mali	40.1		

Source: UNCTAD secretariat compilation based on data from World Bank, *World Development Indicators*, online, May 2008.

a Data for 2003.
b Data for 2002.

Source [86]

1.6 Employment

Table 4. Proportion of Informal workers in the labour force according to country, year range[1] and income (World Bank classification) among male.

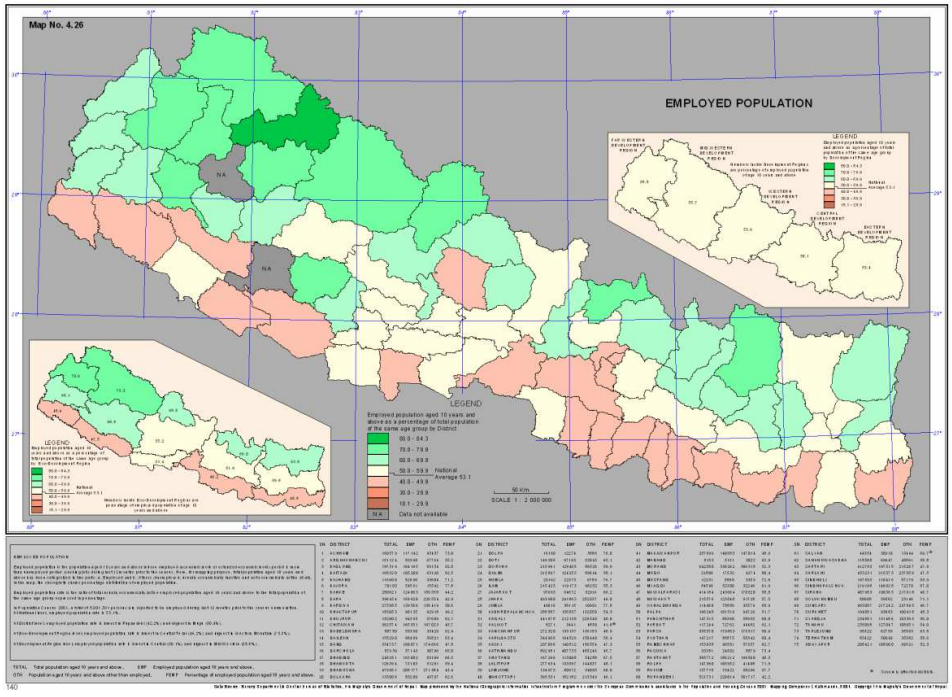
Country	1984-1990	1991-1995	1996-2001	Variation
Low income				
África				
Benin[a, u]		52.5	50.0	-2.5
Ethiopia[a, €]			38.9	--
Gambia[b, $]		66.1		--
Mali[b, &]	67.1			--
Tanzania[b, &]	53.8	59.7	--	+5.9
Asia				
Bangladesh[$]		10.0		--
India[b,c, ¢]			53.7	--
Nepal[b]			60.0	--
Pakistan[b,f]		65.9	64.1	-1.8

Source [40]

Nepal: Usually economically active population 18 years and over by major industry division, 2001				
Sector	Division	Employees	Percent	Cluster %
Self-employed	Agriculture and forestry	6,496,222	65.62	67.50
	Fishing	8,467	0.09	
	Other services	72,575	0.73	
	Private households employees	105,139	1.06	
Formal private	Manufacture and recycling	872,253	8.81	25.41
	Trade, wholesale and retail	863,773	8.72	
	Construction	286,418	2.89	
	Transport, storage, communication	161,638	1.63	
	Hotels and restaurants	120,888	1.22	
	Health and social work	61,797	0.62	
	Foreign organizations	58,273	0.59	
	Financial intermediation	46,765	0.47	
	Real estate, renting, other business	29,922	0.30	
	Mining and quarrying	16,048	0.16	
Formal public	Public administration, social security	301,024	3.04	6.85
	Education	228,381	2.31	
	Electricity, gas, water supply	148,218	1.50	
Not stated		22,395	0.24	0.24
Total		9,900,196	100.00	100.00
Source: Government of Nepal, Central Bureau of Statistics: Website http://www.cbs.gov.np/Pocket%20Book%202006/Chapter01/Chap01_9.htm				

Source [CBS website]

Employed population in Nepal



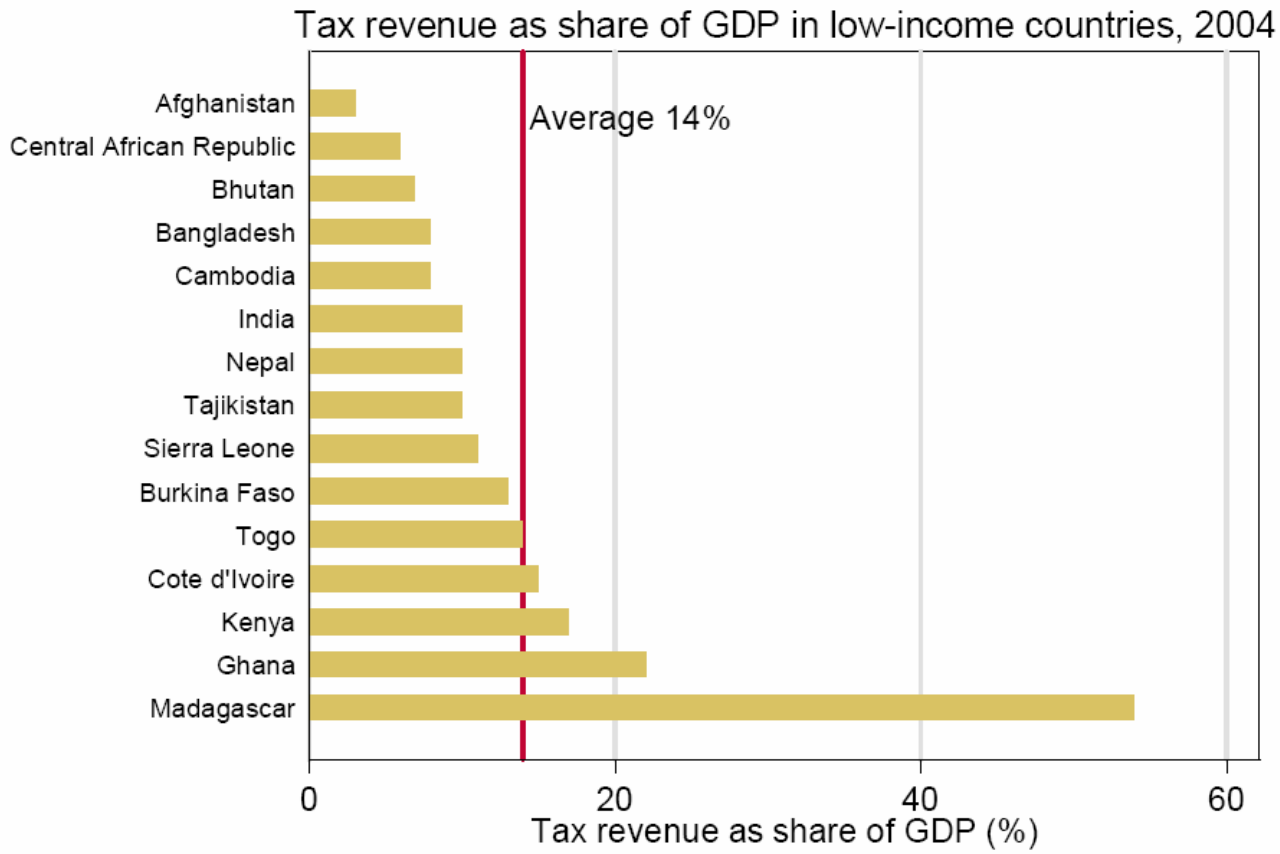
Source [CBS website]

2 Health financing in Nepal

2.1 Economics

1. Revenue-generation capacity is limited in low-income countries

For low-income countries, it may not be feasible to expect higher than 15% of GDP as source of revenue from taxes.



Source [233]

Table 18. Workers' remittances to LDCs, by country, and to the other developing countries, 1995–2006
($ million, per cent)

	$ million				% of GNI				% of LDC remittances
	1995–1999	2000–2002	2005	2006	1995–1999	2000–2002	2005	2006	2006
Countries with remittances > 10% of GNI									
Haiti	253.2	626.0	985.0	985.0	8.1	18.8	24.7	21.3	7.4
Lesotho	349.8	218.3	327.0	327.0	28.1	23.0	18.6	18.7	2.5
Nepal	60.2	312.0	1 211.0	1 211.0	1.3	5.5	15.9	16.2	9.1

Source [86]

2.2 Health accounts

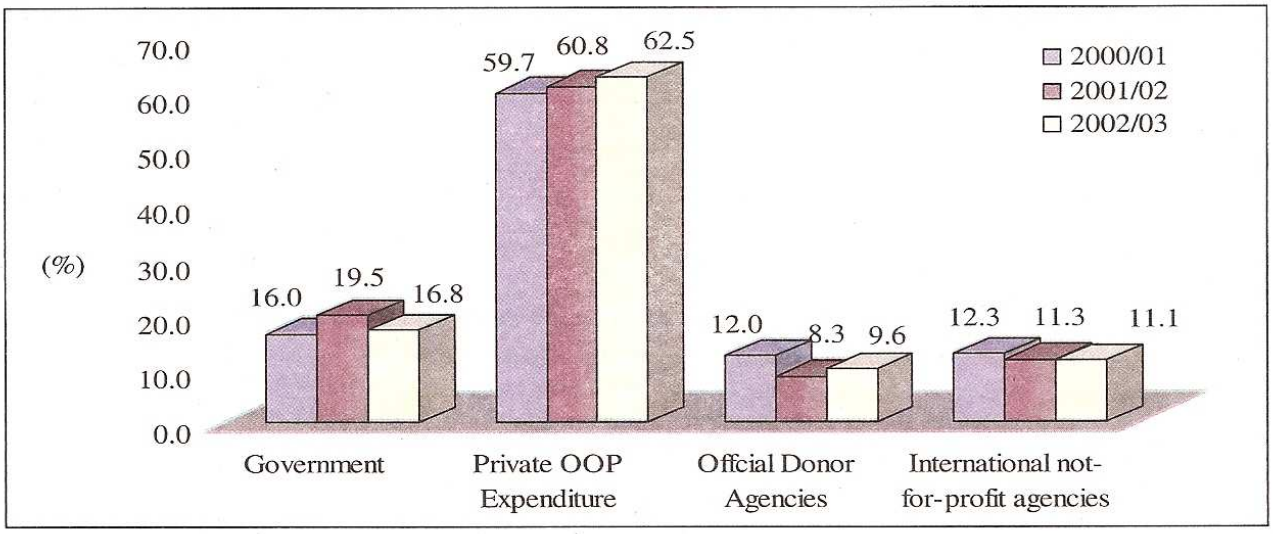
Table 2: Health Expenditure Trend

Health Indicators	2000/01	2001/02	2002/03
Total health Expenditure (THE) (in million NRs)	21,953	23,960	24,913
National Health Expenditure (NHE) (in million NRs)	19,588	20,926	21,899
SHA THE (in million NRs.)	20,907	22,653	23,570
Total Health Expenditure (THE) (in million US$)	294.1	307.2	333.3
National Health Expenditure (NHE) (in million US$)	262.4	268.3	293.0
SHA THE (in million US$)	280.1	290.4	315.3
GDP (in million NRs.)	394,052	406,138	437,546
THE as Percent of GDP	5.6	5.9	5.7
The Growth Rate of GDP (%)		3.1	7.7
The Growth Rate of THE (%)		9.1	4.0
The Growth Rate of NHE (%)		6.8	4.6
The Growth Rate of SHA THE (%)		8.4	4.0
Share of Government to THE (%)	16	19.5	16.8
Share of HHs to THE (%)	59.7	60.8	62.5
Share of EDPs to THE (%)	24.3	19.6	20.7
Per capita expenditure on health in NRs	932	992	1004
Per capita expenditure on health in US $	12.5	12.7	13.4

Source: Nepal National Health Accounts, 2001-2003

Source [427] and [138]

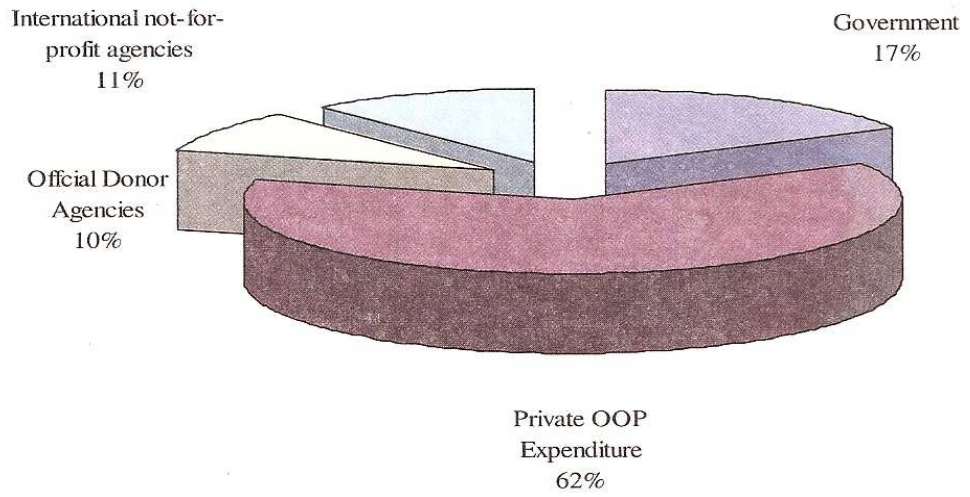
Figure 3.2: Total Health Expenditure by Source of Funding, 2000/01 – 2002/03



Source: Economic Survey 2004/05, NLSS 2003/04, FMIS, and surveys conducted for NHA in 2004.

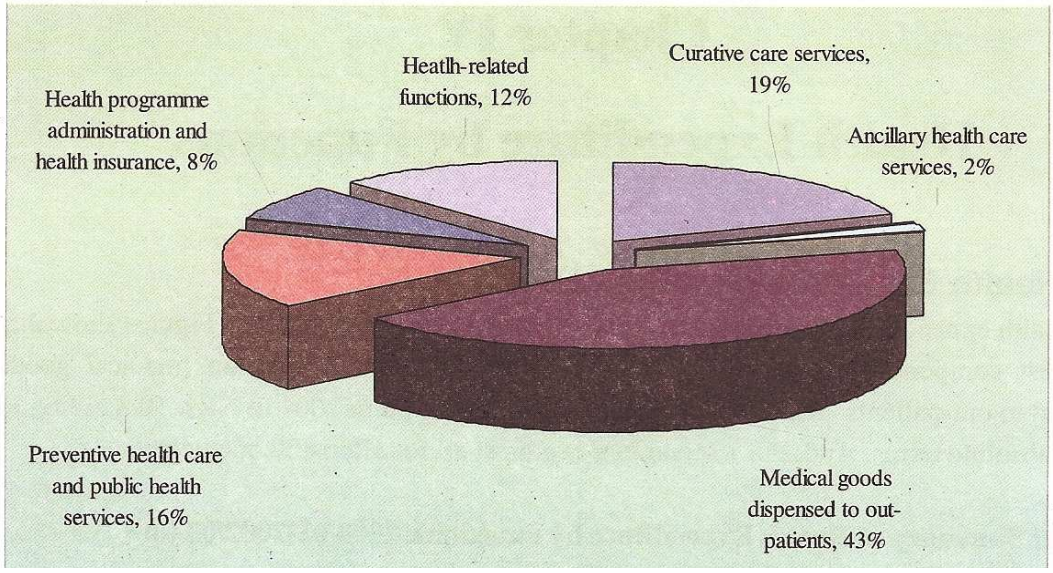
Source [427]

Figure 3.1: Total Health Expenditure by Source of Funding, 2002-2003



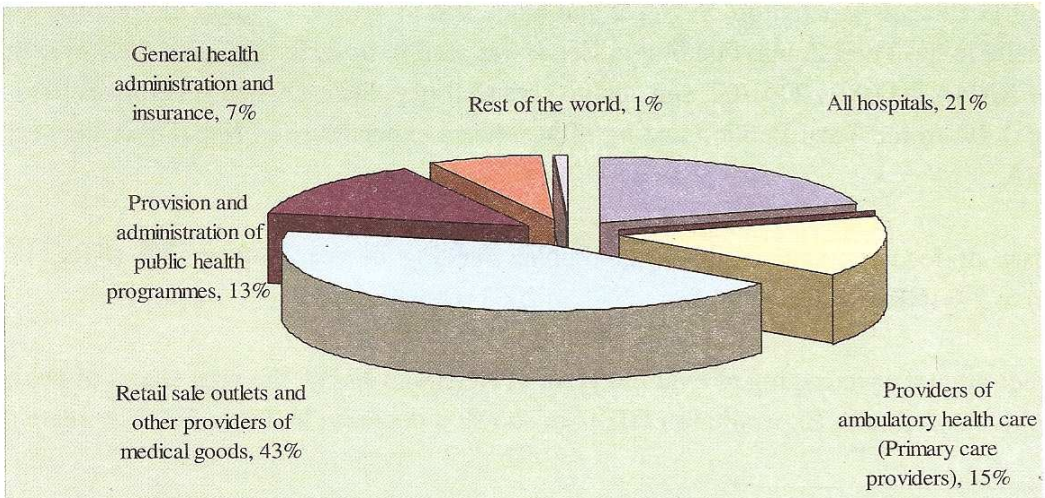
Source [427]

Figure 4.1 Total Health Expenditure by Function, 2002/03



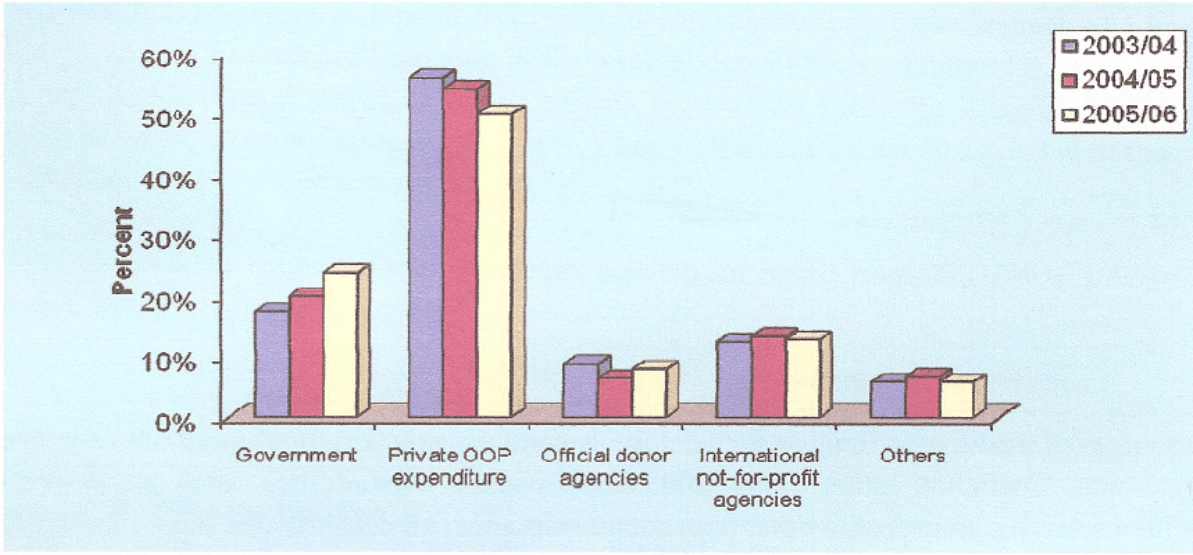
Source [427]

Figure 5.1 Total Health Expenditure by Providers, 2002-2003



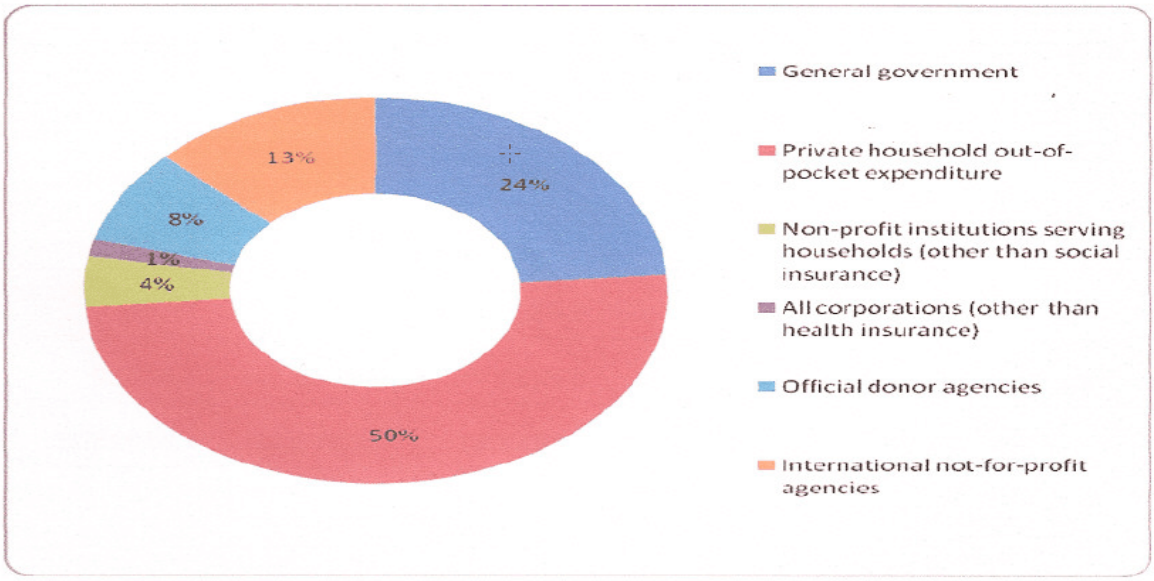
Source [427]

Figure 3.2: Trend of Total Health Expenditure by source 2003/04-2005/06



Source [464]

Figure 3.3: Total Health Expenditure by Source for 2005/06



Source [464]

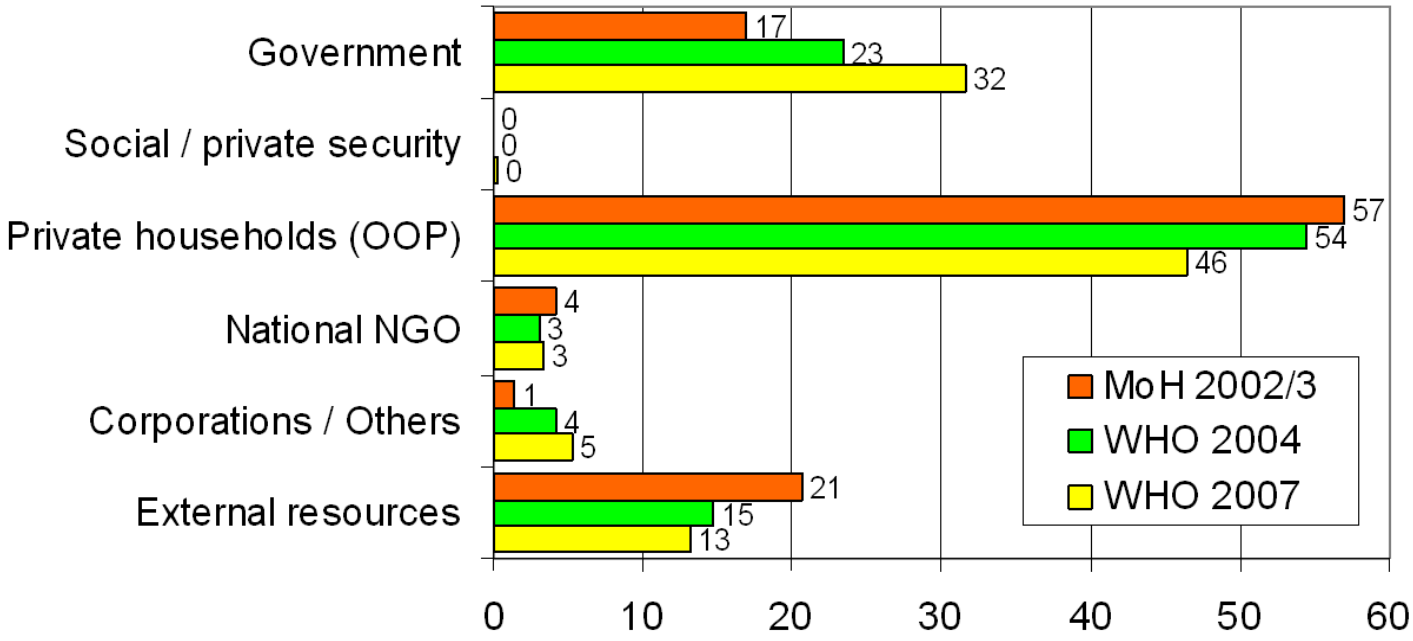
Table 4.1: Health Care Expenditure by Functions (in millions of NRs.)

NCF code	NNHA Functions	2003/04	2004/05	2005/06
NF1	Curative care services	5096.61	5940.12	6069.70
NF2	Rehabilitative care services	0.00	0.00	0.00
NF3	Long-term nursing care	0.00	0.00	0.00
NF4	Ancillary health care services	430.57	633.69	591.27
NF5	Medical goods dispensed to outpatients	10667.25	10917.07	9188.56
NF6	Preventive health care and public health services	5085.74	5148.92	6090.29
NF7	Health programme administration and health insurance	3493.53	3923.55	4512.32
NF R	Health-related functions	5876.73	6396.68	8343.50
THE		**30650.42**	**32960.02**	**34795.63**

Source [464]

Sources of health financing in Nepal according to different sources and periods of time

in percentage shares



Source [465]

Table 5. Summary of public expenditure on health

Source of financing	2003/04		2004/05		2005/06	
	Amount	%	Amount	%	Amount	%
NS1.1.1 Government of Nepal	**4,759.91**	**58.17**	**5,969.82**	**64.70**	**7,693.87**	**68.44**
Development/Capital (based on budget line items) (NS1.1.1.1)	430.19	5.26	991.93	10.75	1,238.85	11.02
Regular (NS1.1.1.1)	4,329.71	52.92	4,977.89	3.95	6,455.02	57.42
Earmarked tax (NS1.1.1.2)	-	-	-	-	-	-
NS9.1 External Development Partners (direct)	**2,672.48**	**32.66**	**2,099.41**	**22.75**	**2,759.25**	**24.55**
NS2.5 State-owned enterprises	**291.17**	**3.56**	**701.41**	**7.60**	**393.92**	**3.50**
NS2.5 Autonomous universities	**259.84**	**3.18**	**214.90**	**2.33**	**94.69**	**0.84**
NS1.1.2 Local bodies	**198.82**	**2.43**	**241.34**	**2.62**	**299.36**	**2.66**
District Development Committees	88.28	1.08	92.49	.00	87.61	0.78
Municipalities	13.45	0.16	20.10	0.22	31.33	0.28
Village Development Committees	97.09	1.19	128.74	1.40	180.42	1.61
Total public spending	**8,182.22**	**100.00**	**9,226.87**	**100.00**	**11,241.08**	**100.00**
As % of GDP	1.45	-	1.54	-	1.70	-
Per capita public spending (NRs)	307.25	-	349.56	-	420.01	-
Per capita public spending (US$)	4.13	-	4.95	-	5.65	-

Source: Ministry of Health and Population, Government of Nepal, (2009)

Source [463]

Table 3.1: Trends in health expenditure in Nepal

Indicators	1990	1995	2000	2005
1. Total Health Expenditure (THE)	NA	11,244	21,953	34,796
2. THE as a percentage of GDP	NA	5.1	5.6	5.3
3. Public Health Expenditure as a percentage of THE	NA	23.8	16.0	23.7
4. Private Health Expenditure as a percentage of THE	NA	76.2	59.7	55.6
- Formal User Charge	NA	NA	NA	NA
- Informal Payments	NA	NA	NA	NA
- Out-of-Pocket Payments (OOP)	NA	72.1	53.9	49.9
- Private Insurance	NA	NA	NA	NA
5. Mean Annual Real in THE	NA	NA	7.2	4.5
6. Mean Annual Growth Rate in THE	NA	NA	14.3	9.6
7. Mean Annual growth Rate in GDP	NA	NA	12.4	10.6
8. Total Government Spending as a percentage of GDP	NA	17.8	18.6	17.4

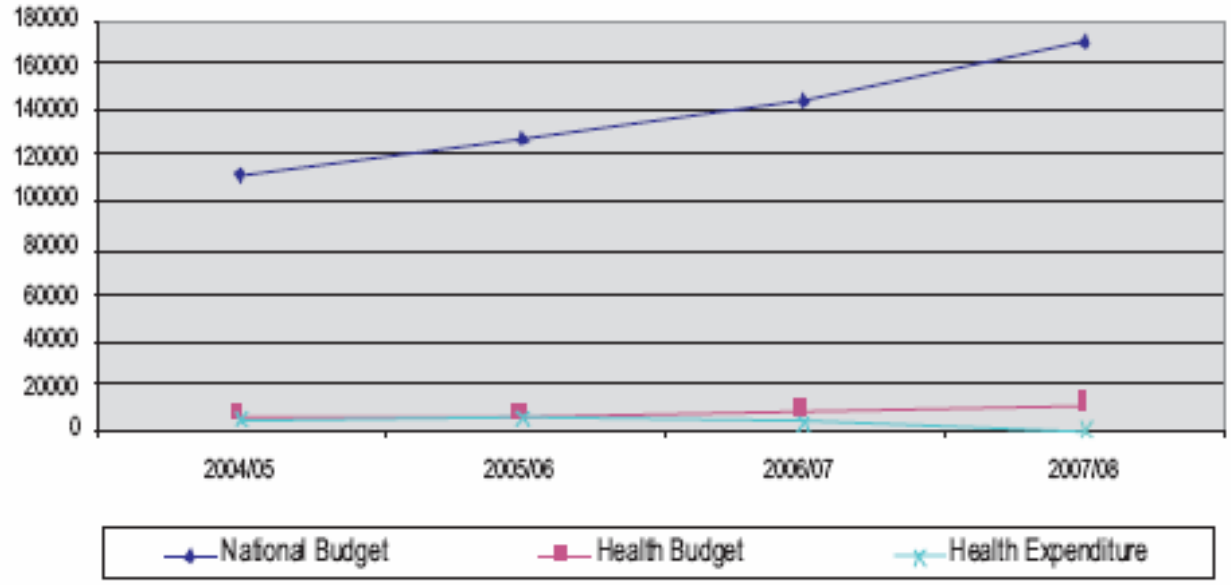
Source [463]

Table 3.2: General Government Expenditure by Source

Source	In Million Rs					
	2000	2001	2002	2003	2004	2005
1. General Government excluding social security	28	14	40	232	258	313
2. Central Government	14	23	28	260	215	95
3. General tax revenue	3,088	4,252	3,795	11,484	8987	11,536
3. Earmarked Taxes (health tax on alcohol and tobacco)	388	284	248	0	0	0
4. Local Government	-	107	84	20	27	31
5. Social security/National health insurance funds	-	-	-	-	-	-
Total	**3,519**	**4,680**	**4,195**	**11,996**	**9,487**	**1,975**
Percentage Share						
1. General Government excluding social security	1	0	1	2	3	3
2. Central Government	0	0	1	2	2	1
3. General tax revenue	88	91	90	96	95	96
3. Earmarked Taxes (health tax on alcohol and tobacco)	11	6	6	0	0	0
4. Local Government	-	2	2	0	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**

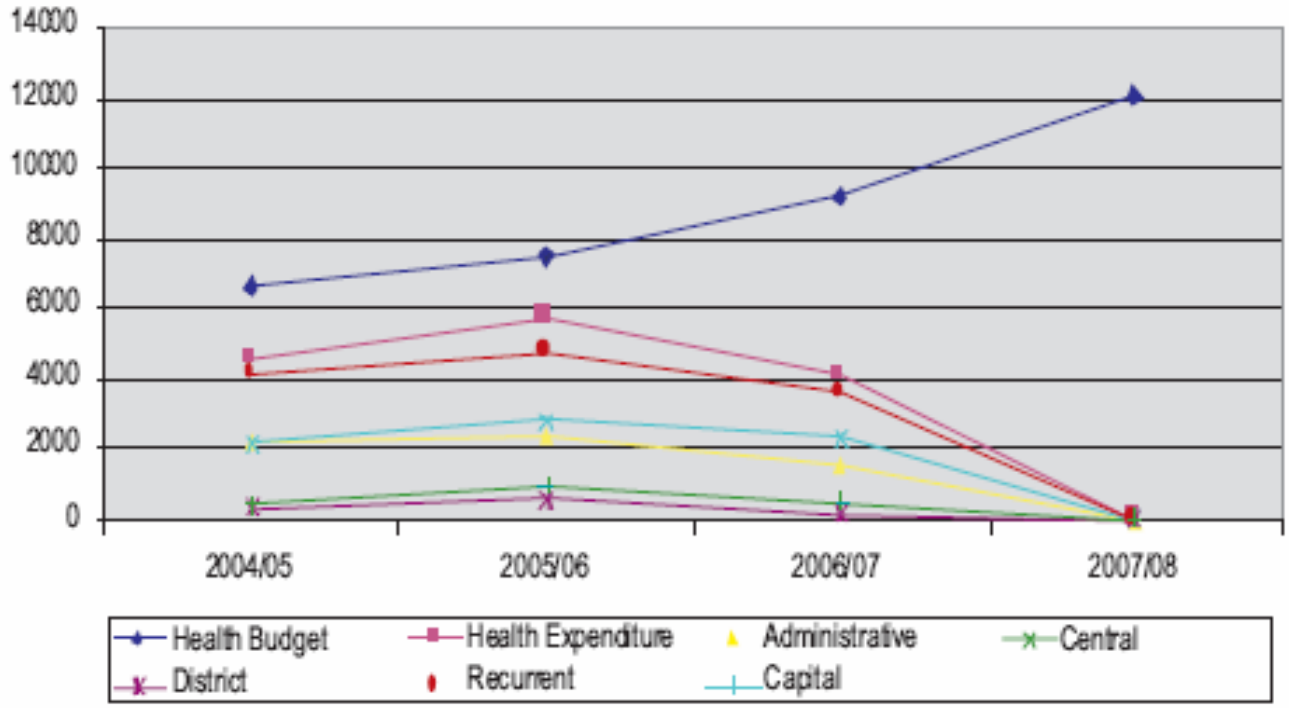
Source [463]

Fig 3: Health Sector Budget and Expenditure



Source [138]

Fig 4: Health Expenditure Distribution



Source: Data from NHA

Source [138]

8

Table 3. **Government revenue/expenditure, and total public social expenditure for selected Asian countries, 2001-2003** (in per cent of GDP)

	Revenue			Expenditure			Total social expenditure		
	2001	2002	2003	2001	2002	2003	2001	2002	2003
Bangladesh	9.5	9.7	9.6	10.8	10.6	10.7	1.0	1.0	1.1
India	16.8	17.4	17.4	25.2	25.6	25.6	1.5	1.5	1.5
Nepal	11.2	11.4	11.8	18.0	17.4	16.3	1.4	1.7	1.7
Pakistan	12.5	13.4	13.5	17.3	18.2	17.4	0.2	0.3	0
Vietnam	21.0	22.1	23.6	24.8	25.3	29.1	3.6	3.2	3.5

Source: IMF 2005c; own calculations.

Table 4. **Public social expenditure for selected Asian countries, 2001-2003** (in per cent of total public expenditure)

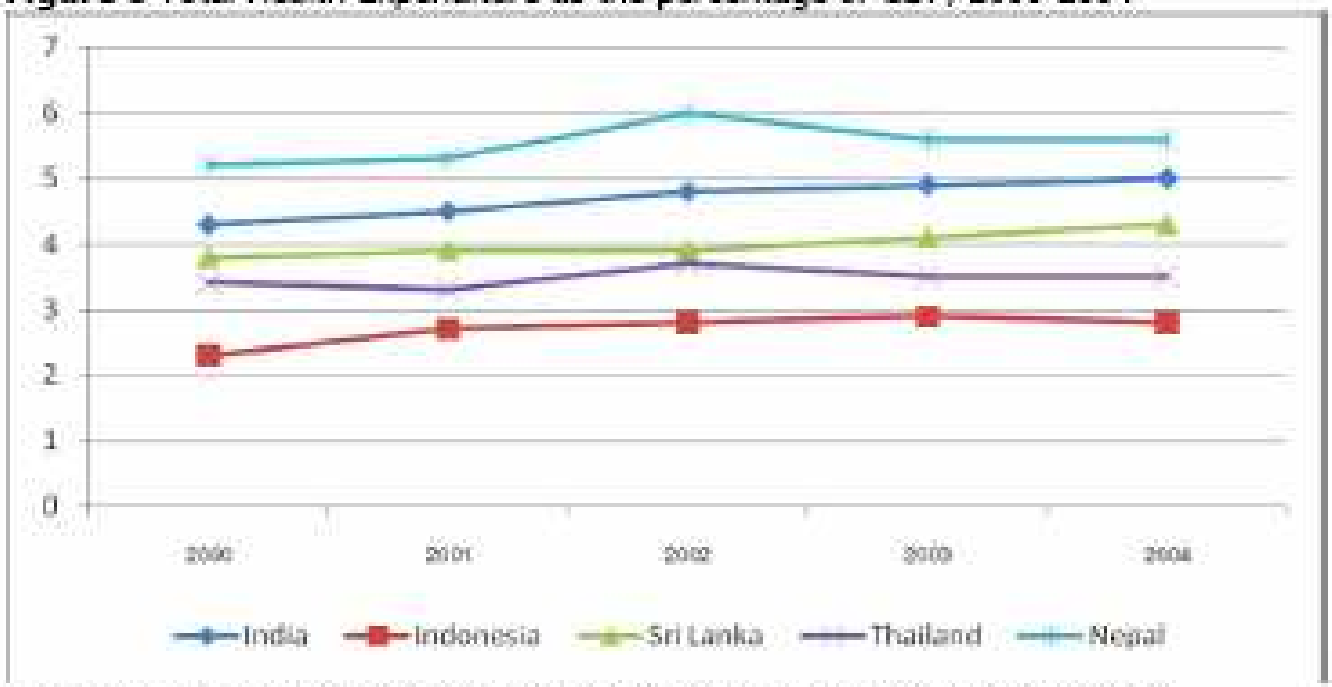
	Total social expenditure			Social security and welfare			Health		
	2001	2002	2003	2001	2002	2003	2001	2002	2003
Bangladesh	9.0	9.9	10.2	3.8	3.5	3.5	5.1	6.4	6.7
India	6.1	5.8	5.8	2.7	2.7	2.7	3.4	3.1	3.1
Nepal	7.6	10.1	10.2	2.8	4.8	5.3	4.8	5.3	4.9
Pakistan	1.3	1.7	1.5	0.7	0.9	0.9	0.6	0.8	0.6
Vietnam	14.4	12.8	11.9	11.2	9.8	9.2	3.2	3.1	2.7

Note: Social protection expenditure (as provided in IMF statistics for the functions of health and social security and welfare).

Source: IMF 2005c; own calculations.

Source [29]

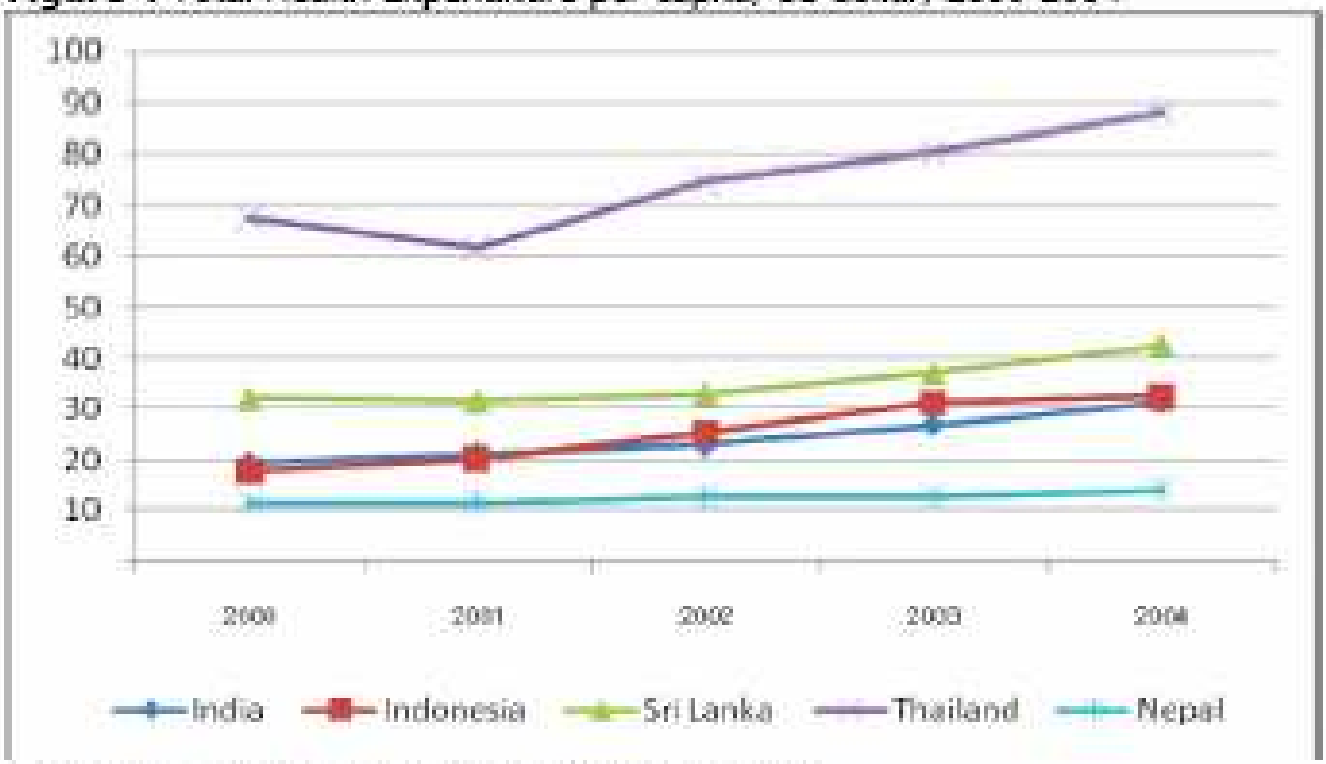
Figure 3 Total Health Expenditure as the percentage of GDP, 2000-2004



Source: National Health Account (NHA) World Health Report 2006, Annex 1

Source [9]

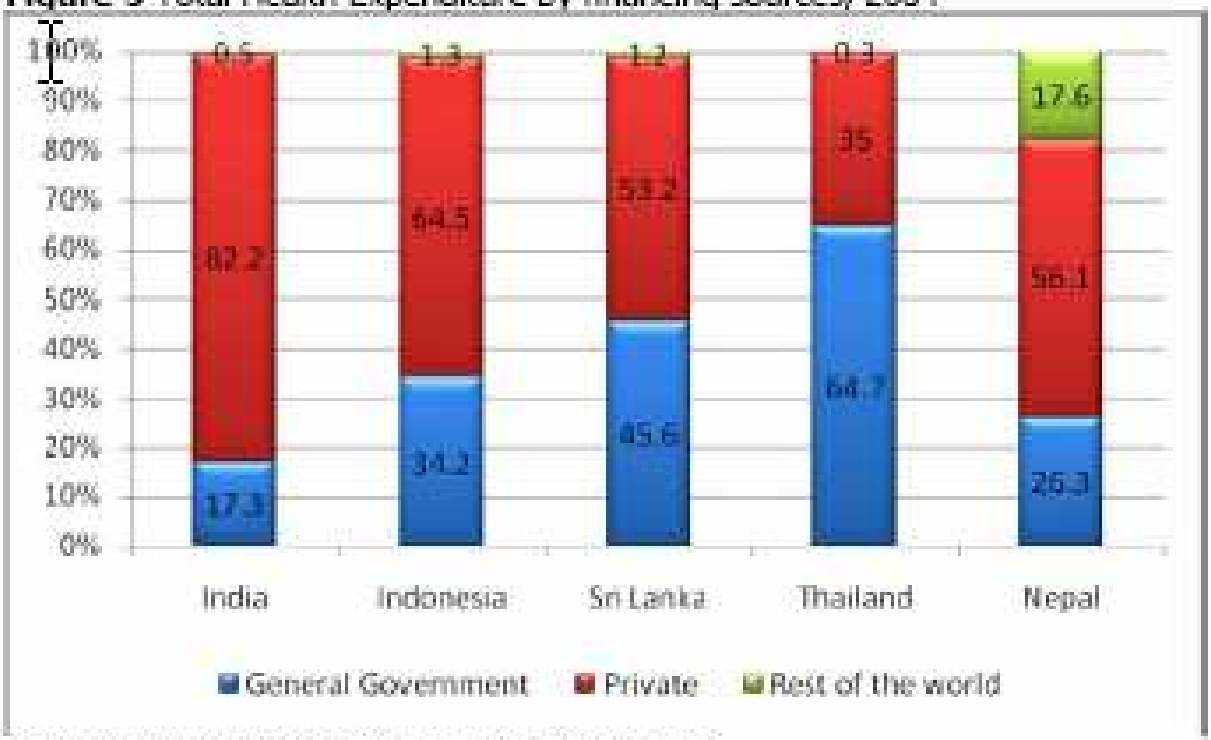
Figure 4 Total Health Expenditure per capita, US dollar, 2000-2004



Source: NHA World Health Report 2006, Annex 2

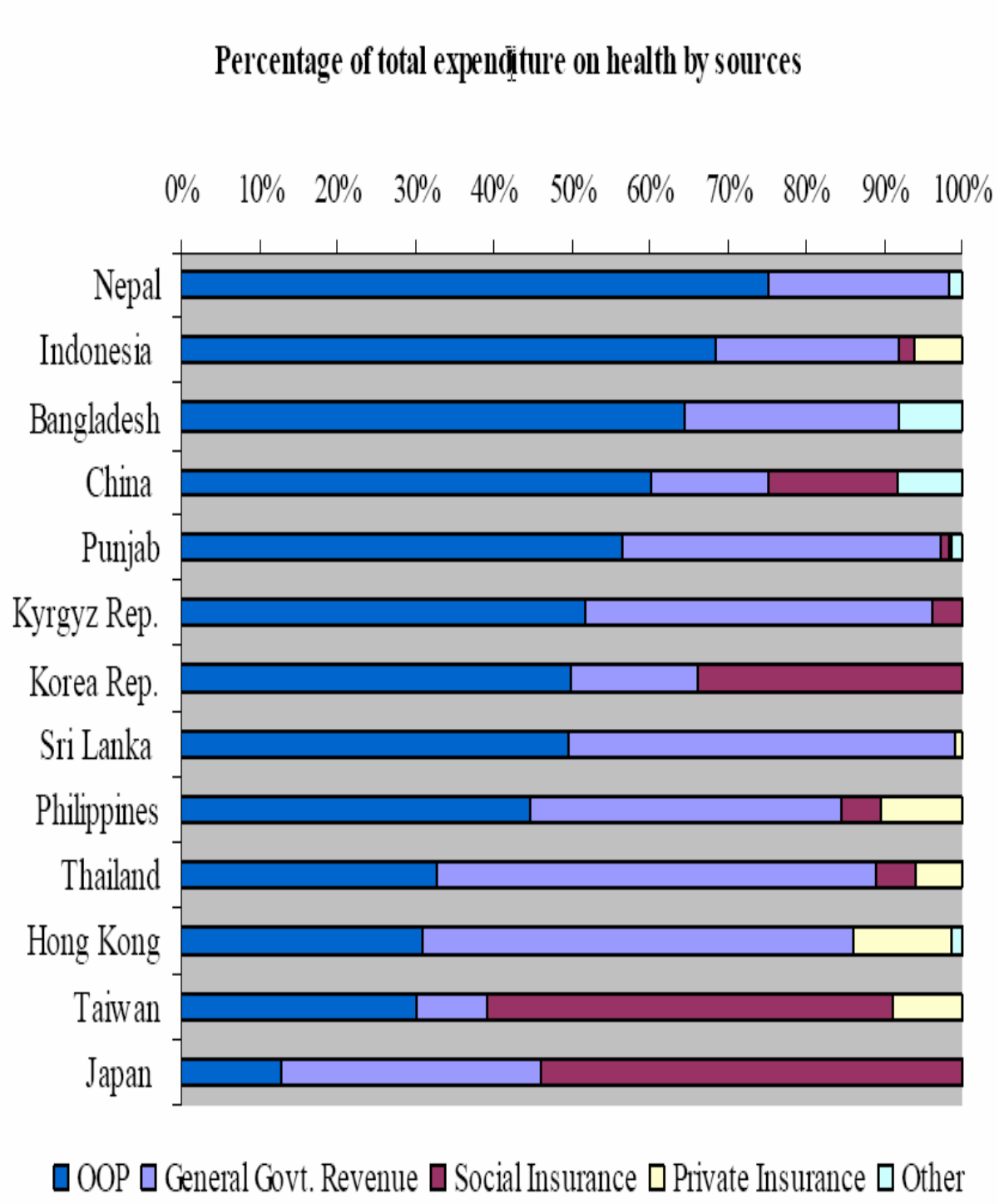
Source [9]

Figure 5 Total Health Expenditure by financing sources, 2004



Source: NHA World Health Report 2006 annex 1

Source [9]


Percentage of total expenditure on health by sources
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Nepal
Indonesia
Bangladesh
China
Punjab
Kyrgyz Rep.
Korea Rep.
Sri Lanka
Philippines
Thailand
Hong Kong
Taiwan
Japan
OOP
General Govt. Revenue
Social Insurance
Private Insurance
Other

Source [10]

Financing

The Health Economics and Financing Unit (HEFU) in the MoH is responsible for all issues related to the financing of public sector health services. Provision is basically financed from taxes and user fees. Both are regressive, as the taxes are mainly indirect (VAT) and the user fees are a fixed amount, meaning that the poor pay relatively more than the rich, if and when they make use of public services at all. There are virtually no insurance schemes in place, except for civil servants. Community health insurance for people not formally employed is being piloted and exemption schemes for user fees will be developed. People pay around $10 per capita out-of-pocket per annum for health care, with government contributing $3.1 and donors $2. The share of locally raised funds by district and village development committees is still low, but growing.

A system of National Health Accounts (NHA) is being set up. In order to collect data that were not available through existing information systems, HEFU has commissioned health expenditure surveys among (I)NGOs, private companies, private health providers, and public health facilities, as well as a drug expenditure survey. The results feed into the NHA.

According to the Public Expenditure Review, done by HEFU for the Health Sector in 2003 over the preceding 3 years, capital costs make up one-fourth of all public health expenditures. Of the recurrent costs 55% is spent on salaries. Of all expenditures directly related to health care 60% is spent at the district level and below. The share of funding going to Priority I programmes (as defined in the Tenth Development Plan and MTEF) has decreased over the last three years, while expenditures on Priority III programmes has increased, contrary to intentions. And although people in the rural areas are likely to have higher health needs than the urban population, the trend is one of decreasing expenditures in rural and increasing expenditures in urban areas. The share of reproductive health in total public expenditures decreased drastically from 14% to 3%, due to the closure of a big donor funded project, illustrating the risks involved in project-based financing systems. The share of health expenditures for children under 5, being more than 12% of the population, is only 4.7%, while they bear more than 50% of the burden of disease.

Nepal will need to allocate more domestic resources to health and/or raise additional external resources to be able to reach the MDG targets on health and provide the poor with other health services considered essential. Assuming that the calculations by the CMH are also valid for Nepal total health expenditures in Nepal would have to double by 2007. HMG of Nepal would at least need to double its investment in health before 2007 and the donors would need to increase their share with $17 per capita, an eigth-fold increase from the present $2. Possibilities to channel the $10 that people now spend on health care out-of-pocket into pre-paid schemes need to be studied.

Photo Jim Matiko

Source [168]

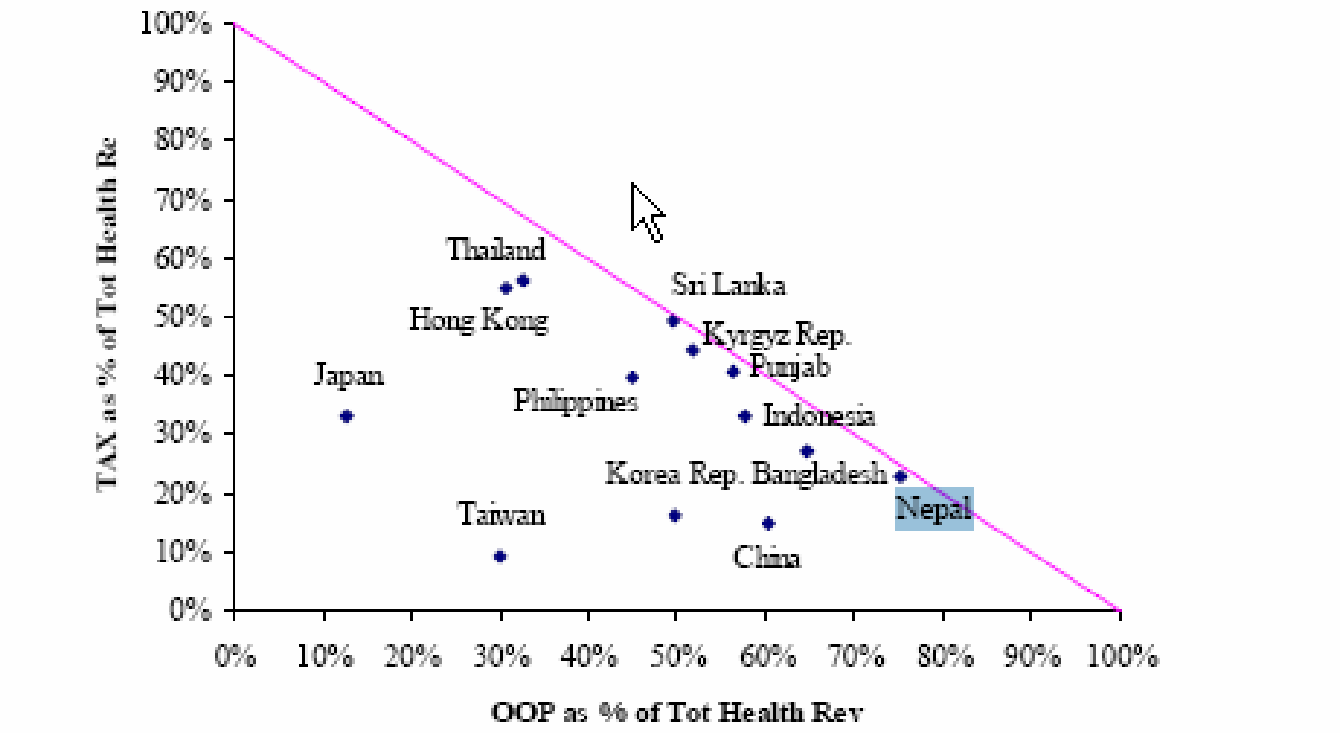
2.3 Out-of-pocket expenditure

Table 3: Distribution of Out-of-pocket Health Payments in Low-income Countries, World Health Survey, 2003

	Out-of-pocket Health Payments				
	Medicines	Inpatient	Outpatient	Traditional	Others
	%	%	%	%	%
Bangladesh	67.1	6.3	8.1	5.0	13.6
Burkina Faso	62.2	9.7	8.0	7.8	12.3
Chad	11.1	43.8	12.0	12.2	20.9
Comoros	47.6	16.9	15.6	3.0	16.9
Cote D'Ivoire	32.2	29.4	15.6	5.5	17.2
Ethiopia	43.3	16.8	24.6	2.3	13.0
Ghana	40.1	23.3	21.8	5.6	9.1
India	44.4	25.4	16.9	3.3	9.9
Kenya	31.0	32.8	17.1	1.5	17.5
Lao PDR	47.8	25.2	10.1	10.7	6.2
Malawi	48.1	15.9	27.1	4.4	4.4
Mali	30.8	23.3	20.2	9.9	15.8
Mauritania	31.0	22.4	12.1	3.6	30.9
Myanmar	47.8	11.9	26.6	5.2	8.4
Nepal	68.8	13.9	4.3	1.5	11.5
Pakistan	45.5	21.2	14.5	7.0	11.8
Senegal	31.5	24.8	13.8	12.9	17.0
Vietnam	37.0	27.2	21.9	5.0	8.9
Zambia	34.8	26.9	15.2	9.3	13.8
Zimbabwe	25.2	12.0	30.6	14.5	17.7
Median	**41.7**	**22.9**	**15.6**	**5.4**	**13.3**
25th percentile	31.4	15.4	12.1	3.5	9.7
75th percentile	47.7	25.8	21.8	9.5	17.1

Source [37]

Figure 1: Out-of-pocket (OOP) and general government taxes (TAX) as share of total expenditure on health



Source [65]

Table IV. OOP payments for health care as a percentage of household consumption (/expenditure)

	Bangladesh	China	Hong Kong	India	Indonesia	Korea Rep.	Kyrgyz Rep.	Malaysia	Nepal	Philippines	Sri Lanka	Taiwan	Thailand	Vietnam
OOP payments as percentage of total household consumption (/expenditure)														
Mean	5.10	4.11	2.29	4.84	1.83	3.83	2.40	1.37	2.77	1.94	2.11	3.74	1.71	5.49
Coefficient of variation	1.92	1.97	2.38	1.59	2.93	1.96	1.81	2.47	2.28	2.66	1.95	1.27	2.46	1.32
Median	1.15	2.33	0.17	2.17	0.00		0.60	0.18	1.15	0.41	0.91	2.35	0.40	2.94
Concentration index	0.2414	−0.0357	0.0480	0.1600	0.1618	0.0037	0.0986	0.1301	0.0781	0.1951	0.1117	−0.0467	0.1082	0.0270
Quintile means														
Poorest 20%	2.94	4.57	1.87	3.30	1.23	4.15	1.77	1.11	2.44	1.19	1.64	4.25	1.25	4.86
2nd poorest	3.17	5.27	2.27	4.41	1.46	3.42	1.96	1.10	2.71	1.60	1.82	3.85	1.48	5.44
middle	4.55	5.39	2.25	5.23	1.69	3.61	2.59	1.14	2.90	1.84	2.00	3.68	1.71	5.74
2nd richest	5.98	4.59	2.15	6.16	2.11	3.89	2.93	1.48	2.86	2.18	2.21	3.52	2.02	5.85
Richest 20%	8.86	3.45	2.67	6.48	2.69	4.08	2.77	2.00	3.64	2.93	2.86	3.38	2.07	5.57
OOP payments as percentage of household non-food consumption (/expenditure)														
Mean	10.66	5.92	3.36	10.72	4.18	5.31	7.48	2.13	9.15	4.18	5.32	4.63	2.93	12.64
Coefficient of variation	1.55	2.18	2.25	1.31	2.39	1.84	1.55	2.24	2.41	2.16	1.56	1.25	2.29	1.09
Median	3.20	5.26	0.24	5.76	0.00		1.88	0.28	4.08	1.03	2.47	2.89	0.71	7.31
Concentration index	0.1608	−0.1851	−0.0125	0.0870	0.0697	−0.0457	0.0783	0.0763	−0.0464	0.0773	0.0074	−0.0969	0.0166	−0.0536

Note: If sample weights exist, they are applied in computation of all statistics to give population estimates.

Source [247]

8.1 Distribution of health payments across different population groups

	Mean Household expenditure (EXP) in local currency	% Poor	% Impoverished	% Catastrophic	OOP % EXP	OOP % non-subsistence spending	Mean OOP in local currency
Catastrophic							
No	5,955	27.3	0.9		2.6	5.8	191
Yes	7,156	24.6	29.2		32.7	65.4	3550
Poor							
No	7,539		7.3	16.2	8.6	16.1	947
Yes	2,355		0.0	14.3	3.8	12.5	95
Insurance							
No	6,123	27.0	5.4	15.7	7.3	15.2	718
Yes	10,347	3.5	0.0	8.8	6.0	10.4	636
Residence							
rural	5,649	30.1	5.8	16.7	7.4	15.7	689
urban	9,016	8.6	2.8	9.8	7.1	11.7	886
Income_Quintile							
1st(poorest)	2,150	100.0	0.0	13.5	3.7	12.1	83
2nd	3,277	34.5	13.6	17.2	4.7	14.8	158
3rd	4,308	0.0	7.2	15.0	6.3	15.2	272
4th	5,735	0.0	3.8	14.3	8.3	15.5	497
5th(richest)	15,256	0.0	2.2	18.3	13.7	18.2	2590
total	6,144	26.9	5.4	15.7	7.3	15.2	718

OOP: Out of pocket

Household consumption expenditure (EXP) comprises both monetary and in-kind payment on all goods and services and the money value of the consumption of home-made products.
Poor - a household is considered poor when its total household expenditure is smaller than its subsistence spending
Impoverishment - a non-poor household is impoverished by health payment when it becomes poor after paying for health services.
Catastrophic health expenditure occurs when a household's total out-of-pocket health payments equals or exceeds 40% of the households capacity to pay or non-subsistence spending.
Out of pocket health payments (OOP) refer to payments made by households at the point they receive health services. It includes doctor's consultation fees, purchases of medication and hospital bills. Spending on alternative and/or traditional medicine is included. Expenditure on health related transportation and special nutrition is excluded. Insurance reimbursements are also excluded.
Subsistence spending - household subsistence spending is the minimum requirement to maintain a basic life in a society. A poverty line is used in the analysis as subsistence spending.
Food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It excludes expenditure on alcoholic beverages, tobacco and food consumption outside the home (e.g hotel and restaurants).
Household capacity to pay - is defined as a household's non-subsistence spending.

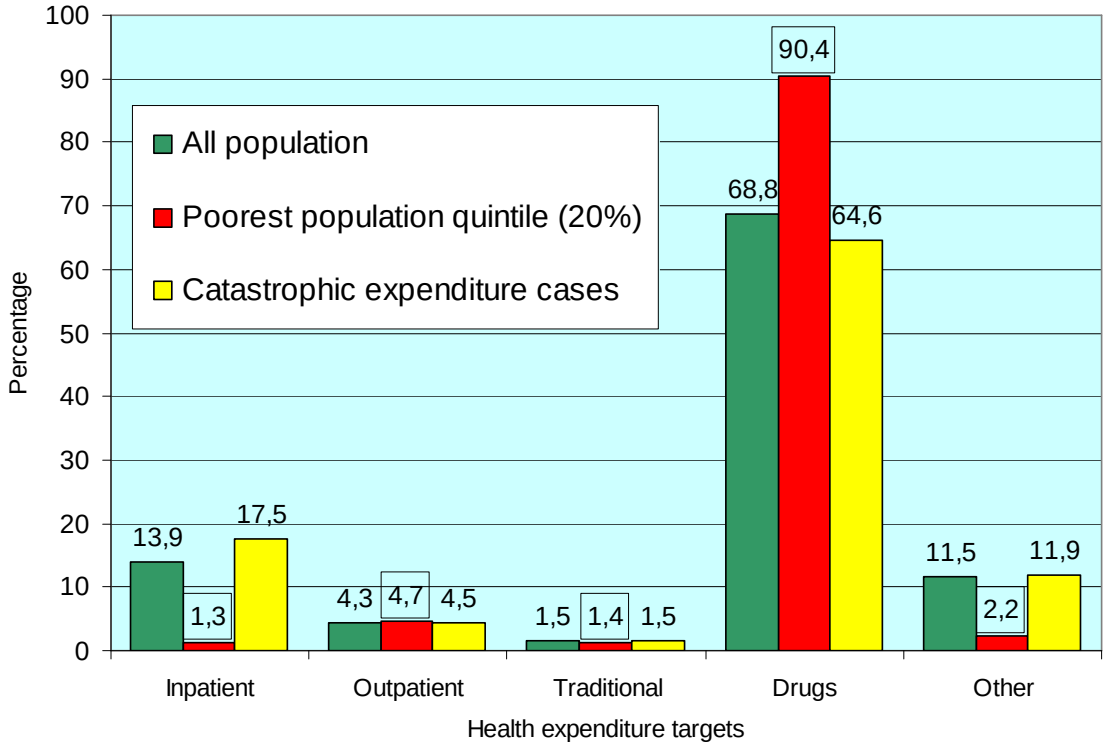
Source [429]

8.2 Percent distribution of structure of out-of-pocket health payments

	Inpatient	Outpatient	Traditional	Drugs	Other	Total
Catastrophic						
No	1.4	3.9	1.3	83.4	10.0	100
Yes	17.5	4.5	1.5	64.6	11.9	100
Poor						
No	14.4	4.3	1.5	68.0	11.8	100
Yes	1.2	4.6	1.3	90.7	2.4	100
Insurance						
No	13.9	4.3	1.5	68.9	11.4	100
Yes	1.6	5.9	1.3	63.4	27.8	100
Residence						
rural	13.9	4.1	1.7	69.1	11.2	100
urban	13.7	5.5	0.4	67.7	12.7	100
Income_Quintile						
1st(poorest)	1.3	4.7	1.4	90.4	2.2	100
2nd	2.0	4.6	1.4	88.3	3.6	100
3rd	3.0	5.1	1.9	83.2	6.8	100
4th	4.2	5.0	1.8	82.0	6.9	100
5th(richest)	18.0	4.1	1.3	62.9	13.6	100
total	13.9	4.3	1.5	68.8	11.5	100

Source [429]

Structure of out-of-pocket payments for health in Nepal



Source [465] based on [429]

2.4

Family health financing

Health financing of the ultra-poor

For ultra-poor women, adverse health events can have devastating consequences. In rural Nepal, for example, women report that illness is the most frequent and costliest of all risks faced, followed by death of an income earner, enterprise risks (crop failure, floods), and life cycle needs. Poor rural women diversify their incomes, save, accumulate assets and forge community ties in an effort to mitigate health risks. The poorest rural women manage health risks by reducing household outlays (i.e. eating less), increasing the number of working hours, borrowing from community groups, friends, relatives and neighbors, and turning to moneylenders (Simkgadam Gautam, Mishra, Acharya and Sharma 2000).

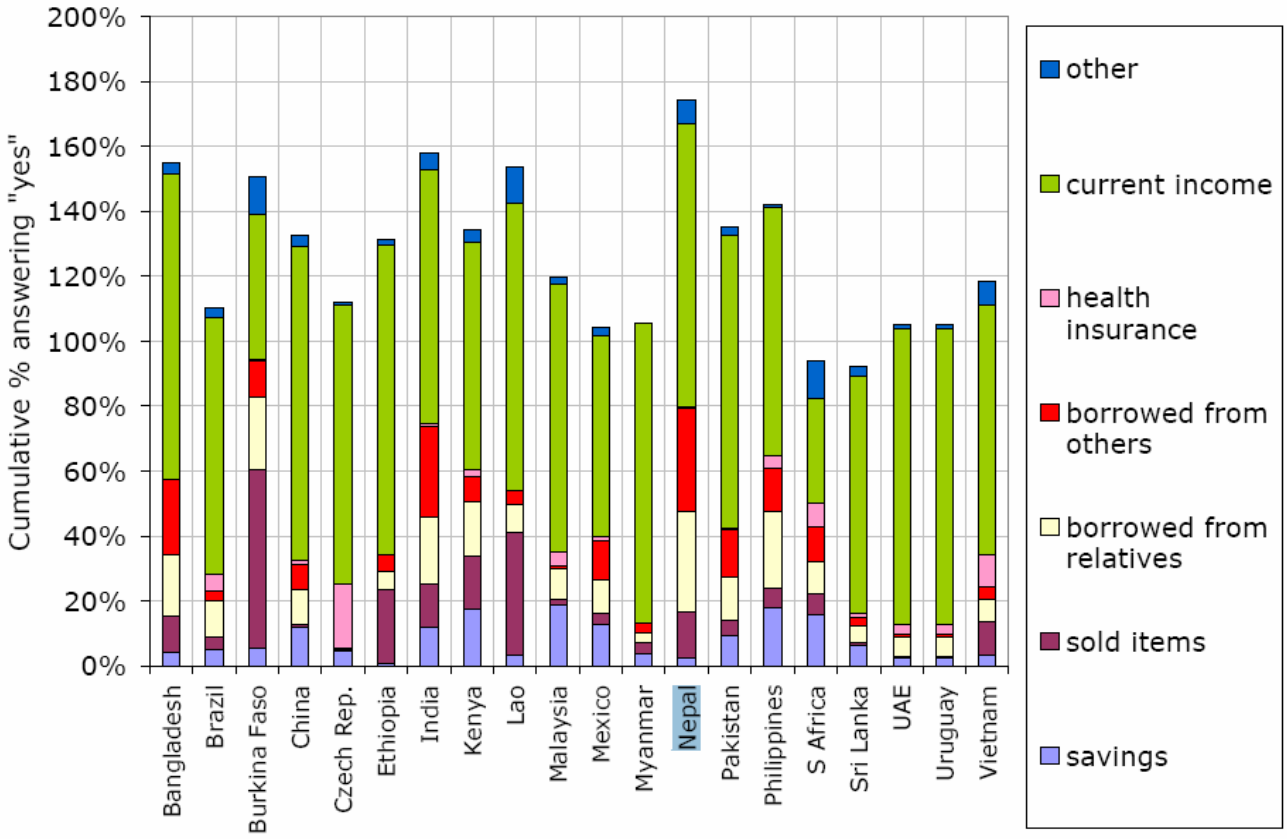
Source [22]

8.3 Financial sources used by households for paying for health services

	Savings	Sold Items	Borrow from relatives &	Borrow from others	Health insurance	Current Income	Other
OOP%non_subsistence_spending							
less than 10%	2.6	14.3	29.2	28.7	0.1	86.2	6.7
10-20%	3.1	12.2	30.0	29.7	0.0	93.6	8.5
20-40%	1.9	11.4	32.3	35.1	0.3	92.7	7.9
above 40%	3.1	15.0	38.9	44.1	0.2	86.0	8.7
Hospitalization							
No	2.0	12.7	27.3	28.5	0.1	88.1	6.9
Yes	6.3	20.4	50.9	49.8	0.1	84.8	9.2
Insurance							
No	2.6	13.9	31.2	32.0	0.1	87.5	7.3
Yes	8.9	3.5	11.2	14.9	8.1	91.3	2.6
Residence							
rural	2.1	15.3	33.4	34.7	0.1	86.1	7.9
urban	5.7	5.7	17.9	15.7	0.1	96.0	3.8
Income_Quintile							
1st(poorest)	1.6	14.2	34.4	30.1	0.1	86.0	8.6
2nd	1.1	13.6	30.7	32.3	0.0	87.0	7.3
3rd	2.4	16.5	32.1	35.6	0.2	85.1	6.5
4th	2.1	12.4	29.5	31.7	0.1	87.2	6.2
5th(richest)	6.0	12.8	28.9	29.7	0.2	92.2	7.7
total	2.6	13.9	31.1	31.9	0.1	87.5	7.3

Source [249]

Figure 7: How households finance their health spending, selected countries



Source: World Health Surveys: http://www.who.int/healthinfo/survey/whsresults/en/index.html .

Source [91]

Medication	Poor (n=107)	Medium (n=22)	Rich (n=46)	P - Value.
Modern Medication	104 (97.2)	20 (90.9)	44 (95.6)	0.3871
Self-Medication	68 (63.6)	14 (63.6)	18 (39.1)	0.0160
Alternative Med.	19 (17.7)	7 (31.8)	40 (87.0)	0.0000

Table 4: Economic condition and medication.
There is close relationship between economic status and health seeking behaviour.

Table 4 presents that 97.2% poor, 90.9% medium and 95.6% rich people were adopting modern medication respectively. Poor 63.6%, medium 63.6% and rich 39.1% people were adopting Self-medication respectively. Similarly Poor 17.7%, medium 31.8% and rich 87.0% people were adopting Alternative medication respectively. There was no difference in the use of modern medication among different economic level that is statistically insignificant (P= 0.3871). It was found that there has highly significant practice of self-medication been adopted by poor i.e., statistically significant (P=0.0160). Likewise, rich are largely adopting alternative medication that is statistically highly significant (P= 0.0000).

Source [134]

Education and Medications

Table 7: Education and medication.

Medications	Uneducated (n=130)	Educated (n=45)	P - Value
Modern Medication	126 (96.9)	42 (93.3)	0.3753
Self-Medication	85 (65.4)	14 (31.1)	0.0000063
Alternative Med.	27 (20.8)	13 (28.8)	0.2635

It was found that there was no difference in the use of modern medication between educated and uneducated that is statistically insignificant (P=0.3753). But use of self-medication by uneducated was significantly higher than educated that is statistically highly significant (P= 0.0000063). And there was no difference in the use of alternative medication between educated and uneducated that is statistically insignificant (P= 0.2635).

Source [134]

4.1.9 Expenses for Treatment.

Table 16: A cross-section of an average expense (in Rupees).

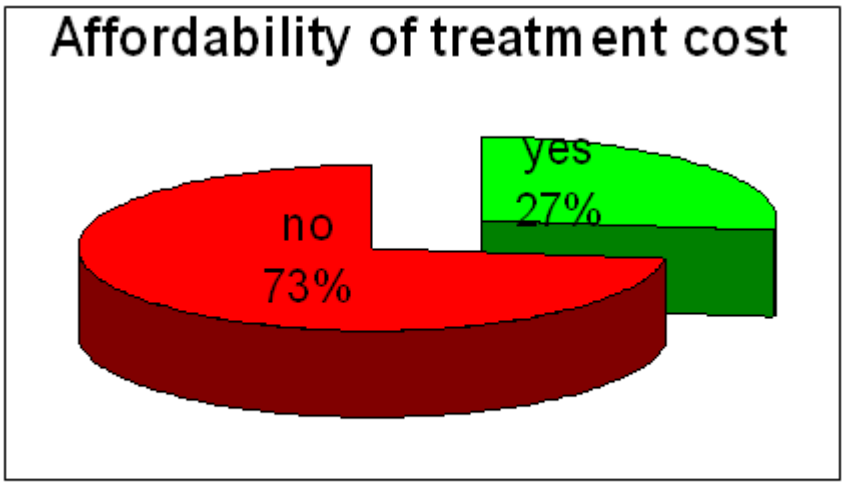
	Buying drugs	598.35
	Paying fees	201.68
	Transportation	52.30
	Helper	38.58
	Other	142.77

Average expenditure per sick is Rs.1 031.64. Bulk amount of expense was (58.0%) for purchasing drugs and paying fees (19.5%). And 5.0% for transportation, 3.7% for helper and 13.8% for others.

37

Health Seeking Behavior of Rajbanshi Nepal by Nawa Raj Subba, 2001

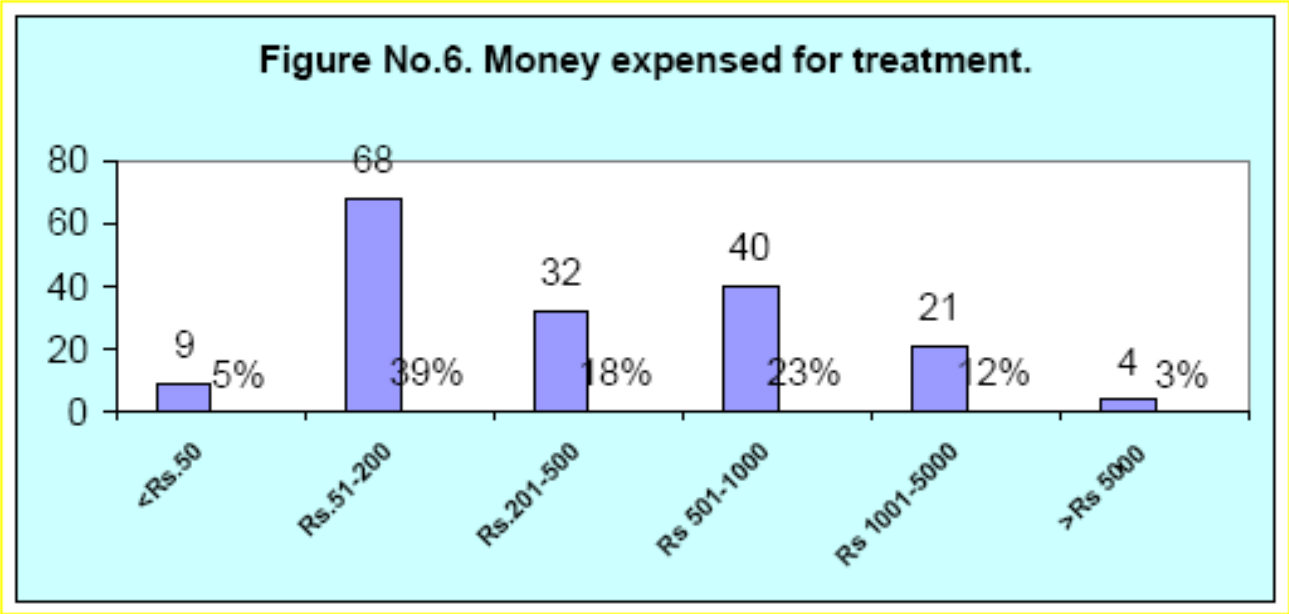
Source [134]



Health Seeking Behavior of Rajbanshi Nepal by Nawa Raj Subba, 2001

Source [465] based on [134]

Figure No. 6: Cost of Treatment.



It was found that usually people (39%) were paying 50-200 rupees for their treatment. Likewise, 23% had paid Rs. 501-1000, 18% paid 201-500, 12% paid 1001-5000, 5% paid less than Rs.50 and 3% paid more than Rs.5000. But it was indeed; found that average person was paying Rs. 1031.64 per sick for a treatment. Bulky proportion of money used to go for the cost of drugs and fees for doctor or healer. Rest of their money was expensed for helper, transportation and others.

4.1.10. Affordability.

Table 17: Affordability as perceived by the Respondents.

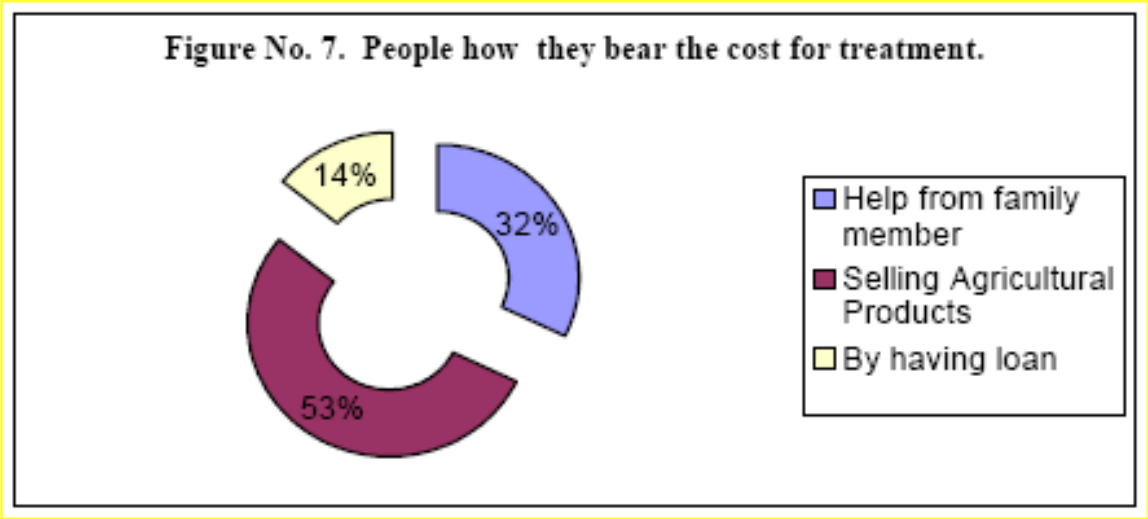
Affordability	Number	Percentage.
Yes	47	26.8
No	128	73.2
Total	175	100.0

Table 12. Suggests that 73.2% people were reported to be unable to afford the cost for treatment. Only 26.8% people were able to afford treatment cost. So it is striking to note that, only less than one-third people were found to be able to afford the cost for treatment.

Source [134]

Figure No.7. Bearing of the cost for treatment.

Figure suggests that 32% people took help or burrowed from their family members. 53% sold their belongings such as agricultural products, land etc., and 14% took loan for treatment. More than two third people were found unable to afford cost for the accomplishment of treatment.



Source [134]

Travel costs

For example, travel costs were over half of all delivery costs of normal deliveries in Nepal (Borghi et al. 2006a).

Source [84]

Medical spending and health outcome in Nepal: problems with technology or its distribution?

Subhash Pokhrel & Rainer Sauerborn

Notwithstanding the great improvements in medical technology, such as oral rehydration therapy, diarrhoea is still one of the leading causes of childhood morbidity and mortality in Nepal. Although easy-to-implement medical technologies help to reduce the health burden of many diseases, the experience in Nepal indicates that how a health system works in terms of fair distribution of such technologies and financing perhaps matters most. Childhood mortality in many developing countries remains higher among poorer people and the gap between rich and poor has grown, which indicates not only the uneven distribution of the benefits of improved medical technologies but also the extent of the economic consequences for households in the event of childhood illness. We argue that unless a national health system addresses distributional problems, the benefits of medical technologies can never be realized fully. To justify our argument, we present a small part of the results obtained from our analysis of the 1996 data of the Nepal Living Standard Survey. The design and implementation of the survey are described elsewhere (*1*).

We estimate annual out-of-pocket spending on medical care for children aged _15 years in Nepal at

0.8% of gross domestic product, which accounts for about 16% of the country's total expenditure on health. Health outcomes could have been different if this substantial amount of funds was organized in a more appropriate way, such as through insurance. For example, the care of ill infants and children aged _5 years costs households, on an average, twice as much as the care of older children (aged 6–15 years), but the former consumes nearly eight times more of household's annual budget than the latter. Although our study underestimated the real economic burden because the analysis took into account only direct treatment and travel costs, households with younger children face a substantial hurdle to financing the medical care of their children. Large out-of-pocket expenditure simply means less use of medical care given other needs, which in turn implies less than optimal health outcomes. Importantly, our analysis showed that diarrhoea was the second most frequent condition among children for which medical care was sought (the first being unspecified fever). Although oral rehydration therapy does not influence the occurrence of diarrhoea, it does influence the course, duration, and outcome of diarrhoea by preventing dehydration — the most common cause of death associated with diarrhoea. In the absence of the fair distribution of oral rehydration therapy, however, because households have to spend large out-of-pocket amounts of money at the point of service delivery, health outcomes are severely compromised. Young children's healthcare needs are greater than older children's needs, and households with younger children face large opportunity costs in terms of the time needed to take care of children, which otherwise would be used for economic activities. The developed world has addressed this disparity through the use of subsidies and insurance policies that target distributional aspects of the health system.

The German healthcare system, for example, offers all necessary preventive and curative child care at no cost to households through its social health insurance programme. Although poorer countries such as Nepal may not have enough funds to offer such free care, they are nevertheless able to provide subsidies for children's health care that would allow families to buy insurance to insure their children at substantially reduced rates. This will soon be the case in Burkina Faso, a West African country with a national income similar to that of Nepal. In order to instate a similar system, Nepal might have to look for some external funds. Would donor assistance be better focussed on funds for distributional endeavours (stimulating need-based demand) than funding projects from the supply side?

Although our study showed no statistically significant difference between whether or not a treatment was given to a child with diarrhoea by income quartile and rural or urban status, the treatment given (oral rehydration therapy or other allopathic or traditional solutions) was significantly different between these groups ($P < 0.05$). Surprisingly, a smaller proportion of urban households than rural households gave oral rehydration salts that could prevent the lethal consequence of diarrhoea. Instead, children in urban areas were given other allopathic or traditional medicines. Income was one of the significant characteristics that affected such a decision. The fact that urban households have better access to drugs other than oral rehydration salts, coupled with higher average incomes, might explain this behaviour. The place at which the oral rehydration salts were bought did not differ significantly, however, between these groups: in most cases oral rehydration salts were bought at public facilities. This may imply that providers other than the public might have offered drugs and not oral rehydration salts as the treatment for diarrhoea: even in the absence of information on severity of illness, we cannot readily assume that children from urban and better off families tend to have more severe episodes of diarrhoea and thus needed drugs other than oral rehydration salts. We therefore offer four possible explanations:

- the distribution of oral rehydration therapy has been confined to public facilities, as pushed largely by donor agencies;
- the knowledge that oral rehydration therapy is perhaps the best treatment for diarrhoea has not been distributed fairly among all types of providers;
- the financial incentives of prescribing drugs instead of oral rehydration salts are so large that

private-for-profit providers, including pharmacies, tend to ignore the benefits of oral rehydration salts; and
- the costs of oral rehydration salts themselves are so high that households take alternative measures.

The affordability of oral rehydration salts in poor countries, including Nepal, has been questioned seriously, and quality control in drug prescription has long been an open debate. In any case, the distribution of access to medical technology for whatever reason seems to play a more pronounced role than the effectiveness of the technology itself in determining health outcomes. In short, health systems should address the distributional aspects of any medical technology to provide better health outcomes rather than boasting that they have the most appropriate technology to fight diseases.

Source [149]

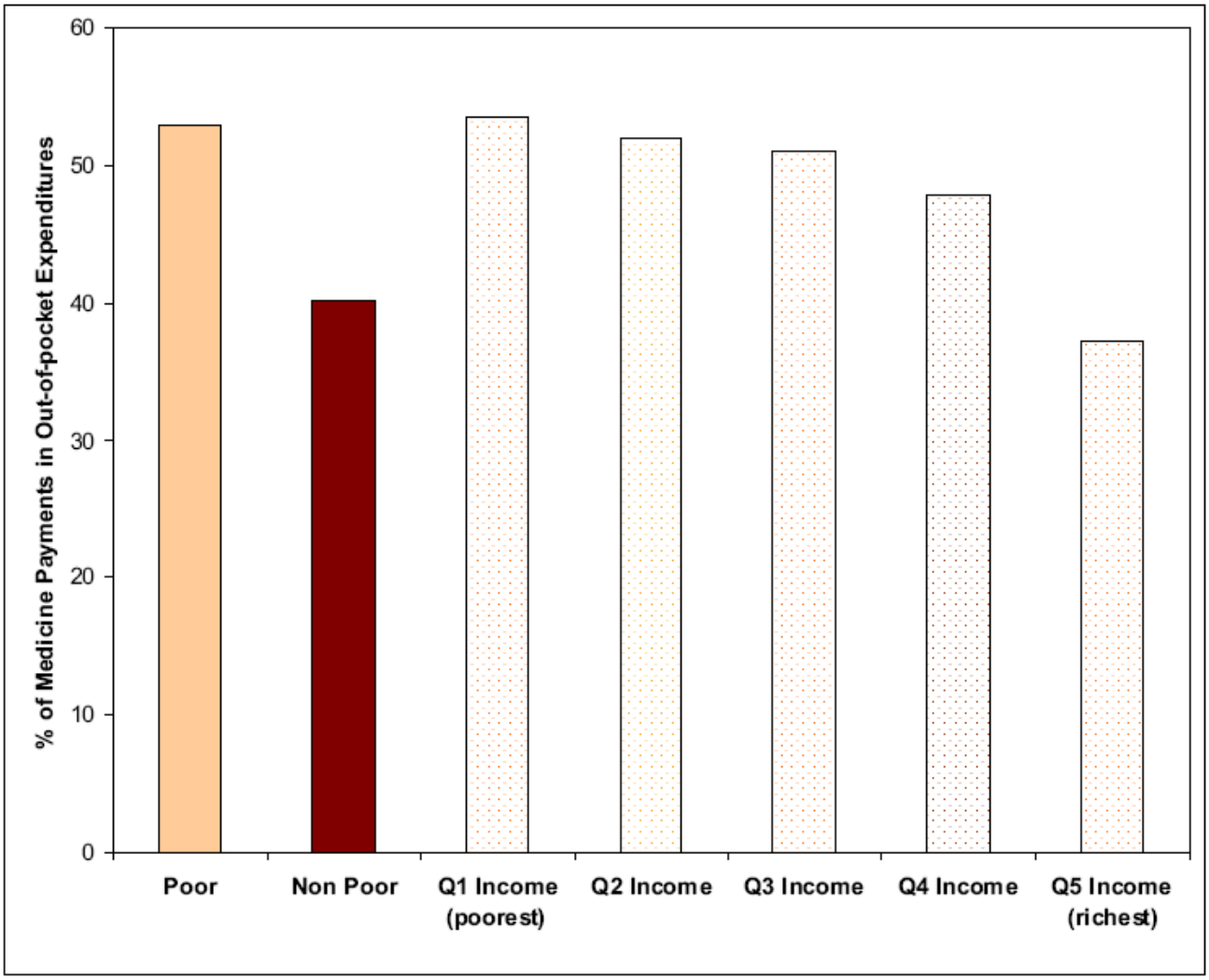
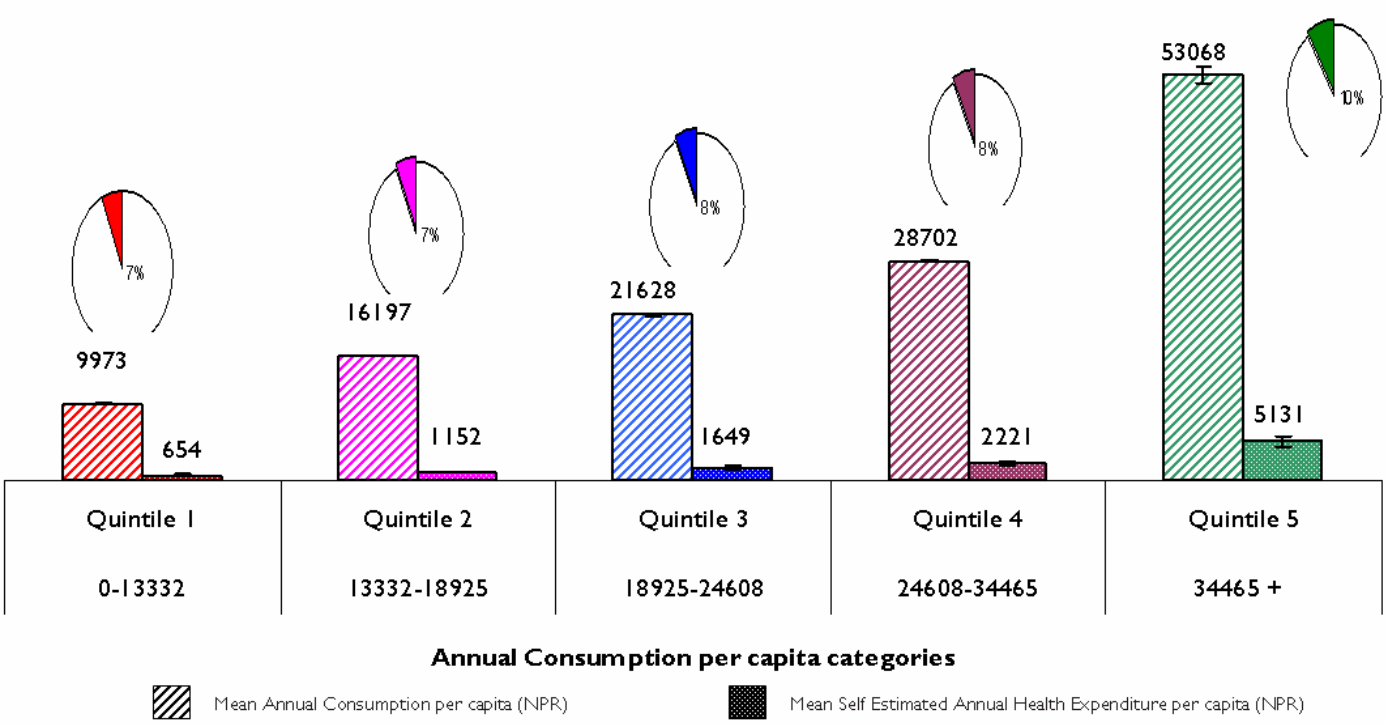


Figure 1
Medicine Payments as a Proportion of Out-of-pocket Expenditures by Income Quintiles in 20 Low-income Countries*, World Health Survey, 2003. * Bangladesh, Burkina Faso, Chad, Comoros, Cote D'Ivoire, Ethiopia, Ghana, India, Kenya, Lao PDR, Malawi, Mali, Mauritania, Myanmar, Nepal, Pakistan, Senegal, Vietnam, Zambia, and Zimbabwe.

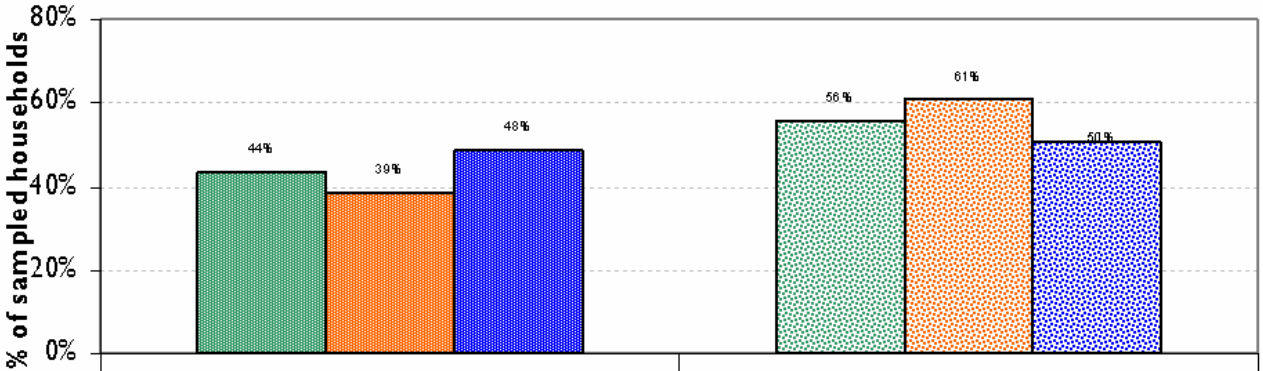
Source [38]

Household (health) expenditure in Dhading District, 2009



Source [462]

Utilization of public and private hospitals in Dhading District, 2009

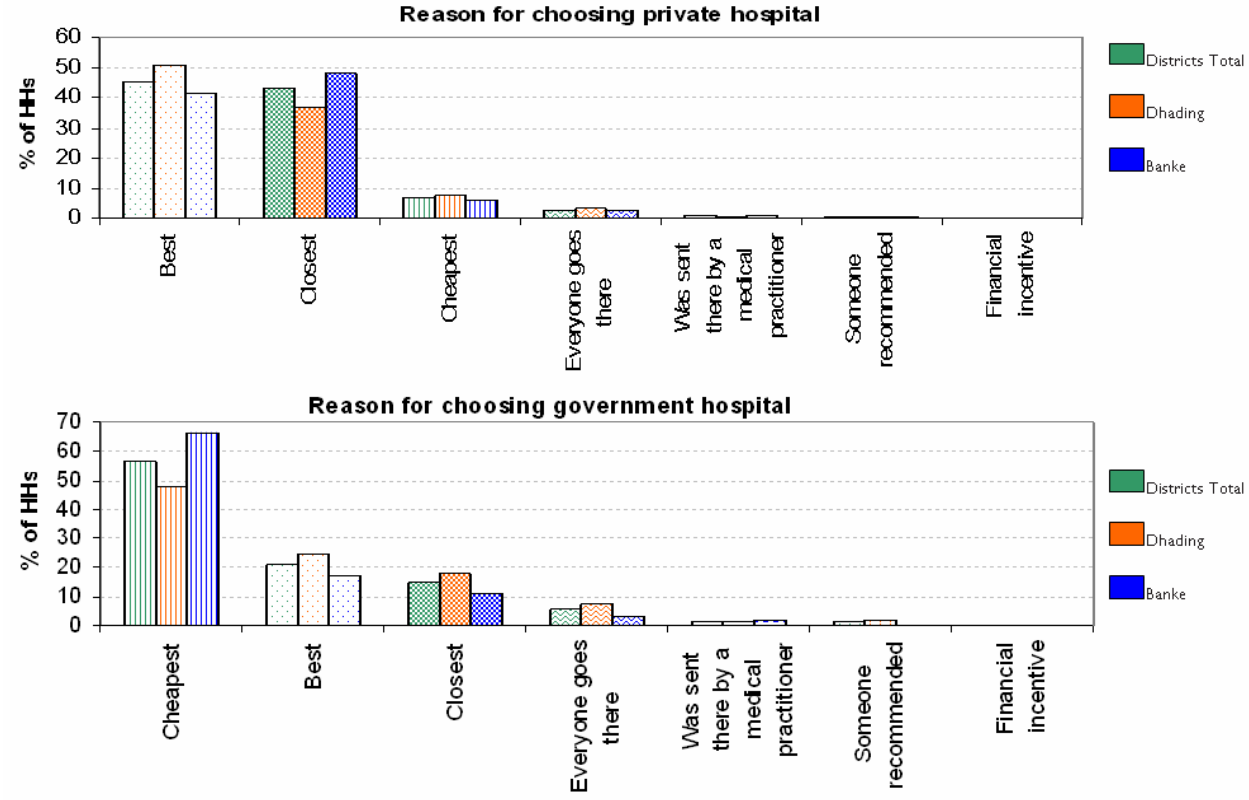


	Private	Government
Districts Total	44%	56%
Dhading	39%	61%
Banke	48%	50%

There was no significant difference in the cost of hospitalizations in private or public facilities

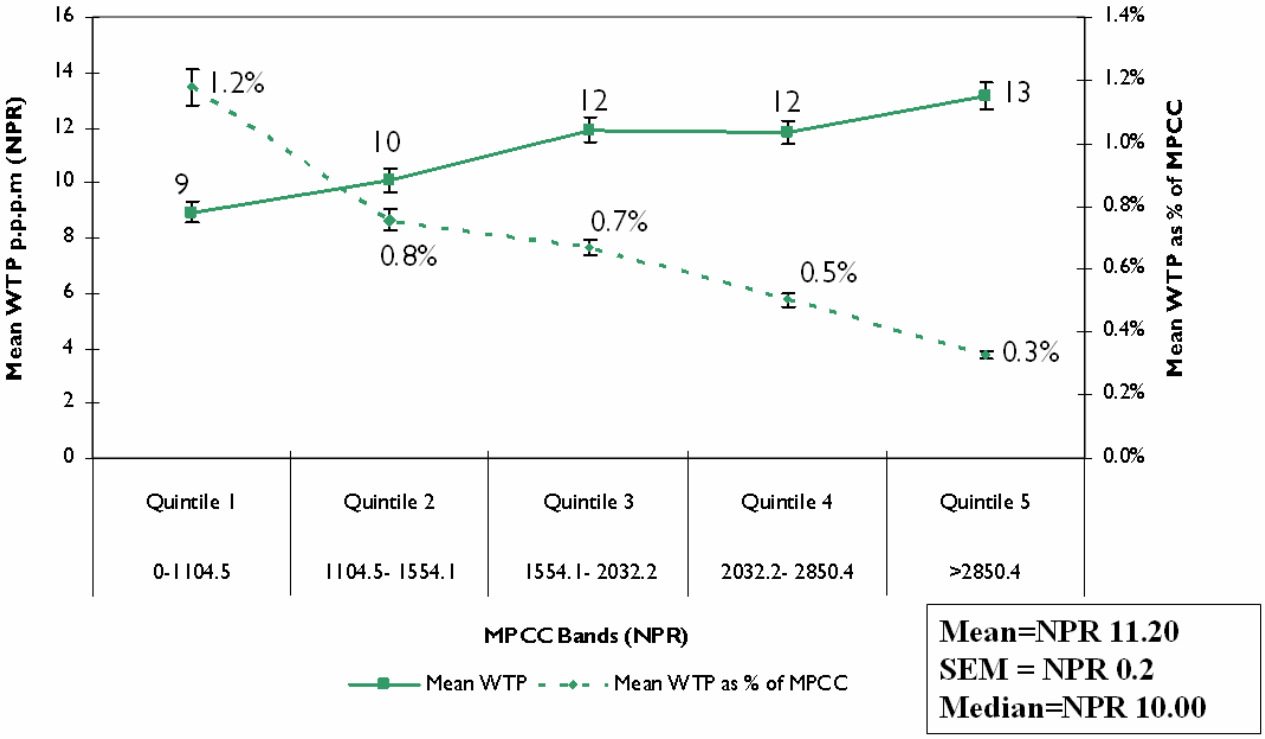
Source [462]

Price, proximity and quality determine the choice of the hospital , Dhading District, 2009



Source [462]

The rich are willing to pay more money but a smaller share of their income for health insurance, Dhading District, 2009



Source [462]

2.5 Health financing inequities

Table 7.1: Nominal household consumption and its distribution, by expenditure category

	Household Consumption (in millions of NRs.)	Percentage Distribution					
		Food	Rent	Education	Health	Other non-food	Total
Urban	126,557	39.1	18.5	5.6	4.3	32.6	100
Rural	223,424	62.9	7.7	2.3	6	21.1	100
Wealth Quintile							
Poorest	21,704	73	5.8	1.3	3.7	16.2	100
Second	32,611	66.9	6.8	1.8	5	19.5	100
Third	44,478	64.8	7.4	2.3	5.4	20	100
Fourth	64,666	58.1	9.4	3.2	6.7	22.6	100
Richest	186,523	40.1	15.5	4.8	7	32.6	100
National	349,981	59	9.5	2.8	5.7	23	100

Source [464]

Table 7.2: Household expenditure on the most recent consultation at government or private institution for acute illness (in NRs.)

Expenditure Category	Government Institution				Private Institution			
	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost
Wealth Quintile								
Poorest	6	116	2	1,24	23	171	50	199
Second Poorest	29	181	14	2,24	21	245	11	277
Third	24	2,15	20	2,59	37	295	34	366
Fourth	38	400	520	4,90	1,12	415	450	572
Richest	3,45	1518	183	2046	338	873	148	1359
Urban	254	1278	80	1612	263	602	66	931
Rural	78	436	58	572	1,12	439	61	612
Nepal	99	538	610	698	1360	465	62	663

Source [464]

Table 7.3: Per capita household expenditure on health per month, by wealth quintile

Wealth Quintile	Modern medicine and health care (code=237)	Tradition medicines and health care (code=238)	Total health expenditure
Poorest Quintile			
Mean expenditure per person NRs.	10.34	0.41	10.75
Share of household budget spent on health (%)	2.42	0.09	2.63
Second Quintile			
Mean expenditure per person NRs.	19.6	1.0	20.56
Share of household budget spent on health (%)	3.2	0.16	3.35
Third Quintile			
Mean expenditure per person NRs.	34.2	1.14	35.34
Share of household budget spent on health (%)	4.07	0.14	4.21
Fourth Quintile			
Mean expenditure per person NRs.	62.1	2.1	64.2
Share of household budget spent on health (%)	5.1	0.17	5.26
Richest Quintile			
Mean expenditure per person NRs.	253.29	2.25	255.54
Share of household budget spent on health (%)	6.2	0.08	7.26
Total	75.88	1.38	77.26
Share of household budget spent on health (%)	4.19	0.13	4.32

Source [464]

Table 3: Mean Expenditure Per Person by Income

Quintiles	Mean Expenditure per Person NRs	Share of Household Budget Spent on Health (%)
Poorest quintile	10.75	2.63
2nd quintile	20.56	3.35
3rd quintile	35.34	4.21
4th quintile	64.2	5.26
Richest quintile	255.54	7.26

Source: DHS/MoHP

Source [138]

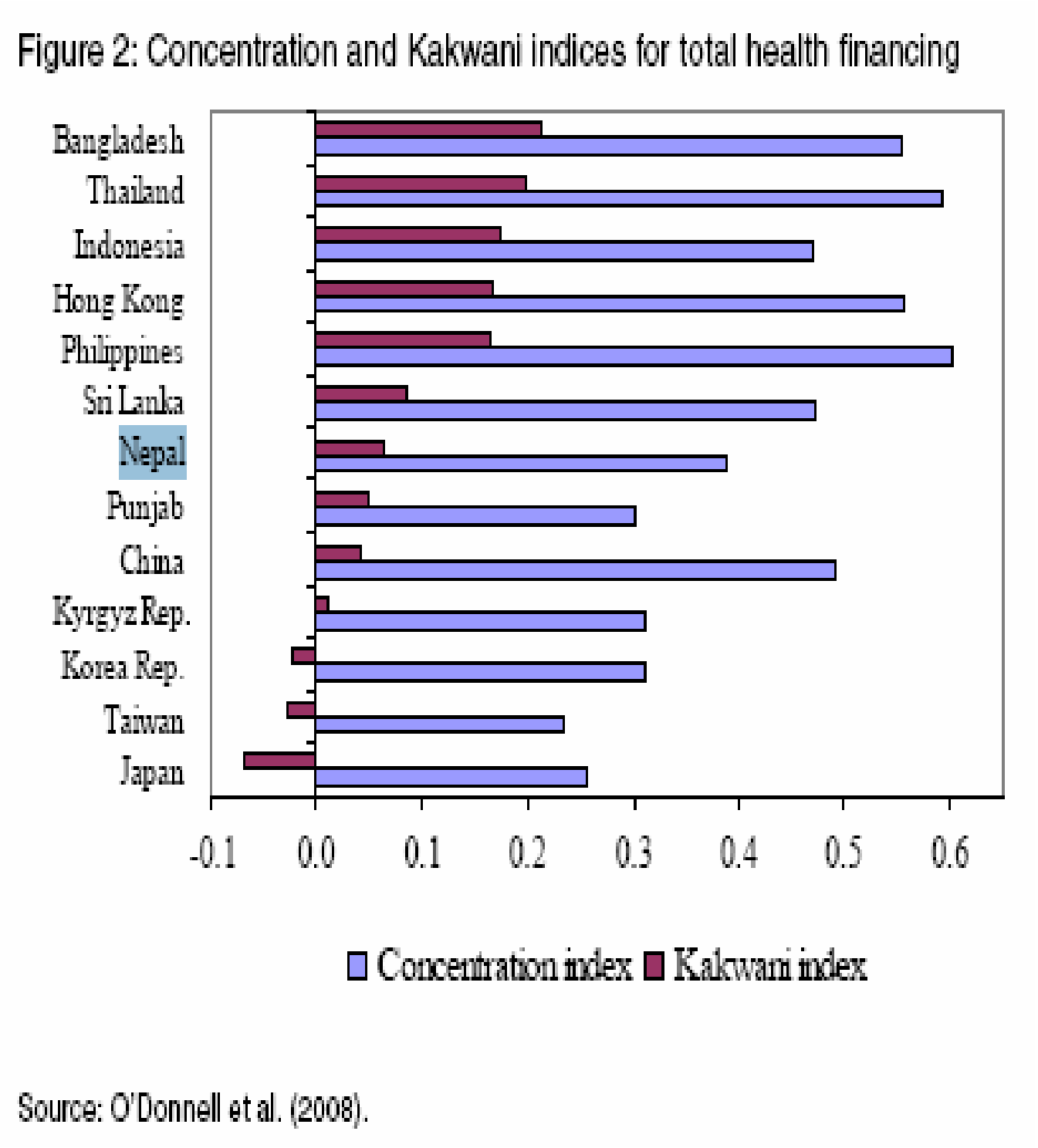
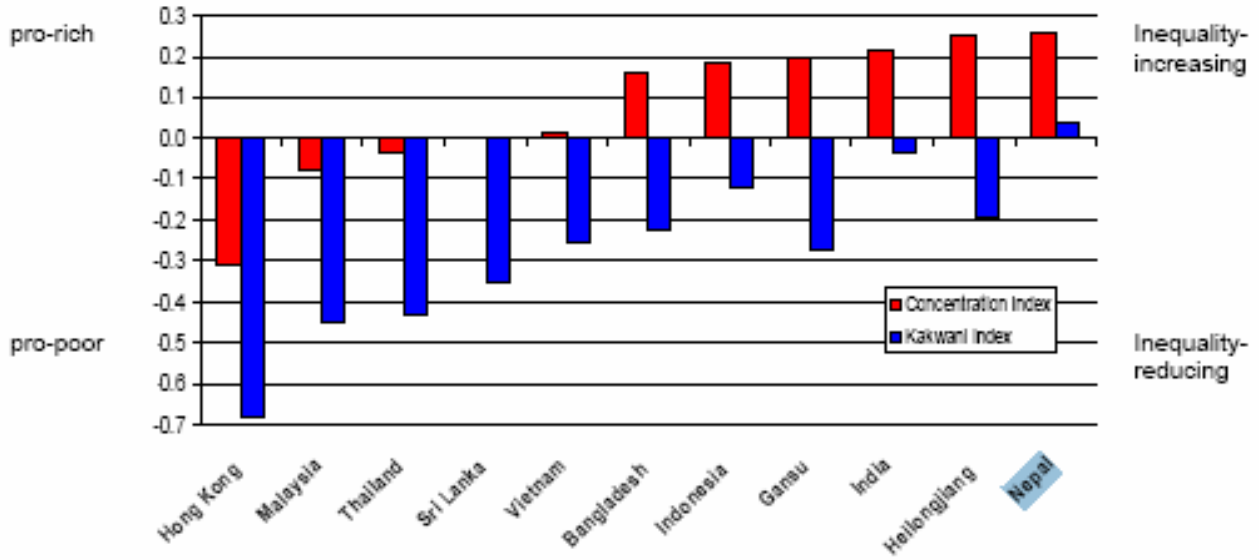


Figure 2: Concentration and Kakwani indices for total health financing
Bangladesh
Thailand
Indonesia
Hong Kong
Philippines
Sri Lanka
Nepal
Punjab
China
Kyrgyz Rep.
Korea Rep.
Taiwan
Japan
-0.1
0.0
0.1
0.2
0.3
0.4
0.5
0.6
Concentration index
Kakwani index
Source: O'Donnell et al. (2008).

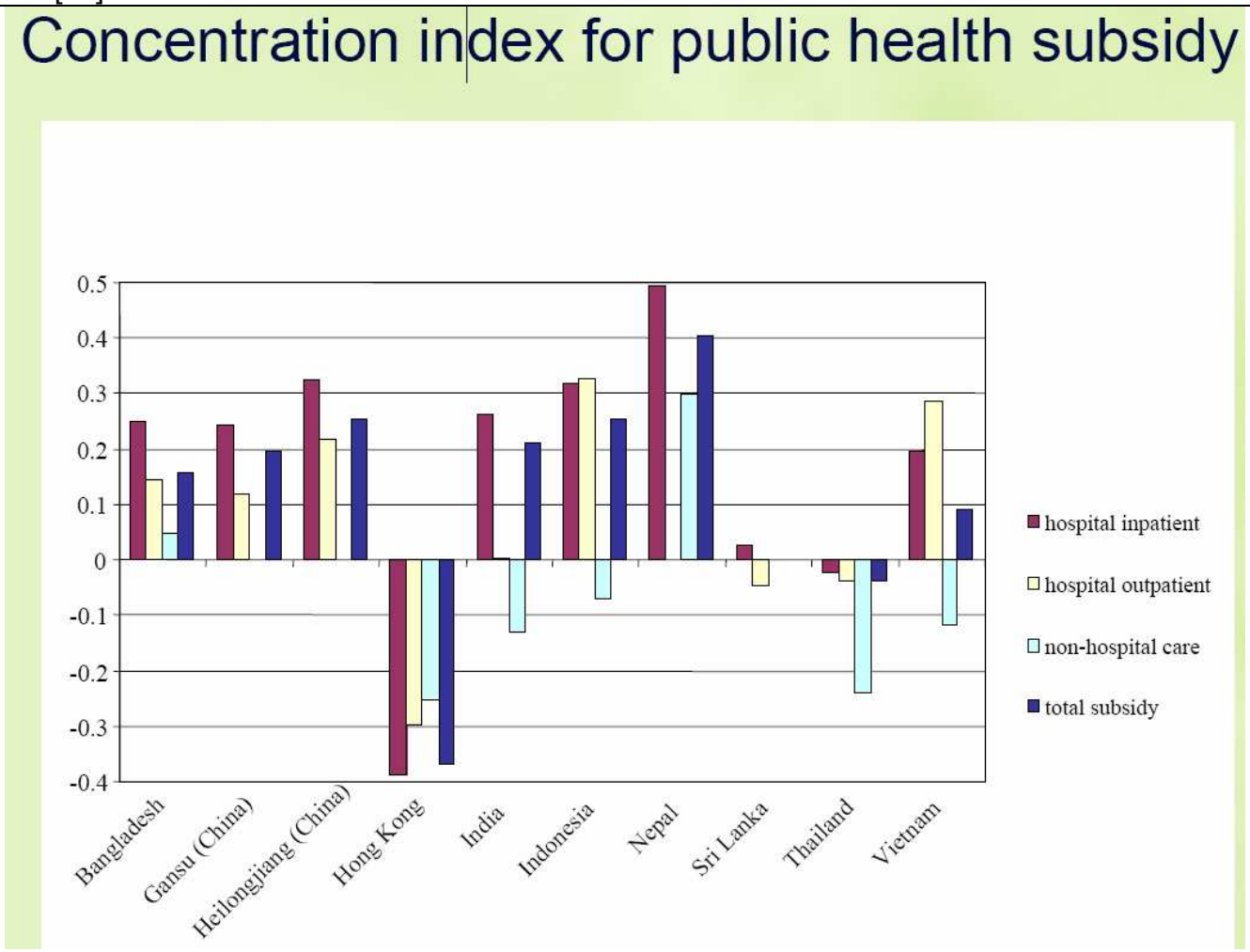
Source [65]

Figure 8: Concentration and Kakwani indices for public health subsidy

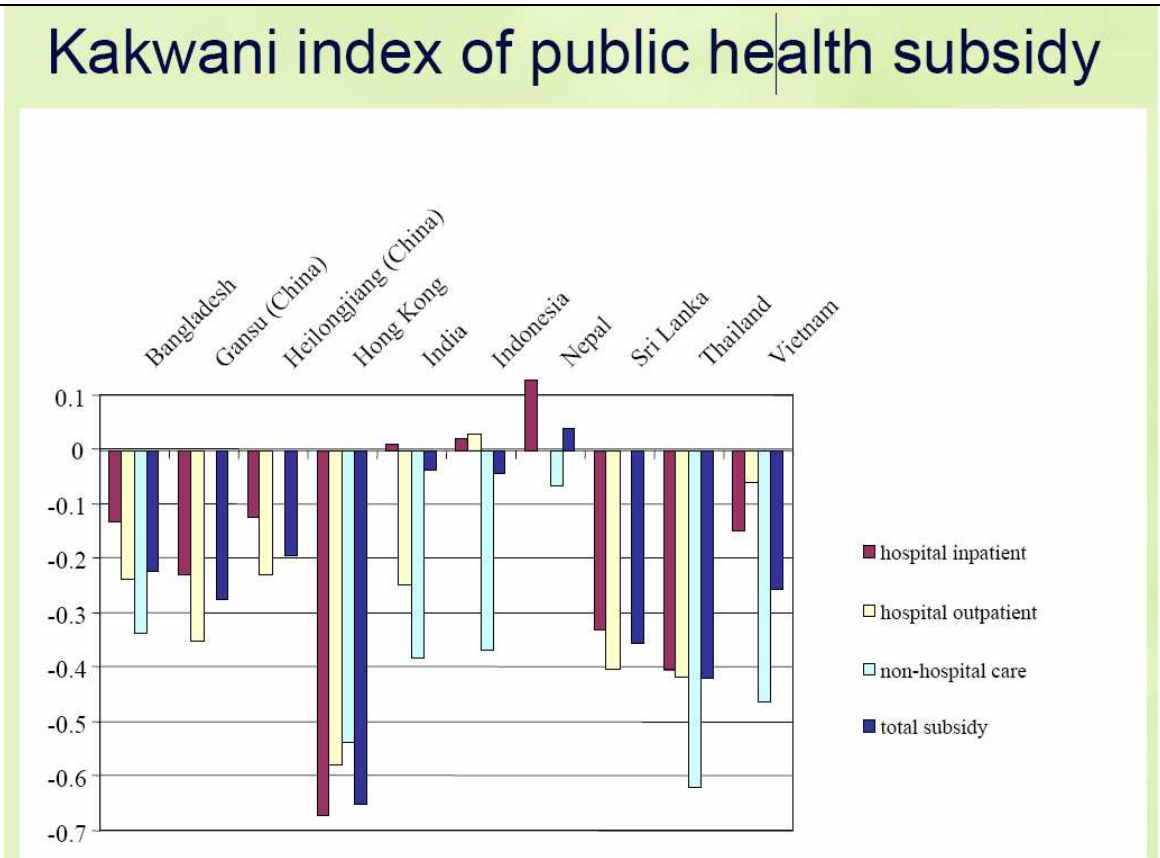


Source: O'Donnell et al. (2007a: Table S.3).

Source [65]



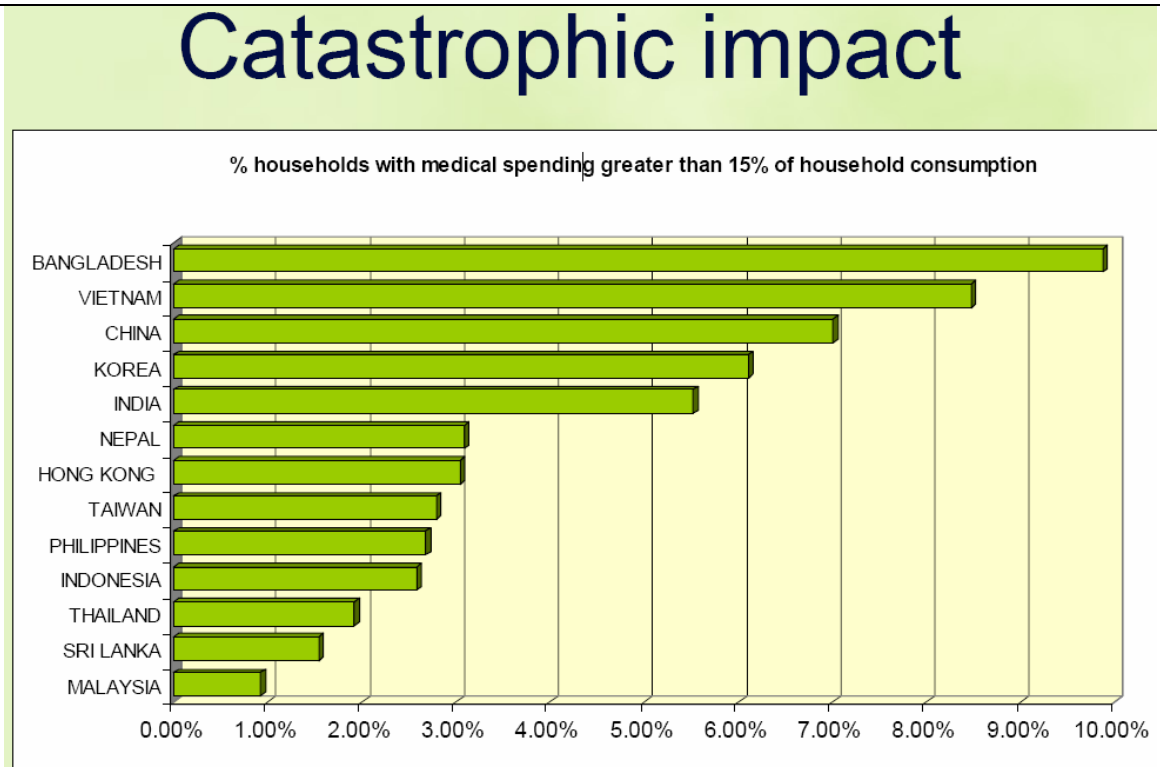
Source [10]



Source [10]

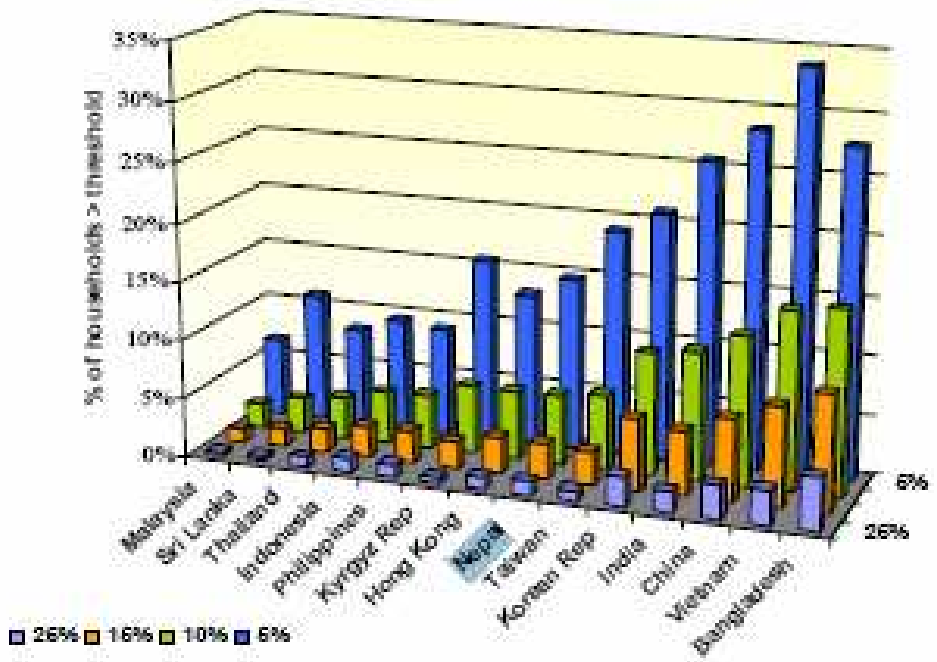
2.6

Catastrophic health expenditures



Source [10]

Figure 3: Percentage of households incurring catastrophic payments: various thresholds for OOP as % of total expenditure



Source: Van Doorslaer et al. (2007).

Source [65]

Catastrophic expenditure for Kala-azar

„Households obtaining health care services in developing countries incur substantial costs, despite services generally being provided free of charge by public health institutions. This constitutes an economic burden on low-income households, and contributes to deepening their level of poverty. In addition to the economic burden of obtaining health care, the method of financing these payments has implications for the distribution of household assets. This effect on resource-poor households is amplified since they have decreased access to health insurance. Recent literature, however, ignores the importance of the method of financing health care payments. This paper looks at the case of Nepal and highlights the impact on households of paying for hospital-based care of Kala-azar (KA) by analysing the catastrophic, impoverishment and economic consequences of their coping strategies. The paper utilizes micro-data on a random selection of 50% of the KA-affected households of Siraha and Saptari districts of Nepal. The empirical results suggest that direct costs of hospital based treatment of KA are catastrophic since they consume 17% of annual household income. This expenditure causes more than 20% of KA-affected households to fall below the poverty line, with the remaining households being pushed into the category of marginal poor; the poverty gap ratio is more than 90%. Further, KA incidence can have prolonged and severe economic consequences for the household economy due to the mechanisms of informal sector financing to which households resort. A heavy burden of loan repayments can lead households on a downward spiral that eventually becomes a poverty trap. In other words, the method of financing health care payments is an important ingredient in understanding the economic burden of disease.

Source [252]

Table VI. OOP health payments in excess of catastrophic payments threshold budget share

		Share of total consumption/expenditure				Share of non-food consumption/expenditure		
	Threshold	5%	10%	15%	25%	15%	25%	40%
BANGLADESH	Mean overshoot (O)	3.04%	2.02%	1.40%	0.72%	4.74%	2.83%	1.26%
	Concentration index (C_O)	0.3299	0.3915	0.4528	0.567	0.3844	0.4667	0.592
	Rank weighted overshoot (O^W)	2.04%	1.23%	0.76%	0.31%	2.92%	1.51%	0.51%
	Mean positive overshoot (MPO)	11.01%	12.98%	14.15%	16.07%	19.32%	19.22%	17.70%
CHINA	Mean overshoot (O)	2.22%	1.28%	0.81%	0.35%	3.39%	1.86%	0.73%
	Concentration index (C_O)	0.0639	0.1056	0.1631	0.2594	−0.0697	−0.0265	0.0653
	Rank weighted overshoot (O^W)	2.08%	1.14%	0.68%	0.26%	3.62%	1.91%	0.69%
	Mean positive overshoot (MPO)	7.84%	10.12%	11.52%	12.38%	16.09%	16.57%	15.24%
HONG KONG	Mean overshoot (O)	0.98%	0.55%	0.34%	0.13%	0.73%	0.34%	0.11%
	Concentration index (C_O)	0.0854	0.1410	0.2052	0.3140	0.0237	0.0762	0.1719
	Rank weighted overshoot (O^W)	0.90%	0.47%	0.27%	0.09%	0.71%	0.31%	0.09%
	Mean positive overshoot (MPO)	7.56%	9.40%	11.08%	12.06%	12.40%	13.66%	12.76%
INDIA	Mean overshoot (O)	1.77%	0.92%	0.53%	0.20%	2.80%	1.35%	0.45%
	Concentration index (C_O)	0.1449	0.2080	0.2788	0.4144	0.1609	0.2451	0.3915
	Rank weighted overshoot (WO)	1.51%	0.73%	0.38%	0.12%	2.35%	1.02%	0.27%
	Mean positive overshoot (MPO)	6.91%	8.49%	9.65%	11.03%	13.39%	13.83%	12.96%
INDONESIA	Mean overshoot (O)	0.83%	0.51%	0.34%	0.17%	1.38%	0.77%	0.32%
	Concentration index (C_O)	0.3125	0.4208	0.5069	0.6367	0.2688	0.3770	0.5391
	Rank weighted overshoot (O^W)	0.57%	0.29%	0.17%	0.06%	1.01%	0.48%	0.15%
	Mean positive overshoot (MPO)	8.71%	11.48%	13.09%	14.64%	16.68%	17.62%	16.64%
KOREA	Mean overshoot (O)	1.90%	1.16%	0.76%	0.36%	1.42%	0.73%	0.27%
	Concentration index (C_O)	0.0325	0.0778	0.1263	0.2302	0.0233	0.0916	0.2073
	Rank weighted overshoot (O^W)	1.84%	1.07%	0.67%	0.28%	1.39%	0.66%	0.22%
	Mean positive overshoot (MPO)	9.07%	11.23%	12.48%	13.94%	14.52%	15.20%	14.82%
KYRGYZ REP.	Mean overshoot (O)	0.84%	0.35%	0.15%	0.04%	2.38%	1.06%	0.28%
	Concentration index (C_O)	0.1224	0.1938	0.2039	0.2830	0.0851	0.1120	0.1192
	Rank weighted overshoot (O^W)	0.74%	0.28%	0.12%	0.03%	2.18%	0.94%	0.25%
	Mean positive overshoot (MPO)	5.44%	6.02%	6.71%	7.46%	13.19%	11.44%	10.70%
MALAYSIA	Mean overshoot (O)	0.36%	0.17%	0.10%	0.05%	0.24%	0.10%	0.03%
	Concentration index (C_O)	0.2542	0.4204	0.5370	0.7232	0.2641	0.4730	0.7388
	Rank weighted overshoot (O^W)	0.27%	0.10%	0.05%	0.01%	0.18%	0.05%	0.01%
	Mean positive overshoot (MPO)	5.39%	8.58%	10.58%	13.15%	9.62%	12.46%	14.82%
NEPAL	Mean overshoot (O)	1.11%	0.64%	0.43%	0.24%	4.35%	3.11%	2.15%
	Concentration index (C_O)	0.0579	0.0474	0.0475	−0.0418	−0.2368	−0.2949	−0.3695
	Rank weighted overshoot (O^W)	1.06%	0.61%	0.41%	0.25%	5.38%	4.02%	2.94%
	Mean positive overshoot (MPO)	7.54%	10.85%	13.88%	20.59%	25.42%	33.66%	47.15%
PHILIPPINES	Mean overshoot (O)	0.82%	0.50%	0.32%	0.14%	1.15%	0.62%	0.24%
	Concentration index (C_O)	0.2766	0.3427	0.4089	0.5429	0.2055	0.2674	0.3819
	Rank weighted overshoot (O^W)	0.60%	0.33%	0.19%	0.07%	0.91%	0.46%	0.15%
	Mean positive overshoot (MPO)	8.94%	10.81%	12.01%	12.68%	15.89%	16.36%	15.36%
SRI LANKA	Mean overshoot (O)	0.56%	0.27%	0.16%	0.07%	0.97%	0.42%	0.15%
	Concentration index (C_O)	0.2969	0.4412	0.5553	0.7575	0.1064	0.2376	0.4258
	Rank weighted overshoot (O^W)	0.39%	0.15%	0.07%	0.02%	0.87%	0.32%	0.08%
	Mean positive overshoot (MPO)	5.09%	8.89%	10.41%	15.56%	10.74%	13.70%	15.05%
TAIWAN	Mean overshoot (O)	1.03%	0.47%	0.26%	0.10%	0.45%	0.18%	0.06%
	Concentration index (C_O)	−0.0293	−0.0457	−0.0528	−0.0421	−0.0442	−0.0430	−0.0088
	Rank weighted overshoot (O^W)	1.06%	0.50%	0.28%	0.11%	0.47%	0.19%	0.06%
	Mean positive overshoot (MPO)	5.40%	7.46%	9.39%	11.79%	9.97%	12.07%	14.04%
THAILAND	Mean overshoot (O)	0.61%	0.33%	0.20%	0.07%	0.55%	0.26%	0.08%
	Concentration index (C_O)	0.2474	0.3337	0.3907	0.5349	0.1508	0.1970	0.2172

Health Econ. (in press)
DOI: 10.1002/hec

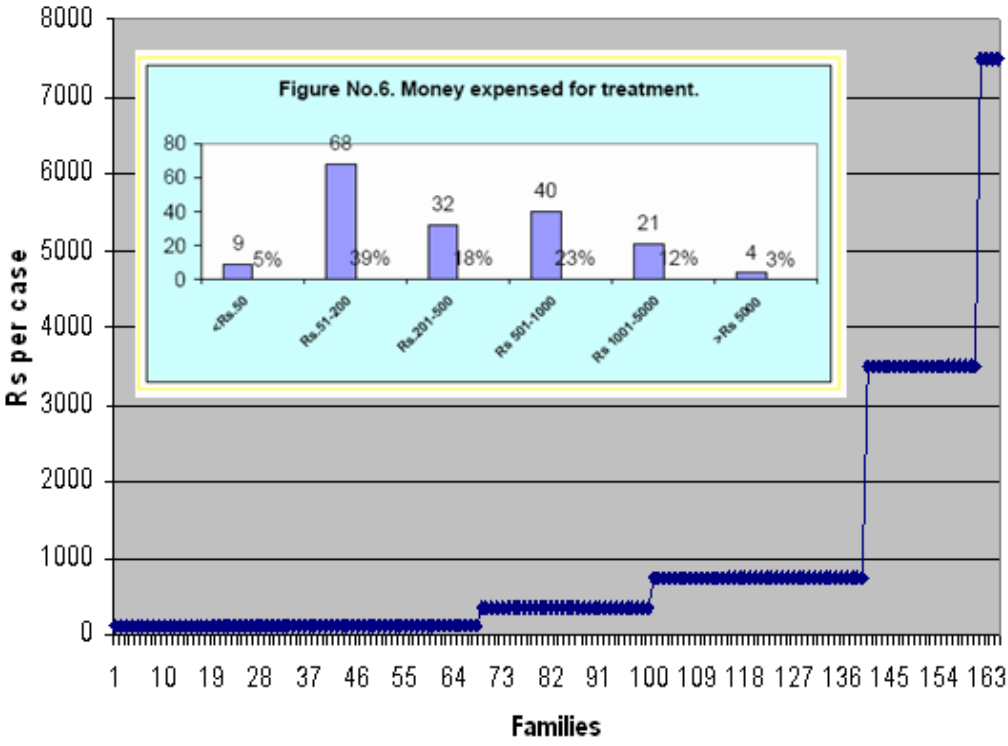
Source [247]

Table V. Percentage of households incurring catastrophic payments for health care

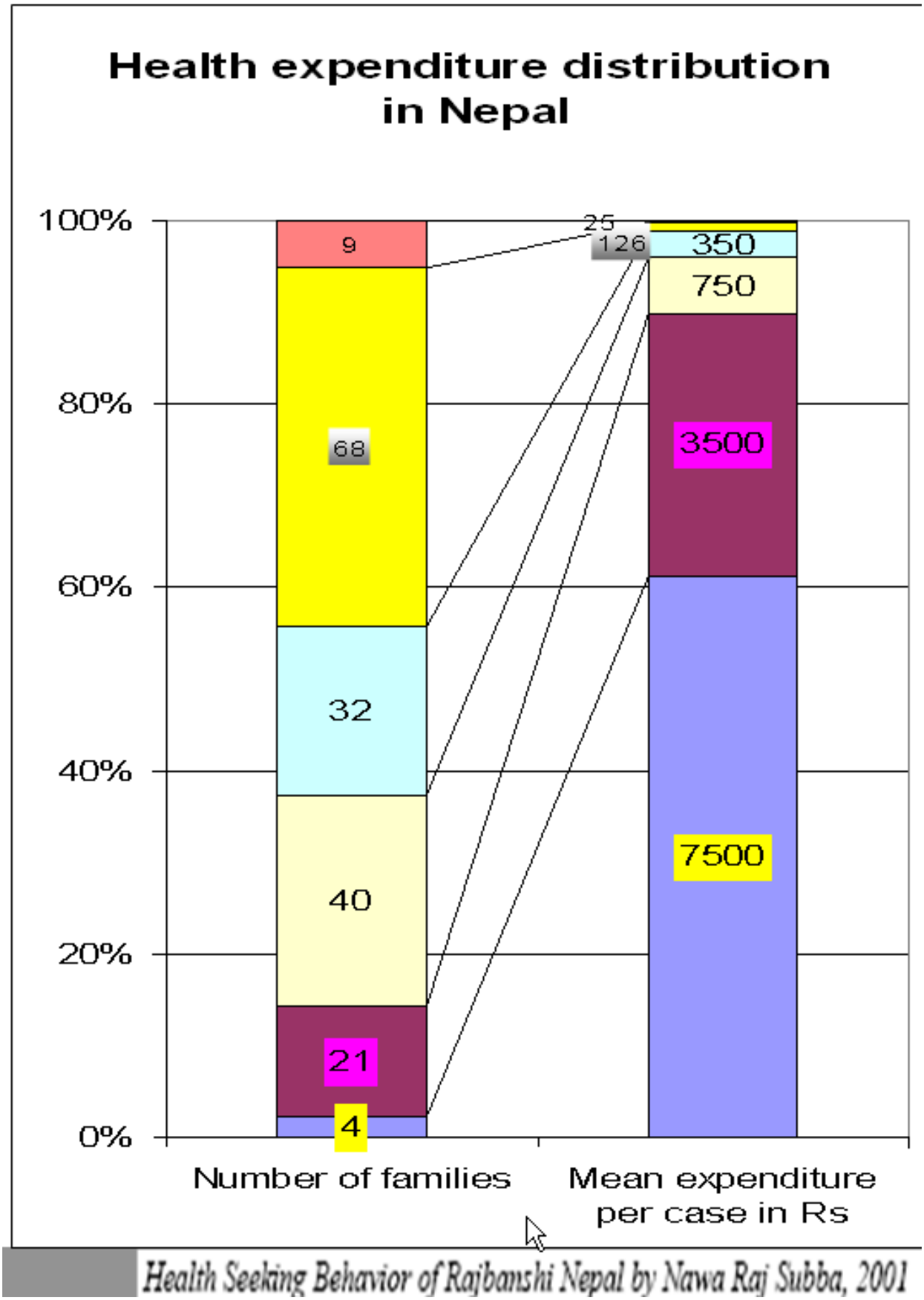
		OOP payments as share of total household expenditure				OOP payments as share of non-food expenditure		
	Threshold	5%	10%	15%	25%	15%	25%	40%
BANGLADESH	Headcount (H_C)	27.63%	15.57%	9.87%	4.49%	24.55%	14.73%	7.13%
	Concentration index (C_E)	0.1821	0.2332	0.2797	0.391	0.2123	0.3145	0.458
	Rank weighted headcount (H_C^W)	22.60%	11.94%	7.11%	2.73%	19.33%	10.10%	3.86%
CHINA	Headcount (H_C)	28.37%	12.61%	7.01%	2.80%	21.05%	11.23%	4.81%
	Concentration index (C_E)	0.0103	−0.0078	0.0293	0.1597	−0.1147	−0.1202	−0.0334
	Rank weighted headcount	28.08%	12.71%	6.80%	2.36%	23.47%	12.58%	4.98%
HONG KONG	Headcount (H_C)	12.98%	5.86%	3.04%	1.09%	5.86%	2.46%	0.86%
	Concentration index (C_E)	0.0168	−0.0019	0.0935	0.1676	−0.0590	−0.0050	0.0875
	Rank weighted headcount	12.76%	5.87%	2.76%	0.91%	6.20%	2.47%	0.78%
INDIA	Headcount (H_C)	25.59%	10.84%	5.52%	1.83%	20.92%	9.76%	3.44%
	Concentration index (C_E)	0.0722	0.0915	0.1425	0.2780	0.0623	0.1213	0.2601
	Rank weighted headcount	23.74%	9.85%	4.73%	1.32%	19.62%	8.57%	2.54%
INDONESIA	Headcount (H_C)	9.57%	4.43%	2.59%	1.13%	8.28%	4.40%	1.95%
	Concentration index (C_E)	0.0978	0.2001	0.3006	0.4777	0.0822	0.1828	0.3590
	Rank weighted headcount	8.63%	3.54%	1.81%	0.59%	7.60%	3.60%	1.25%
KOREA REP.	Headcount (H_C)	20.94%	10.36%	6.11%	2.56%	9.79%	4.82%	1.85%
	Concentration index (C_E)	−0.0453	−0.0244	0.0011	0.0956	−0.0640	−0.0195	0.0860
	Rank weighted headcount	21.89%	10.61%	6.10%	2.32%	10.42%	4.91%	1.69%
KYRGYZ REP.	Headcount (H_C)	15.53%	5.84%	2.30%	0.50%	18.05%	9.29%	2.64%
	Concentration index (C_E)	0.1720	0.2097	0.2372	0.2372	0.1035	0.1210	0.1916
	Rank weighted headcount	12.86%	4.62%	1.75%	0.38%	16.18%	8.16%	2.13%
MALAYSIA	Headcount (H_C)	6.62%	2.01%	0.98%	0.36%	2.48%	0.78%	0.21%
	Concentration index (C_E)	0.0562	0.1633	0.3018	0.5238	0.0491	0.2123	0.5742
	Rank weighted headcount (H_C^W)	6.25%	1.68%	0.68%	0.17%	2.36%	0.61%	0.09%
NEPAL	Headcount (H_C)	14.72%	5.90%	3.09%	1.18%	17.12%	9.24%	4.57%
	Concentration index (C_E)	0.1039	0.0320	0.0963	0.2193	−0.0743	−0.1125	−0.1415
	Rank weighted headcount	13.19%	5.71%	2.79%	0.92%	18.39%	10.28%	5.21%
PHILIPPINES	Headcount (H_C)	9.21%	4.60%	2.68%	1.14%	7.23%	3.81%	1.58%
	Concentration index (C_E)	0.1529	0.1952	0.2404	0.3755	0.1093	0.1526	0.2593
	Rank weighted headcount	7.80%	3.70%	2.04%	0.71%	6.44%	3.23%	1.17%

Source [247]

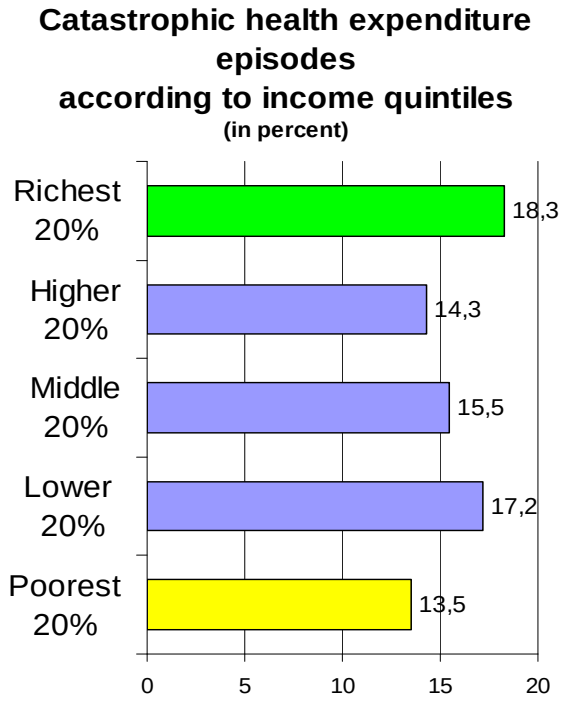
Health expenditure distribution in Nepal



Source [465] based on [134]



Source [465] based on [134]



Source [465]
based on [429]

2.7

User fees, informal payments, etc.

The effect of user fees on prescribing quality in rural Nepal: two controlled pre-post studies to compare a fee per drug unit vs. a fee per drug item.

Holloway KA, **Karkee S**, **Tamang A**, **Gurung YB**, **Pradhan R**, **Reeves BC**.
Department of Medicines Policy and Standards, World Health Organization, Geneva, Switzerland. hollowayk@who.int

OBJECTIVE: To compare prescribing quality with a fee per drug unit vs. a fee per drug item. METHODS: Prescribing data were collected prospectively over 10 years from 21 health facilities in two districts of rural eastern Nepal. In 1995, both districts charged a fee per drug item. By 2000, one district was charging a fee per drug unit, and the second district continued to charge a fee per drug item (control group). By 2002, the second district was also charging a fee per drug unit. These fee changes allowed two pre-post 'cohort' with control analyses to compare INRUD/WHO drug use indicators for a fee per drug unit vs. a fee per drug item. RESULTS: Charging a fee per drug unit increased the percentage of antibiotics prescribed in under-dosage by 11-12% (P = 0.02 and 0.02), decreased the percentage of patients prescribed injections by 4-6% (P = 0.002 and 0.02), reduced the units per drug item prescribed by 1.7 (P = 0.02 and 0.03), and decreased compliance with standard treatment guidelines by 11-15% (P = 0.02 and 0.06). CONCLUSION: A fee per unit was associated with prescription of fewer units of drugs and fewer expensive drugs (such as injections), resulting in significantly poorer compliance with standard treatment guidelines. This finding is of great concern for public health in countries where patients are charged a fee per unit of drug.

Trop Med Int Health. 2008 Apr;13(4):541-7. Epub 2008 Feb 25.
PMID: 18312474 [PubMed - indexed for MEDLINE]
Source [188]

BOX 70. CHANGING THE PRACTICE OF DRUG SELLERS IN NEPAL

In Nepal, the Britain-Nepal Medical Trust (BNMT) has a long-running programme operating with private drug shops. It uses a combination of of training, supervision, and access to buying drugs at cost price to improve the quality of care. Private drug shops are a predominant source of primary health care for many people in Nepal (and many other developing countries).

Since the early 1980s, BNMT operated a scheme in which it formed contracts with shop retailers chosen by communities. Under these contracts, BMNT undertook to sell essential drugs to the retailers at cost price plus 10% for handling; the retailer was allowed to sell the drugs for a further 12.5% mark-up. This total mark-up of 22.5% was considerably less than that found in many commercial shops. In addition, BNMT subsidized transport costs and arranged for training and supervision of the retailers. The shops were only accepted into the programme on the condition that they sold only essential drugs (including prescription-only drugs provided a health facility was within half a day's walk) at the agreed price and handled drugs to an adequate standard.

A comparative study of BNMT supported and non-supported drug shops in 1996 found that the average mark-up was 36% and 80%, respectively; the percentage of patients issued a bill was 31% and 2%; the percentage of customers sold antibiotics was 28% and 23%; the percentage of antibiotics sold in adequate amount was 76% and 86%; and the percentage of drugs belonging to the national essential drug list was 87% and 59%, respectively. In both types of shops, the average interaction time between retailer and customer was 3.6 minutes, 76% of customers knew their correct dosing schedules, and 63–66% of prescription-only drugs were sold without prescription. Retailers supported by BNMT stated that they could not avoid selling prescription-only drugs without prescription because of competition from commercial shops that often started up within 1–2 years of the BNMT-supported shop.

The shop support programme was associated with lower mark-ups, greater issuing of customer bills, greater use of essential drugs, and a slightly lower rate of antibiotic underdosing. However, many poor practices such as selling prescription-only drugs without prescription could not be changed due to commercial competition.

Source: Holloway KA, Gautam BR (2004). *Impact of an NGO-supported supervisory program on quality of care in private drug shops in rural East Nepal.* Presentation at the International Conference on Improving Rational Use of Medicines, 2004. ICIUM, Chiang Mai, Thailand. http://mednet3.who.int/icium/icium2004/poster.asp?keyword=Access+and+Use. An article on the study was also published in *Nepal Pharmaceutical Association Bulletin*, 1998, vol.19:4–12.

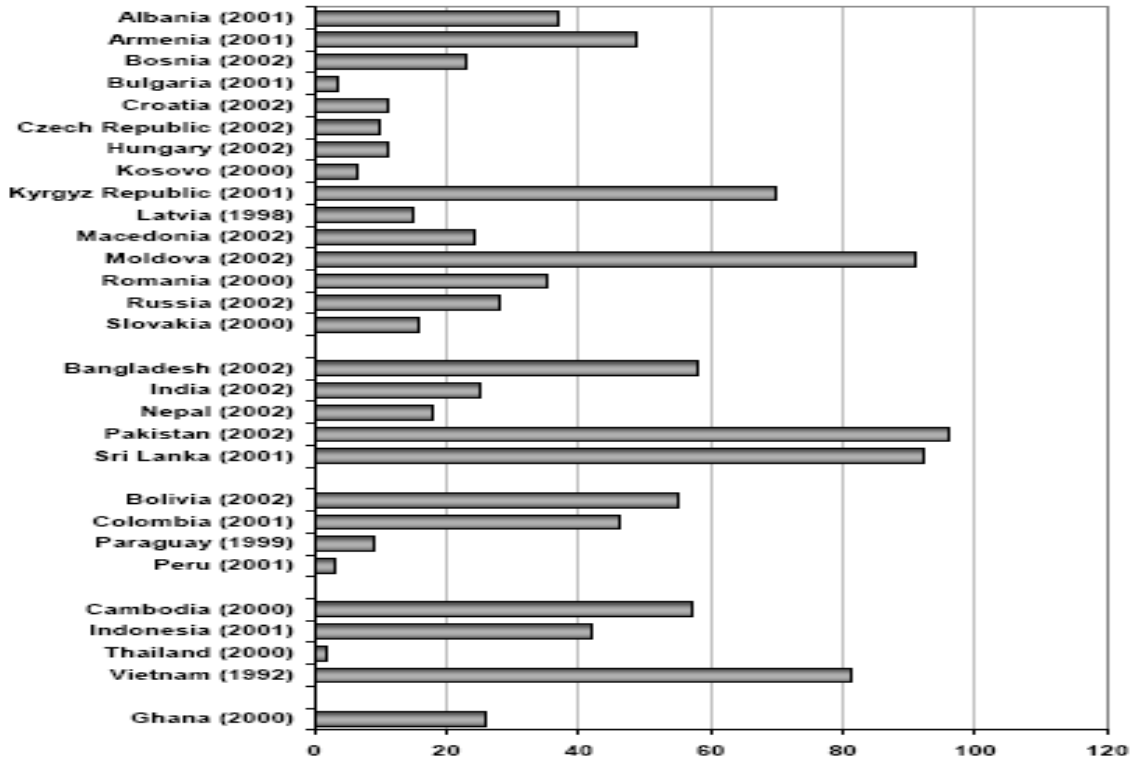
Source [36]

Bribes

"A study in Bangladesh, India, Nepal, Pakistan and Sri Lanka showed that bribes are required for admission to the hospital, to obtain a bed, and to receive subsidised medications."

Source [249]

Figure 5. Proportion who make Informal Payments Among Users of Health Services, Selected Countries



Source [50]

Source [247]

Table II. User charges for public sector care and co-payments for care covered by Social Health Insurance

	Charged services	Free services	Income/poverty related fee waivers	Non-poor groups exempt from charges
Bangladesh	Secondary services (nominal registration fee for inpatient/outpatient); Inpatient care in major hospitals	Most primary care (/local services); medicines within facility; immunisation; some reproductive healthcare	Poor exempt or pay lower charge	Civil servants (selected services)
China	Inpatient (incl. medicines); Outpatient (incl. medicines)	Vaccination; immunisation; family planning	None	Old Red Army soldiers and Retirees
Hong Kong SAR	Inpatient (incl. medicines); outpatient (incl. medicines); dental	accident and emergency (until December 2002)	Welfare recipients exempt	Civil servants and dependents (reduced rate for IP); hospital staff and dependents
India	Inpatient bed charge; outpatient registration charge; certain medicines; tests/X-rays; dental	Hospital consultation and certain medicines. Primary care/health centre/polyclinic consultation and medicines. Family planning. Vaccinations and immunisations.	None formally. Indirect relation to income through price differentiation in inpatient care. Informally, 'poor' can be exempted partially or fully from charges	Civil servants
Indonesia	All medical care and medicines	None	Poor exempt from all charges. Indirect relation of inpatient charges to income through price discrimination	Charges determined at local government level. Some better-off local govts. provide free health centre care
Korea Rep.	All medical care and medicines. Co-payments under SHI are 20% (to limit) for inpatient and 30–55% for outpatient depending on institution. In addition, some services are not covered by SHI and paid for OOP. Sum of co-payment and OOP estimated at 40–50% for outpatient and 60–70% for inpatient care.	None	None. SHI premium is proportional to income but co-payments and charges not related to income	Elderly (>65yrs.) pay half deductible for outpatient care from clinics
Kyrgyz Rep.	Consultations with specialist primary care (e.g., physiotherapy; psychotherapy). Dental care. Complex diagnostics. Family planning	GP consultation and prescribed medicines. Hospital care – IP, OP and medicines (payment for medicines may be requested). Certain diagnostics and X-ray. Vaccination and immunisation.	None	Children up to 18; pensioners; war veterans and dependents; disabled; pregnant women; those with state awards; military
Nepal	All medical care and medicines. Nominal charge for outpatient varying with facility	Emergency services; selected vaccines, immunisation and reproductive health services. 60% subsidy for medicines at Health Posts and Primary Care centres	Poor either exempt or pay reduced charge but not fully implemented	None
Malaysia	Hospital inpatient and outpatient. Primary care. Dental care. Diagnostics and X-rays	Family planning and vaccinations/ immunisations. Outpatient ante and post natal care. Treatment of infectious diseases on 3rd class wards. Dental care for pregnant women and pre-school children	Hospital directors have discretion to waive fees for destitute. Upper limit on charges for 3rd class ward patients	Infants less than 1 year (outpatient). State rulers, Governors and families. Civil servants (incl. retired) and dependents. Local authority employees and dependents

2.8 Health taxes, free health care

Interim Constitution of Nepal 2006

"*Every citizens have the rights to basic health services free of costs as provided by the law".*

Source [349]

Nepal health tax fund

Nepal Health Tax Fund has an opportunity to reorient towards primary prevention rather than focusing on hospital based cancer treatments

Source [9]

In 1994, Nepal introduced sin-tax on cigarettes and alcohol consumption, and earmarked to establish the Health Tax Fund, managed by BP Koirala Memorial Cancer Hospital (Pande et al 2007). The analysis of its revenue and expenditure in Table 5, of the total Rp 214 million spending in 2005/06, reveals that 69.6% of total revenue went to the BP Koirala cancer hospital, and 16.2% went to the National Health Education, Information and Communication Centre. The current spending of Nepal Health Tax Fund is dominated by cancer treatment purposes, and has rooms for reorientation towards primary prevention of cancer and other NCD through community based social mobilization towards healthy lifestyles and appropriate diets.

Table 5 Income and Expenditure Statement of Health Tax Fund, 1000 Rp

	2005/06	2004/05	2003/04
Income	223,000	220,000	220,000
Expenditure	214,166	218,120	219,720
o BP Koirala Memorial Cancer Hospital	100.0%	100.0%	100.0%
o Bhaktapur Cancer Hospital	69.6%	75.6%	65.1%
o National Health Education, Information and Communication Centre	16.2%	13.8%	20.1%
o Bir Hospital	4.2%	3.9%	7.3%
o Nepal Cancer Relief Society	3.4%	3.7%	2.8%
o Koshi Zonal Hospital	2.3%	0.0%	0.0%

	2005/06	2004/05	2003/04
o Dhulikhel Community Hospital	2.1%	2.2%	2.0%
o Nepal Blood Hypertension Control Society	1.3%	0.0%	0.0%
o Village Service Fund (Gaun Sewa Kosh) – Tanahu	0.4%	0.3%	0.3%
o Nepal Heart Foundation	0.3%	0.3%	0.3%
o Shahid Gangalal National Heart Centre	0.1%	0.2%	0.2%

Source [9]

Health Sector Reform Support Programme

Technical Brief 1: May 2008

A Summary of the Cost of Free Health Care in Nepal

The Government of Nepal, through the interim constitution, has embraced the concept of "health for all" as a fundamental human right. To realize this vision, the Ministry of Health and Population has committed itself to providing free health services.

Two major pro-poor programmes have been implemented to date. The first is a programme of free essential health care services targeted to poor and vulnerable citizens at primary health care centres (PHCCs) and district hospitals (up to 25-bed capacity). Second is a programme of free essential health services for *all* citizens at health and sub-health posts.

The targeted programme, which began in 2006, provides free emergency and inpatient services nationwide for the poorest, less poor, vulnerable or helpless, elderly citizens (over 60), and Female Community Health Volunteers. In addition, in the 25 districts that rank lowest in the Human Development Index (later expanded to 35 districts), the programme provides free outpatient services to the same groups.

The universal programme, which commenced in January 2008, provides free essential health care services to all citizens at health and sub-health posts nationwide. There are *no* charges for registration or for the 32 essential drugs provided at health posts and the 22 essential drugs provided at sub-health posts.

The costing study summarized in this brief used a rapid costing approach to provide rough estimates of the costs. Table 1 summarizes the cost estimates for the targeted and universal programmes described above for a variety of scenarios of increased demand.

Table 1. Costs of the Free Health Care Policy

Service	Level at Which Service Is Available	Cost in NRs (in Millions), Depending on Demand Scenario	Cost in USD (in Millions), Depending on Demand Scenario
Inpatient care: Free for the poorest, 50% off for less poor	District hospitals and PHCCs	49.1– 53.19	.76–.82
Emergency care: Free for the poorest, 50% off for less poor	District hospitals and PHCCs	40.39–43.75	.63–.68
Outpatient care: Free for the poorest, 50% off for less poor	District hospitals and PHCCs in 25* districts with lowest HDI	10.42– 14.59	.16–.23
Universal free outpatient care	Health and sub-health posts	566.21– 905.93	8.92– 14.27
Total cost of policy		**666.12– 1,017.46**	**10.47– 16**

*Expanded to 35 districts after this study

HSRSP Funded by DFID and implemented by RTI International
Ministry of Health and Population, PO Box 8975, EPC 535, Kathmandu, Nepal
Tel: 977-1-426-6160; Email: hsrsp@np-hsr.rti.org

Source [300]

The estimated total cost of the free health care policy for a scenario of a medium increase in demand is NRs 798.11 million or USD12.57 million.

In the near future, the government intends to expand universal free care beyond health and sub-health posts to PHCCs and district hospitals, thereby providing essential health care free of charge to *all* citizens at *all* district facilities. Table 2 shows estimates of the projected costs of universal free health care at all district facilities—district hospitals, PHCCs, health and sub-health posts.

Table 2. Projected Costs of Universal Free Health Care for All District Facilities

Service	Level at Which Service Is Available	Cost in NRs (in Millions), Depending on Demand Scenario	Cost in USD (in Millions), Depending on Demand Scenario
Outpatient care	District level and below	819.33–1,147.06	12.7–17.78
Inpatient care	District level and below	85.03–92.12	1.32–1.43
Emergency care	District level and below	86.95–94.2	1.35–1.46
Total cost of universal free health care at district level and below		**991.31–1,333.38**	**15.37–20.67**

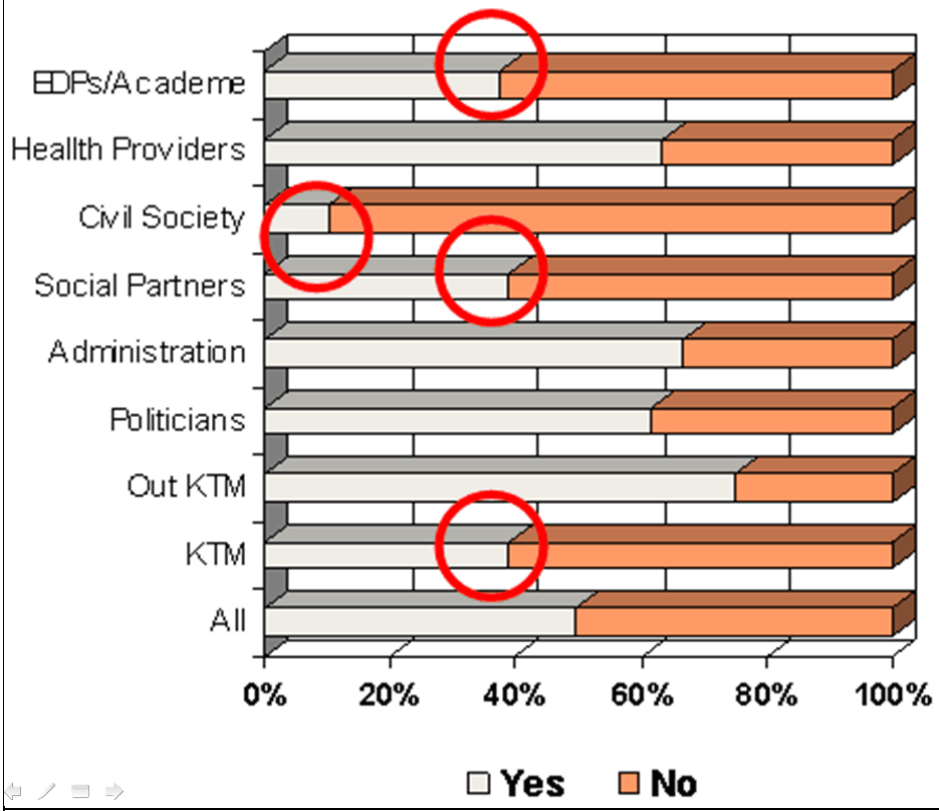
The estimated total cost for the medium-demand scenario increases to NRs 1,162.35 million or USD18.01 million if health care is free of charge for all citizens at all district facilities.

Source [300]

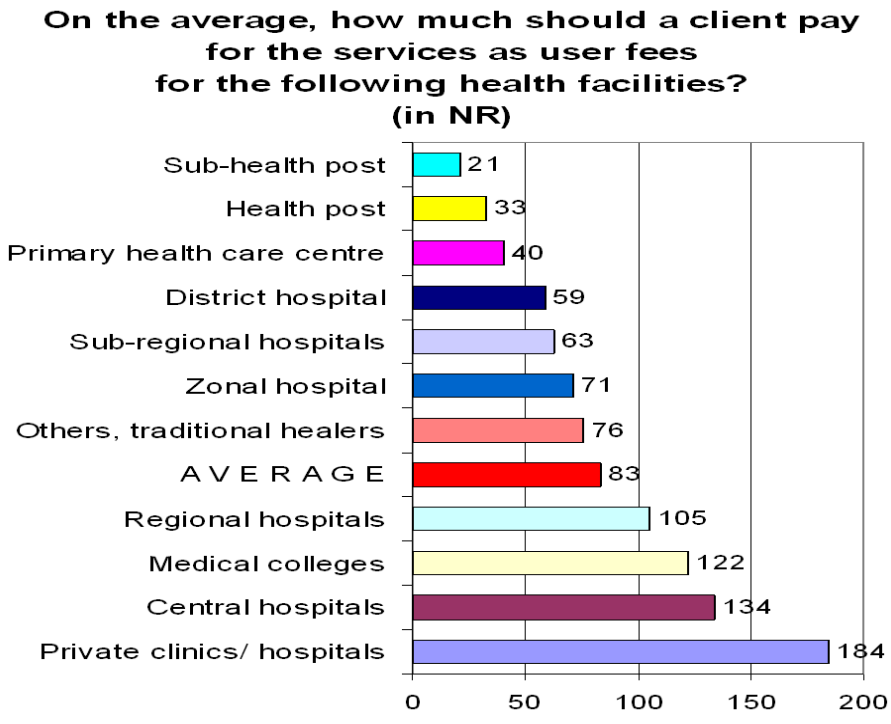
2.9

Opinion leaders opinion on health financing

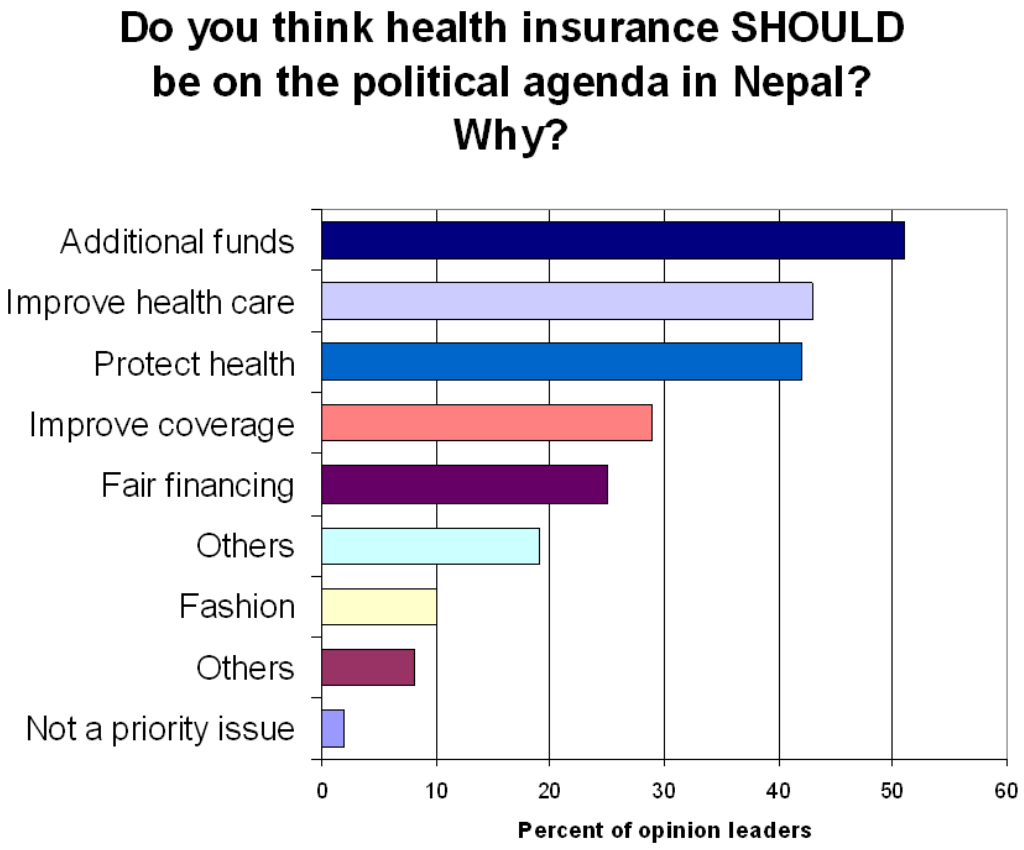
Figure 09. Distribution of responses on whether or not people are benefiting from Free Health Care



Source [467]



Source [466]



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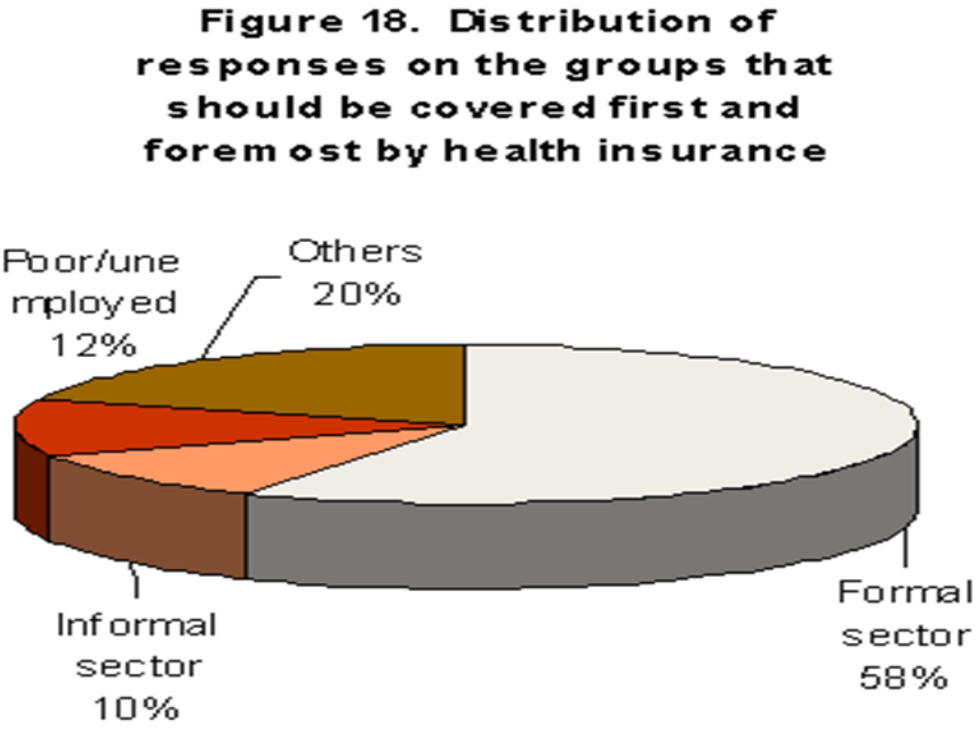
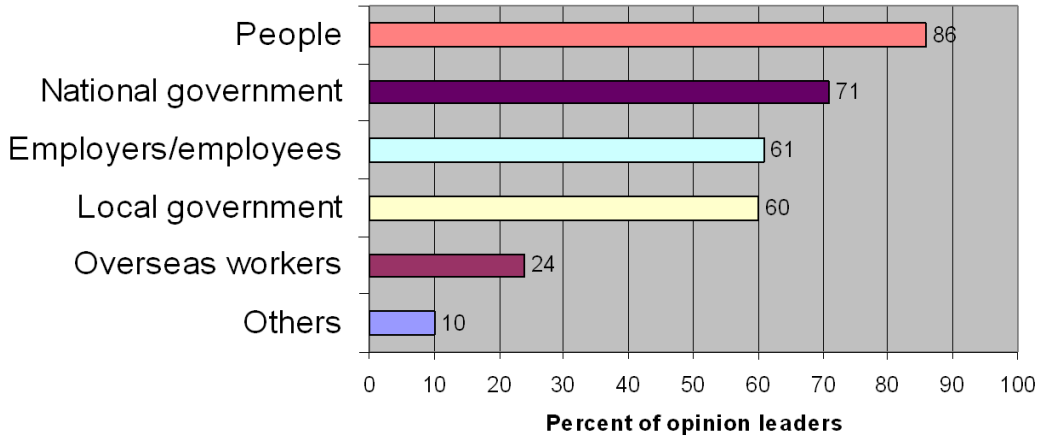


Source [467]

Who should contribute ?



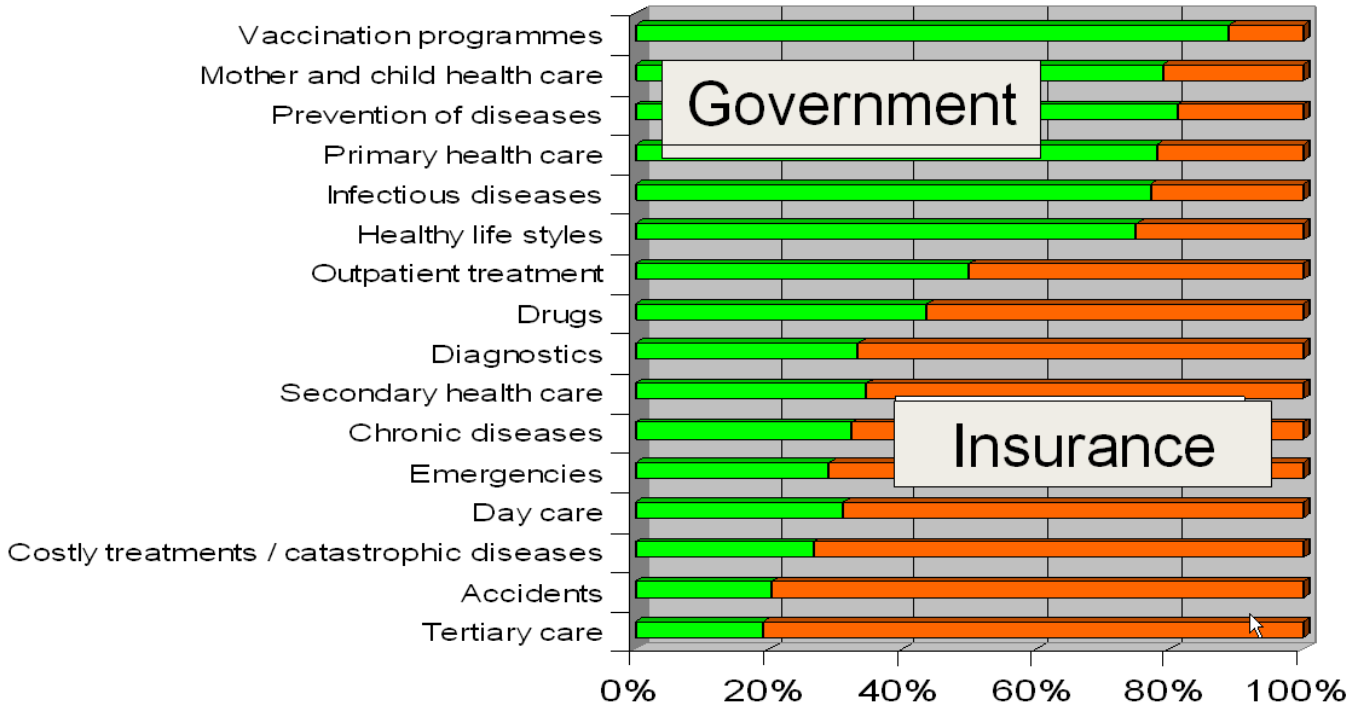
Source [466]

What percentage of the population in Nepal cannot pay for health care and should be exempted from any user fee, however little?

31.4 %

Source [466]

Health insurance can not cover all health services. Which of the following services should be provided by health insurance and which services should be provided by government?



Source [466]

Nepal main opinion survey results

94 %	National health insurance system is really needed now in Nepal
94 %	Would like their family to join health insurance
95 %	Autonomous national health insurance fund would be trusted
90 %	People should be mandated to give pre-payments for health care
90 %	The poor should be included in health insurance without contributions
87 %	Health insurance should be implemented within next 2 years
70 %	Health insurance should be established at the national level
64 %	People should contribute with user fees
61 %	There should be one health insurance organization
60 %	Poor people often postpone treatments in case of user fees
51 %	Free health care up to district can not be financed
49 %	People are really benefiting from free health care
40 %	New autonomous organization should manage health insurance
39 %	Informal payments are never paid
39 %	MoHP should manage health insurance
35 %	Health care should be free for all levels
34 %	Health insurance should start with government employees
33 %	National health insurance is on the national agenda
19 %	Only workers / employees should be covered by health insurance

Source [468]

Results of an opinion survey of opinion leaders on free health care, user fees and health insurance, GFA 2009

Nr.	Topic	Answer	n	%
A	**Location of interviewee**	KTM	59	71
		Outside KTM	24	29
B	**Gender of interviewee**	Male	73	88
		Female	10	12
1	**Should all health care services be for free at all levels?**	For free at all levels	29	35
		Not for free at all levels	28	34
		Some services for free at all level	18	22
		All services for free at some levels	3	4
		Others	5	6
2	**Who should pay?**	Rich	24	29
		Formally employed	12	14
		Officially poor	0	0
		others	40	48
3	**The government promised free health care services up to the Primary Health Care Centre. Are the people really benefiting according to your knowledge and experience?**	Yes	41	49
		No	42	51
4	**Do you think the Free Health Care Policy up to the district hospital level can be financed entirely by the government?**	Yes	40	48
		No	42	51
		Neither yes nor no	1	1

5	**What is your view of user fees?**	People should contribute	53	64	
		It prevents abuses	11	13	
		User fee applied appropriately	7	8	
		User fee misused	1	1	
		Poor cannot pay	24	29	
		Imposition/tax	5	6	
		others	31	37	
7	**Do you think that <u>poor people postpone treatments</u> because of user fee?**	yes, often	50	60	
		yes, sometimes	17	20	
		no	15	18	
9	**How often do clients have to make <u>informal payments</u> (or any payment without a receipt) or give gifts in public facilities?**	every time	3	4	
		often	10	12	
		occasionally	27	33	
		never	32	39	
		don't know	11	13	
11	**How often do clients have to exert or need political pressure or influence to get faster and better service?**	every time	13	16	
		often	26	31	
		occasionally	41	49	
		never	1	1	
12	**Do you think that it is good that people are mandated or obliged to pay regularly and in advance small pre-payments to cover their sometimes high health care costs in the future?**	yes	75	90	
		No	9	11	
13	**Who should be the <u>leading agent in a national health insurance</u>?**	MoHP	39	47	
		Ministry of Women	3	4	
		Ministry of Labour	2	2	
		Ministry of General Administration	0	0	
		Ministry of Finance	2	2	
		Prime Minister's office	0	0	
		New autonomous organisation	40	48	
		Private insurance companies	3	4	
		Others	5	6	
15	**Do you think that an autonomous national health insurance fund will be accepted and trusted by the people?**	yes	79	95	
		no	4	5	
16	**How can misuse and corruption of health insurance be avoided?**	Transparency	51	61	
		Control and heavy fines	25	30	
		Independent financing org	9	11	
		Regional/local public control	11	13	
		Others	40	48	
17	**Do you think a national health insurance system is really needed now in Nepal?**	yes	78	94	
		no	5	6	
		don't know	0	0	
18	**Do you think, health insurance is on the political agenda in Nepal?**	yes	27	33	
		no	48	58	
		don't know	8	10	
19	**Do you think health insurance SHOULD BE on the political agenda in Nepal? Why?**	Additional funds	42	51	
		Protect health	35	42	
		Fair financing	21	25	
		Fashion	8	10	
		Improve health care	36	43	
		Improve coverage	24	29	
		Others	16	19	
		Not a priority issue	2	2	
		Others	7	8	

Nr.	Topic	Answer	n	%
20	**Would you like to have your family join a health insurance?**	yes	78	94
		no	4	5
21	**Interviewer**: BASED ON SECTION D, DOES THE INTERVIEWEE UNDERSTAND THE CONCEPT OF HEALTH INSURANCE?	yes	82	99
		no	1	1
22	**Which of the following groups should be covered first and foremost by health insurance i.e. that they pay regularly contributions for health insurance for getting free or cheap treatment in case of need?**	Employees larger companies	17	20
		Employees smaller companies	7	8
		Employees of government	28	34
		Employees public/mixed co	13	16
		Self-employed/small own business	6	7
		Informal sector	1	1
		Unemployed	10	12
		others	17	20
23	**Which of these groups should not be covered by health insurance?**	Employees larger companies	16	19
		Employees smaller companies	7	8
		Employees of government	16	19
		Employees public/mixed co	8	10
		Self-employed/small own business	7	8
		Informal sector	12	14
		Unemployed	8	10
		None	27	33
		others	14	17
24	**Which family members should be covered by a health insurance?**	Employees/workers only	16	19
		Including the wife	26	31
		Including the children	26	31
		Including the parents	32	39
		Incl. extended family members	26	31
		others	26	31

25	**Health insurance can not cover all health services. Which of the following services should be provided by health insurance and which services should be provided by government**?	Gov %		HI %
	Vaccination programmes	88		11
	Prevention of diseases	86		20
	Mother and child health care	86		23
	Primary health care	82		23
	Infectious diseases	81		24
	Healthy life styles	75		25
	Outpatient treatment	53		53
	Drugs	49		63
	Diagnostics	36		72
	Secondary health care	35		66
	Chronic diseases	34		71
	Emergencies	31		76
	Day care	30		66
	Costly treatments / catastrophic diseases	29		80
	Accidents	22		86
	Tertiary care	20		84
	Others	2		2

Nr.	Topic	Answer	n	%
26	**What type of services is most important to be included in the benefit package of a health insurance?**	Drugs	17	20
		Drugs for chronic diseases	16	19
		Diagnostics	29	35
		Outpatient care	10	12
		Day care	13	16
		Inpatient care in the hospitals	15	18
		Long/costly inpatient care	46	55
		Others	6	7
27	**Who should pay contribution or premium to the health insurance fund?**	People	71	86
		National government	59	71
		Local government	50	60
		employers/employees	51	61
		overseas workers	20	24
		others	8	10
		All of the above	0	0
28	**Are there any population groups that should be included in the health insurance schemes without paying contributions? For whom the government should care?**	Poor	79	95
		unemployed	18	22
		self-employed	1	1
		none	1	1
		others	4	5
29	**Should health insurance funds rather be established at the national or at regional and local levels or at professional levels?**	national	58	70
		regional	12	14
		zonal	6	7
		district	30	36
		village	13	16
		professional	7	8
		others	10	12
30	**Regarding health insurance organisation, should there be just one national corporation, several funds, funds for public employees only; funds for private employees only, special fund for the poor or other options?** ?	one	51	61
		several	19	23
		public employees	8	10
		private employees	5	6
		poor	24	29
		others	5	6
32	**How soon should the implementation of a health insurance system start?**	immediately	58	70
		next 2 years	14	17
		next 3-5 years	6	7
		next 6-10 years	1	1
		after 10 years	1	1
33	**Do you know what the difference is between private and social health insurance?**	yes	60	72
		no	21	25
34	**Do you have any experience as a member of a public or private health insurance?**	yes, public	11	13
		yes, private	11	13
		yes, community	2	2
		no	45	54
35	**Did you get good services with the health insurance?**	yes	12	14
		no	2	2
36	**Which type of health care has better quality?**	public	28	34
		private	52	63

Source [468]

2.10

Other issues

Table 7 Perception on financing healthcare and health promotion (percent)

	Indonesia	Nepal	Sri Lanka	Thailand	Total
Sufficiency of health care finance					
Adequate	8.1	3.1	19.6	16.2	13.8
Not adequate	86.5	93.8	78.3	82.1	83.6
Don't know	5.4	3.1	2.2	1.7	2.6
Total N	37	32	46	117	232
Government priority on HP					
high priority	8.1	18.8	15.2	24.8	19.4
Moderate	16.2	50.0	54.3	59.0	50.0
low priority	75.7	31.3	30.4	14.5	29.7
no priority	0.0	0.0	0.0	1.7	0.9
Total N	37	32	46	117	232
Evidence on government priority to HP					
high policy level statement	Na	59.1	53.1	80.6	67.7
National policy documents	Na	72.7	43.8	80.6	67.7
Existing government budget for HP	Na	45.5	37.5	79.6	62.1
earmarked revenue	Na	54.5	12.5	81.6	59.6
specific earmarked budget	Na	22.7	9.4	46.9	33.5
Others	Na	0.0	0.0	5.1	3.1
Total N [moderate or high priority]	Na	22	32	98	161

Source [9]

Table 8 Spending on health promotion in relation to burden from NCD (percent)

	Indonesia	Nepal	Sri Lanka	Thailand	Total
Sufficiency of financing HP in relation to NCD burden					
Abundant	0.0	0.0	0.0	0.9	0.4
Sufficient	13.5	0.0	4.3	15.4	10.8
Moderate	5.4	25.0	32.6	22.2	22.0
Insufficient	62.2	65.6	52.2	52.1	55.6
severely insufficient	18.9	9.4	4.3	8.5	9.5
Don't know	0.0	0.0	6.5	0.9	1.7
Total N	37	32	46	117	232
How much should government spend on health promotion?					
Double of current level of spending on health promotion	24.3	50.0	43.5	26.5	32.8
Triple	43.2	21.9	21.7	16.2	22.4
Quadruple	13.5	9.4	4.3	4.3	6.5
more than quadruple	18.9	3.1	6.5	9.4	9.5
Don't know	0.0	9.4	19.6	11.1	10.8
Missing	0.0	6.3	4.3	32.5	18.1
Total N	37	32	46	117	232

Source [9]

Health financing for primary health care in Nepal:

Conclusion

Data from rural Nepal showed that village development committees with a greater proportion of lower caste members were more likely to contribute financially to the local health facility. Community financial contributions for PHC are thus associated with the political inclusion of those with lower social status. The background factors responsible for inclusiveness may themselves be the cause of a greater willingness to support PHC. More evidence is needed before we could conclude that all the lower castes require is effective representation in local politics in order to direct more resources towards PHC. If future studies are able to confirm this interpretation, then policies that institutionalize the inclusion of low caste Nepalis on their local village development committee would improve the financing and sustainability of PHC.

"

Source [284]

3 Policies

3.1 Structure

NEPAL

NEPAL	
Head of state and government:	Girija Prasad Koirala
Death penalty:	abolitionist for all crimes
Population:	28.2 million
Life expectancy:	62.6 years
Under-5 mortality (m/f):	71/75 per 1,000
Adult literacy:	48.6 per cent

Both the government and the Communist Party of Nepal (Maoist) (CPN (M)) largely failed to implement human rights commitments in the Comprehensive Peace Accord (CPA), signed in November 2006. Elections were postponed twice. Measures to address impunity for past violations and abuses were grossly inadequate. Vulnerable groups, including women and minorities, remained at risk of human rights abuses.

Background

The Seven Party Alliance coalition government, which took office after King Gyanendra's reinstatement of the House of Representatives in April 2006, remained in power. On 15 January the House of Representatives ratified an Interim Constitution which established an interim parliament and facilitated Constituent Assembly elections. The Interim Constitution concentrated significant power in the executive and did not address transitional justice and impunity. The UN Security Council established the UN Mission in Nepal (UNMIN) in January to support the peace process and elections.

N

On 31 March the Seven Party Alliance and the CPN (M) formed an interim government. The CPN (M) left the government in September after disagreements on declaring Nepal a republic and on the voting system to be used in elections. It rejoined the government in late December following a new 23-point agreement. Elections to the Constituent Assembly, scheduled for June and then November 2007, were due to be held by mid-April 2008.

Concerns were raised by a number of parties outside the Seven Party Alliance about being excluded from the political process. Following a proliferation of armed groups and violent uprisings in the southern Terai region, in particular by members of the Madheshi community, the government conceded to some demands from Madheshi and other minority groups. However, few of these commitments were implemented.

Impunity

Inaction by police and public prosecutors

Police and public prosecutors continued to fail in their duty to investigate and prosecute cases of human rights abuse.

■ In the case of Maina Sunuwar, a 15-year-old girl who died after being tortured in Nepal Army custody in 2004, the army failed to cooperate with the police investigation. A DNA sample collected in March from an exhumed body believed to be Maina's, was reportedly only sent for further analysis in November.

Accountability mechanisms

In June appointments to the Constitutional Council were finalized, enabling new appointments to the National Human Rights Commission (NHRC) in August. There had been longstanding vacancies after Commissioners appointed by the King resigned in July 2006, damaging the NHRC's ability to monitor and investigate human rights violations.

The report of a commission to investigate atrocities committed by the government in April 2006 was finally made public in August. The report recommended action against more than 200 people, as well as the prosecution of at least 20 members of the army, police and armed police force. However, little action was taken to implement the recommendations.

Transitional justice mechanisms

The CPA provided for the establishment of a Truth and Reconciliation Commission (TRC) and in July 2007 the Ministry of Peace and Reconstruction invited comments on a draft bill. The UN, several international NGOs, and local NGOs raised concerns about provisions granting amnesty to perpetrators of gross human rights violations.

On 1 June the Supreme Court ordered the government to investigate all allegations of enforced disappearance, introduce a law making enforced disappearances a criminal offence and set up a Commission of Inquiry to investigate disappearances. However, a three-member Commission set up on 26 July to investigate enforced disappearances during the armed conflict did not meet the standards set out in the Supreme Court judgment. The 23-point agreement of late December included provision for a

Source [5]

new Act to establish a commission of inquiry into disappearances and to criminalize enforced disappearances. The Interim Parliament passed a bill to amend Civil Code provisions on abduction.

Abuses by armed groups

The youth wing of the CPN (M), the Young Communist League, reportedly committed a number of human rights abuses including abductions and ill-treatment in captivity, assaults and violent disruption of political activities.

According to UNMIN, almost 3,000 under-18s remained within CPN (M) cantonments (military areas where, under the CPA, the CPN (M) had agreed to be quartered). CPN (M) activists reportedly coerced minors who left the cantonments to return.

Members of the CPN (M) were also accused of abductions, torture and killings, including the killing of journalist Birendra Sah following his abduction on 5 October in Bara District, as well as seizing land and property and extorting money.

A number of armed groups committed human rights abuses. Factions of the Janatantrik Terai Mukti Morcha, an armed Madheshi group which split from the CPN (M) in 2004, were allegedly responsible for unlawful killings, kidnappings and bomb attacks. Armed groups carried out bomb attacks including placing devices at the homes of two human rights activists in March, and a series of bomb blasts in Kathmandu in September which killed three people. On 16 September, the killing of a former armed group member, Mohit Khan, triggered violence between different groups in Kapilbastu and Dang districts, reportedly leaving at least 14 dead and thousands displaced.

Violations by police and security forces

There were a number of reports of torture and rape by police and members of the security forces, some of whom were off-duty at the time. Among those raped were women with mental illnesses and girls.

The majority of torture victims received no compensation. National laws to regulate torture fell short of international standards, and were inadequately implemented.

At least 29 civilians were reportedly killed by the police or armed police force, many allegedly as a result of excessive use of force.

Human rights defenders

Human rights defenders across the country reported threats and attacks by security forces personnel, CPN (M) members and others. At least 17 were reportedly threatened with death, rape, kidnapping and beating if they did not stop carrying out their work for WOREC, a local women's rights NGO.

Minority groups

Following pressure from the Nepal Federation of Indigenous Nationalities (NEFIN), the government signed a 20-point agreement on 7 August, including provision for proportional representation of all indigenous groups and castes. However, implementation was slow.

The Madheshi Janadhikar Forum (also known as Madheshi People's Rights Forum (MPRF)), an umbrella political group, organized regular protests to demand autonomy for the Madheshi people in Terai. Some of the demonstrations became violent. On 21 March in Gaur, 27 individuals, most of them linked to the CPN (M), were killed in clashes with MPRF members. The government formed high-level commissions to probe this incident and others during the Terai unrest, but to Amnesty International's knowledge, the commission had not finalized its investigations by the year's end and no one had been held accountable for these killings.

Freedom of expression

According to the Federation of Nepalese Journalists, between May 2006 and 7 November 2007, 619 journalists and media organizations faced intimidation from the government, CPN (M), and other groups. At least two journalists were killed in 2007 and many others were attacked, abducted and threatened with death.

Refugees and internally displaced people

Tens of thousands of people reportedly remained internally displaced as a result of the conflict that ended in 2006 and ongoing violence in the south. There were concerns about the safety of returnees and about property restitution for internally displaced people, mainly due to threats and attacks by CPN (M) activists.

Approximately 106,000 Bhutanese refugees, forcibly expelled from Bhutan in the early 1990s, remained in camps in Nepal. Refugees were reportedly divided about options for voluntary

Source [5]

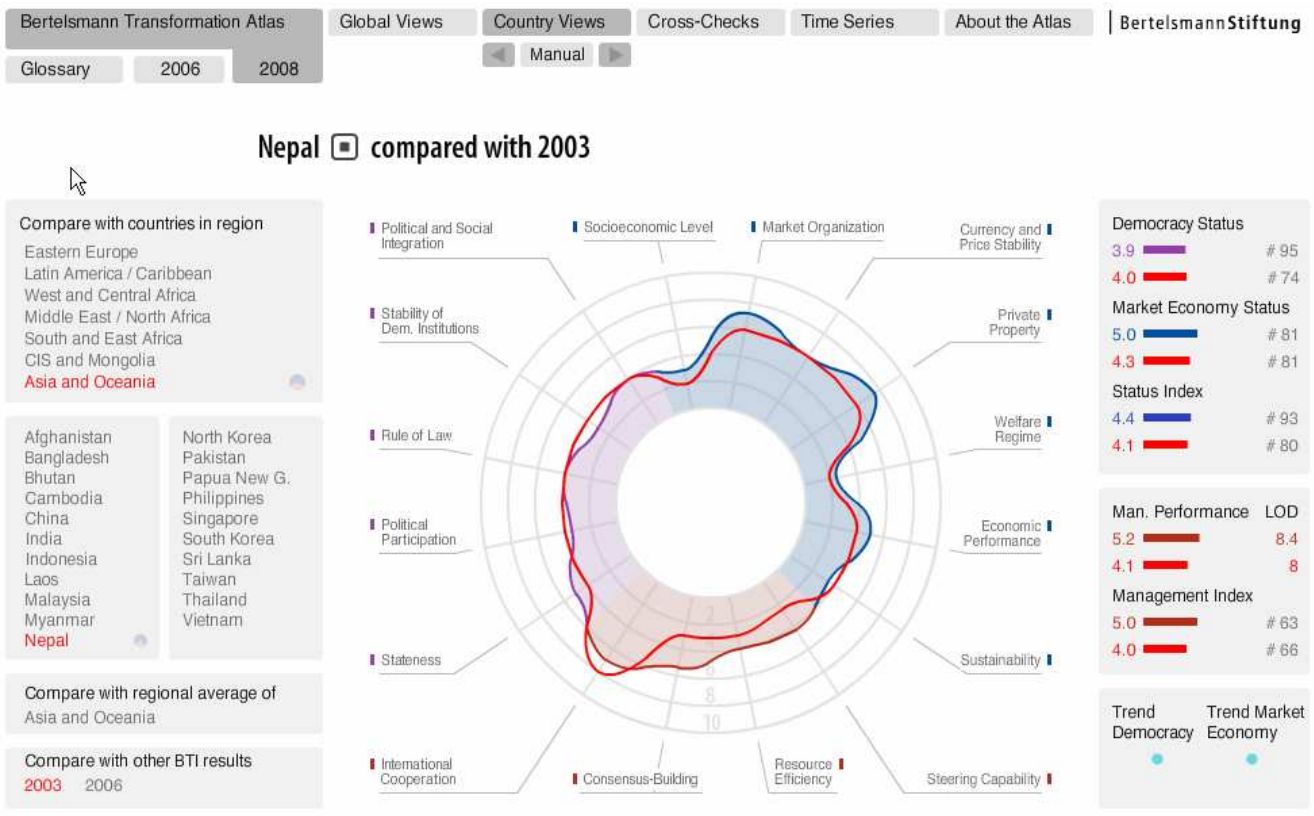
resettlement in third countries, scheduled to begin in 2008, with some fearing that accepting resettlement would end all hopes for repatriation to Bhutan. There were reports of growing frustrations in the camps, prompted by security concerns and uncertainty about durable solutions in Nepal. One refugee was killed and several injured by the Indian Border Security Force on the border with Nepal in May, when thousands of refugees attempted to enter India in an effort to return to Bhutan.

Amnesty International reports

- Nepal: Reconciliation does not mean impunity. AMemorandum on the Truth and Reconciliation Commission Bill (ASA 31/006/2007)
- Nepal at acrossroads – urgent need for delivery on transitional mechanisms for truth, justice, inclusion and security (ASA 31/011/2007)
- Nepal: Amnesty International urges investigation into killings (ASA31/001/2007)
- Impunity for enforced disappearances in Asia Pacific Region must end (ASA01/007/2007)

Source [5]

Source [17]



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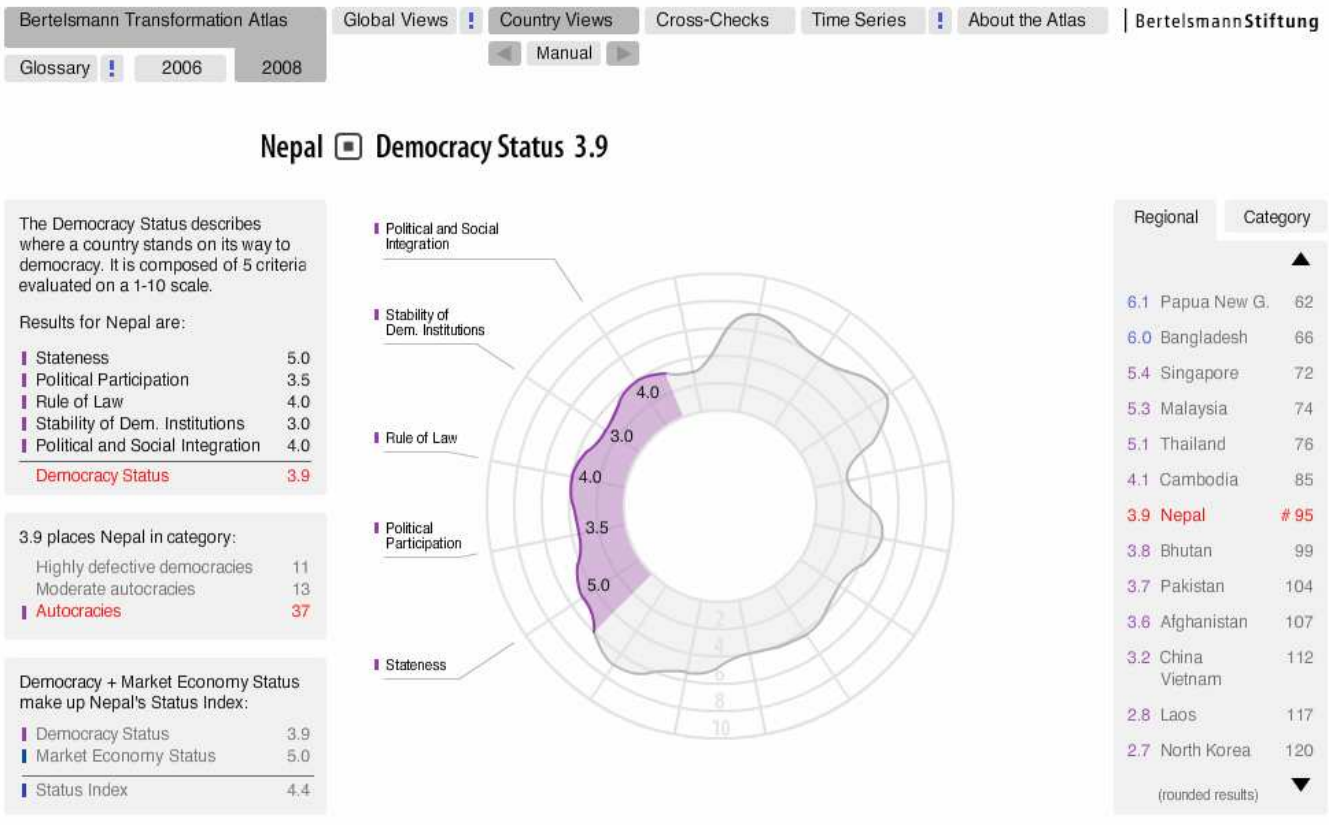

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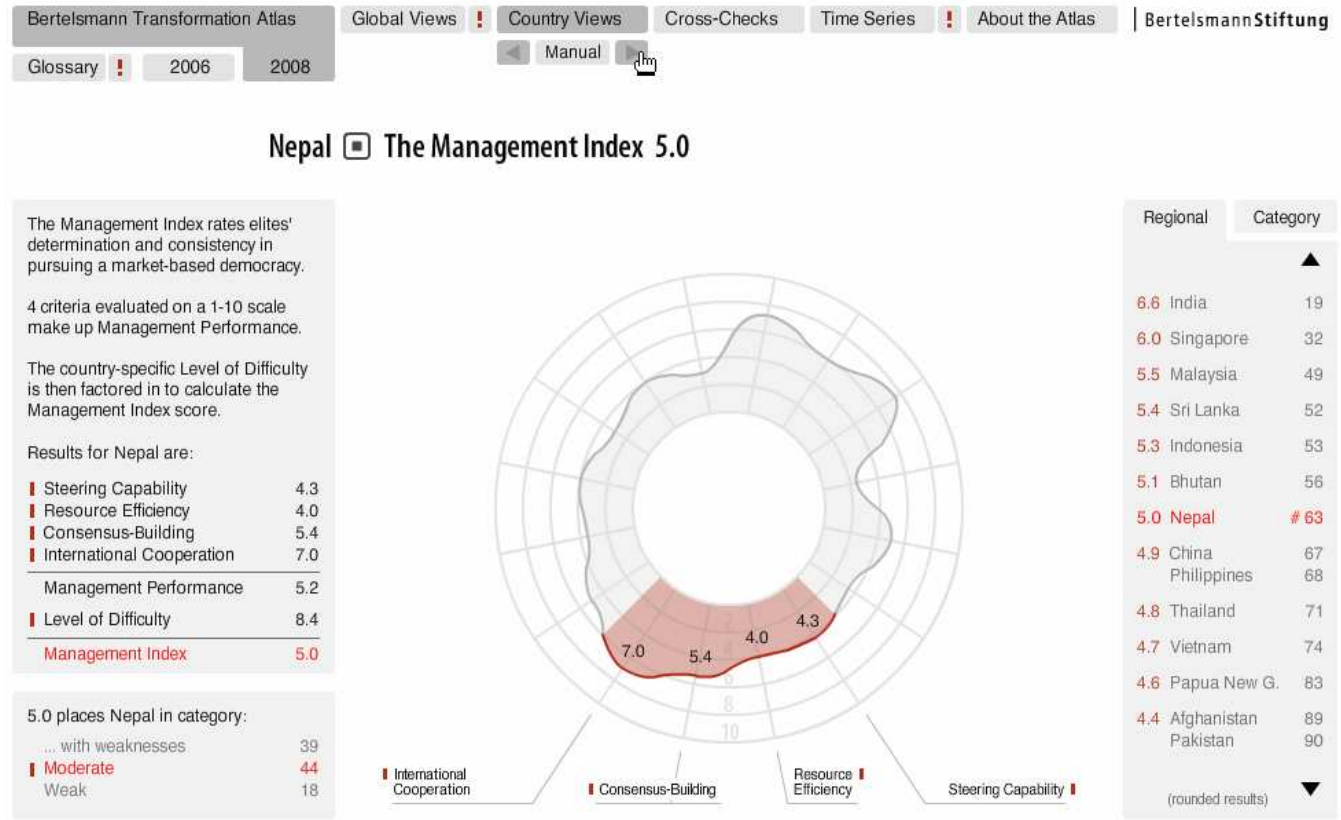

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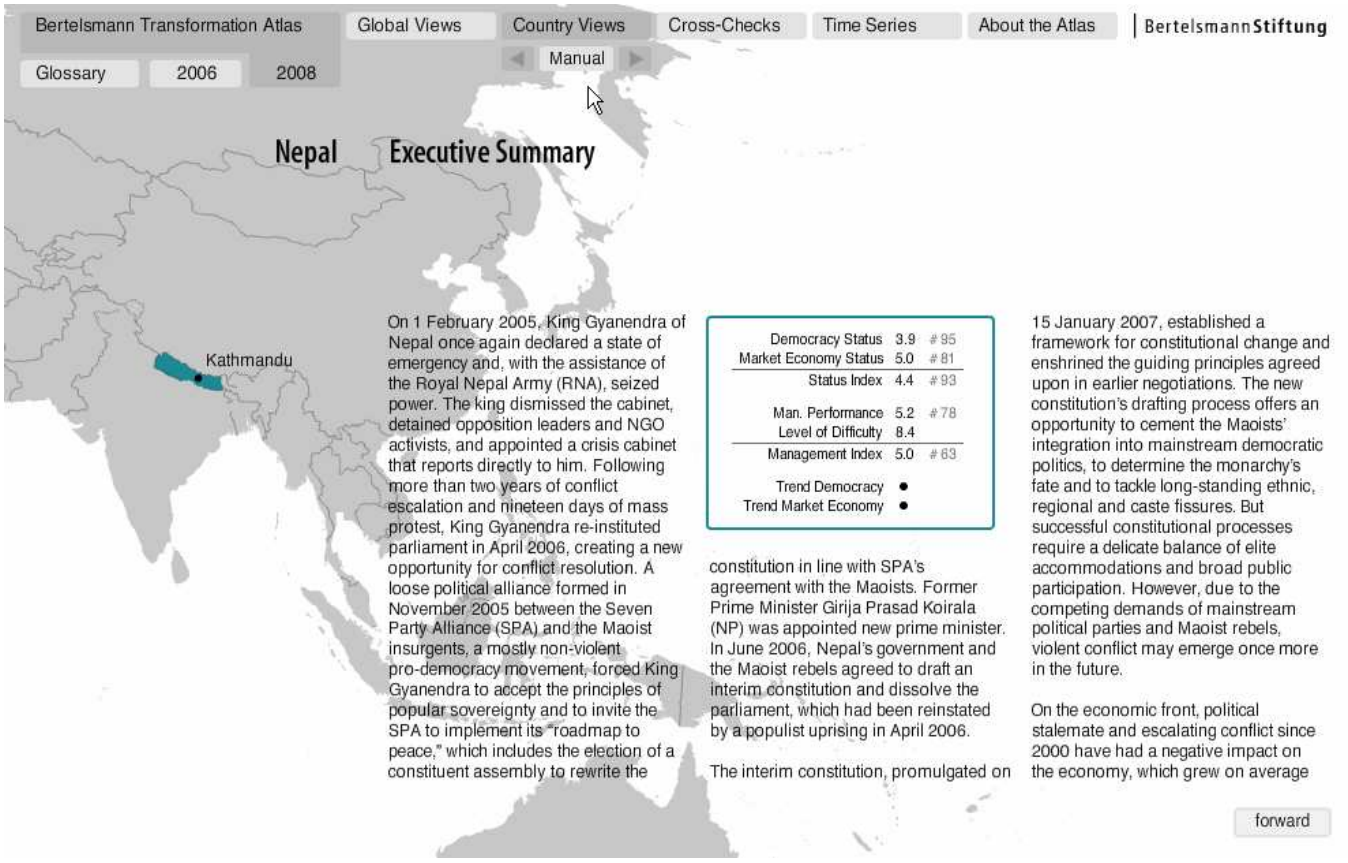

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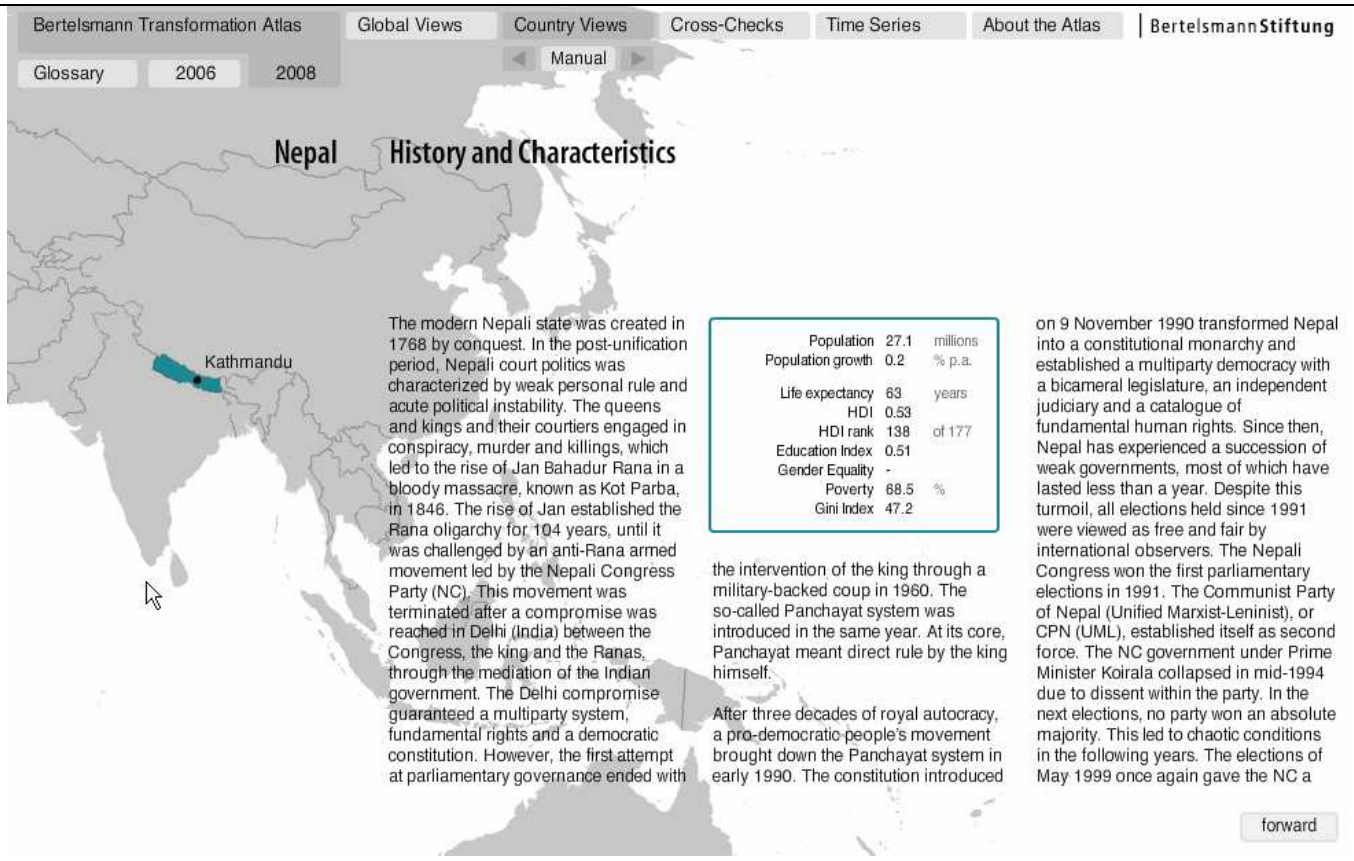

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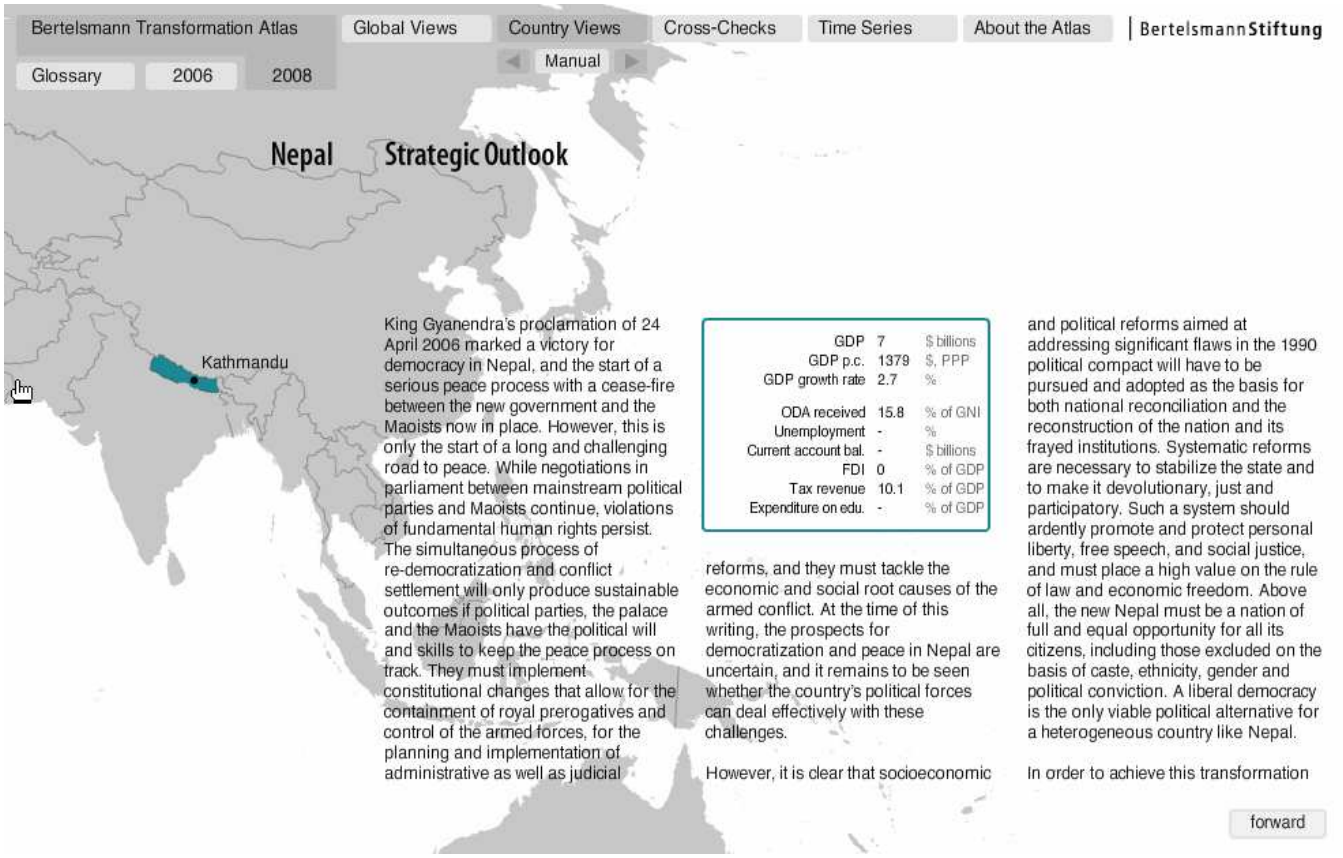

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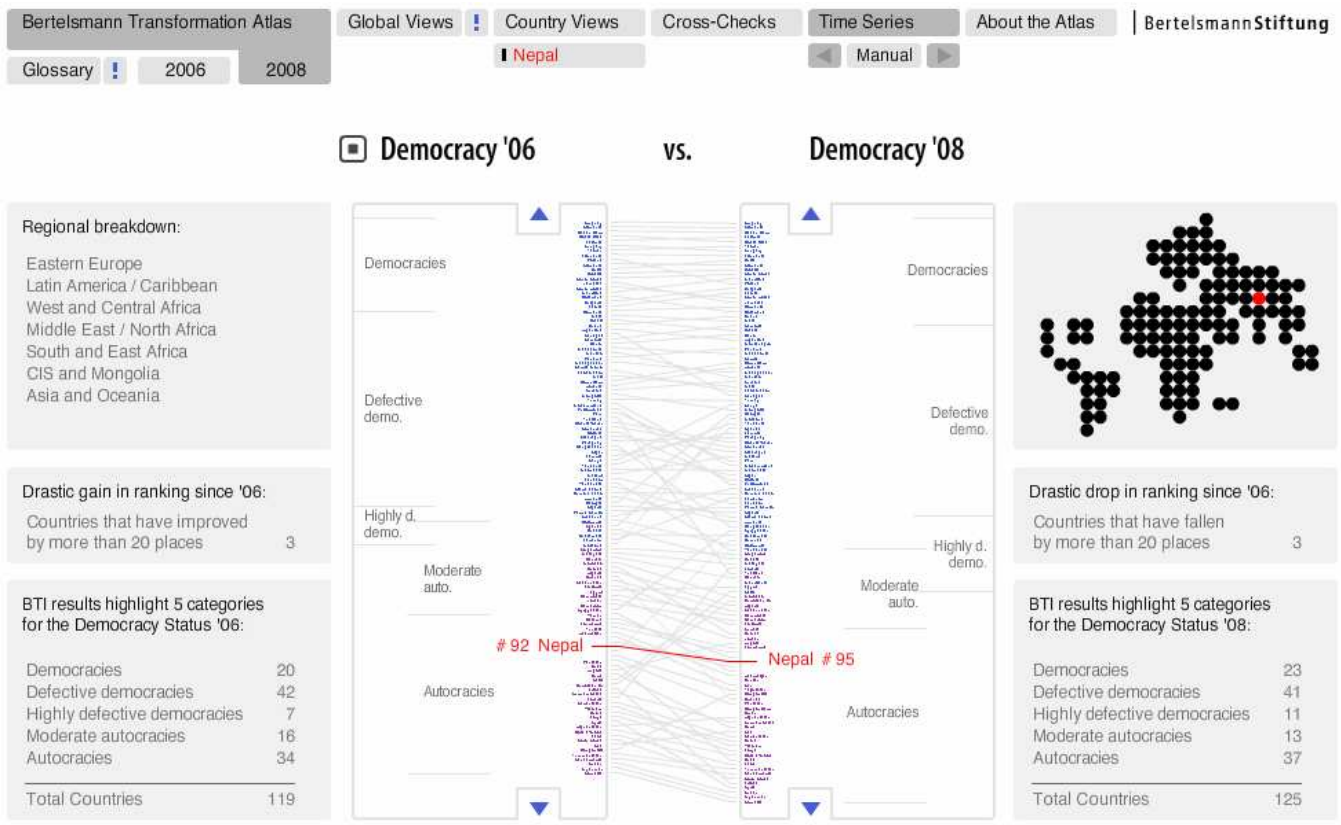

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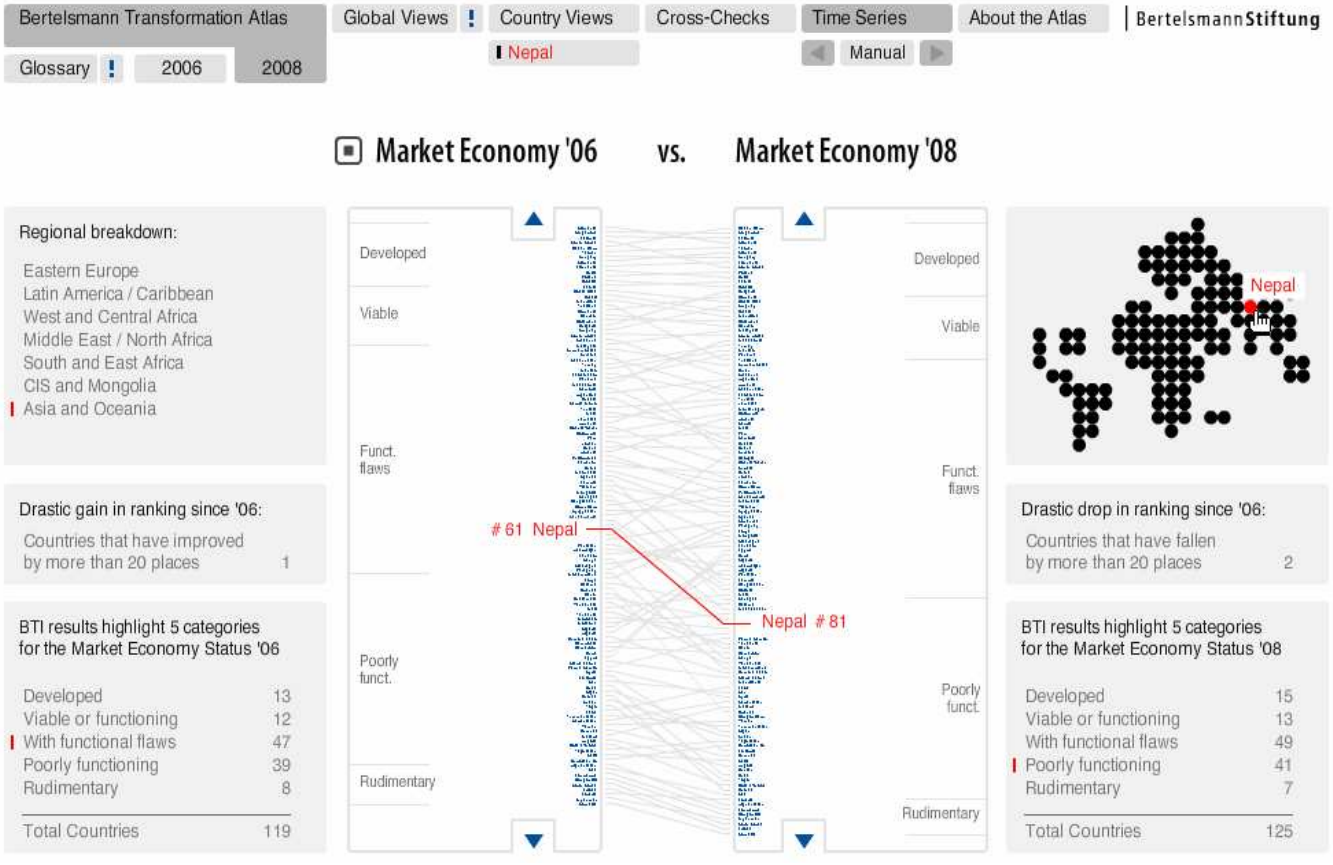

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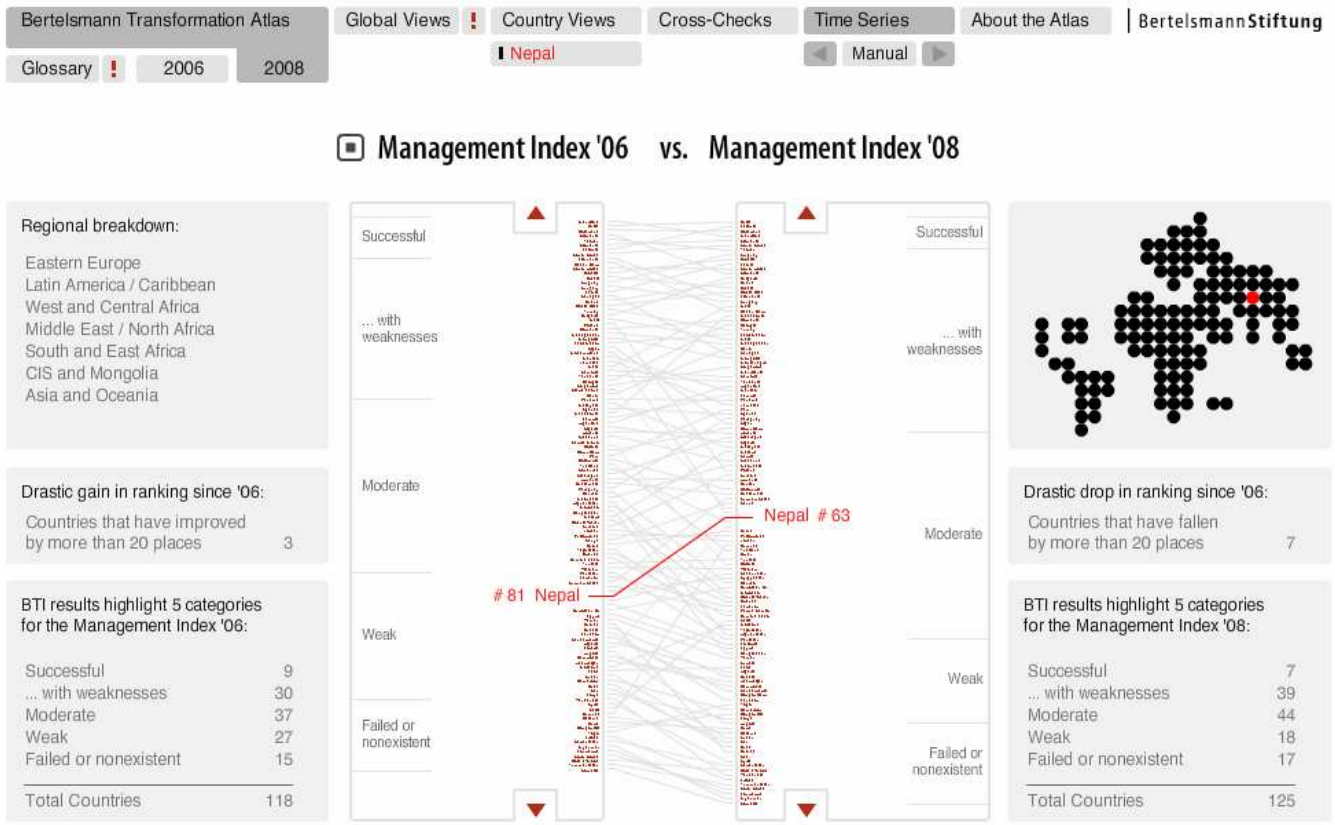


Source [17]

3.2

Social policies

Social protection and poverty reduction

The **Nepa**l Interim Government also aims to use social protection as a means of achieving further poverty reduction, reducing inequality and disparities, and closing the gap between opportunities and access, as well as increasing social cohesion. It is argued that social protection needs to be "responsive, affordable, sustainable and effective".7 Nepal is the only country in South Asia with a universal social pension, introduced in 1995 (Senior citizens above 75 years and widows above 60 years and for persons with disabilities receive a pension, i.e. living allowance) and it has recently institutionalised and expanded ist maternal birth grant (involving cash incentives to health institutions and health workers, transport services, free delivery services and cash incentives for mothers) nation-wide. The government is considering to further institutionalise recent innovations – e.g. the “One Family One Employee” Employment Scheme in the Karnali zone, trainings in employment related skills for Dalits and other disadvantaged communities and school stipends for dalit and girl children. It is noted that for social protection to be expanded and strengthened in Nepal, there is a need to explore new institutional arrangements, such as the possibility of one single implementing agency, as well as new funding arrangements (such as a SWAp approach for instance). There is also the issue of assessing the current delivery mechanisms and exploring new ones.

Source [15]

Nepal: Key issues of Inclusion

- Group inequality based on caste, gender, ethnicity and geography has been a critical factor in Nepal's conflict. The need to restructure the state to address issues of discrimination, social and political exclusion is now widely recognised among Nepal's political forces.
- There are high aspirations for the forthcoming Constituent Assembly elections and many formerly excluded groups have demanded more equitable representation – sometimes through violent street protest
- Excluded groups and political parties may have different understandings of inclusion. For the parties the issue is about physical presence in political structures and ensuring particular issues articulated in these structures. For the excluded groups themselves it is more about the assertion of a collective identity.
- The conflict in Nepal is taking place within a poverty context. Inclusive growth is therefore vital in keeping the economy afloat and in ensuring that poor people, not just elites can access both political and economic opportunities.
- Lack of access to the benefits of state employment – in the civil service and the security forces – is a key grievance for many groups. The civil service and security forces are overwhelmingly dominated by high caste groups, and recruitment from the lowland plains (terai) – where 50% of the population lives – is negligible.
- The extension of citizenship to landless groups in the tarai, which may have a significant impact on the balance of political power, will be a critical test of the political will of the state to become more inclusive.

Source [8] (DFID)

3.3 Cooperation policies

Key insights for donors in Nepal (based on group discussions)

1. Donors should focus on national programmes defined by Nepalis. Nepal has strong government systems and it is important to build on these.
2. Donors should work with local level and emerging structures – the political details of what federalism means will take some time to figure out.
3. Donors should focus on the implementation of existing programmes rather than inventing new programmes. Donors should focus on helping government to improve its implementation and absorptive capacity
4. Spending on Security Sector Reform (SSR) may need to increase, however it is important to have an understanding of fiscal tensions of investing in SSR over a 5-10 year period
5. Donors should listen and respond to the needs of youth. They should not just focus solely on education at primary or tertiary level; it is important to look at secondary level and those out of school.
6. Donors may need to restructure their development programmes in order to facilitate processes for ownership. Perhaps there is a need for a donor/government compact for Nepal.

Source [8] DFID

3.4 Health policies

Typology of health systems

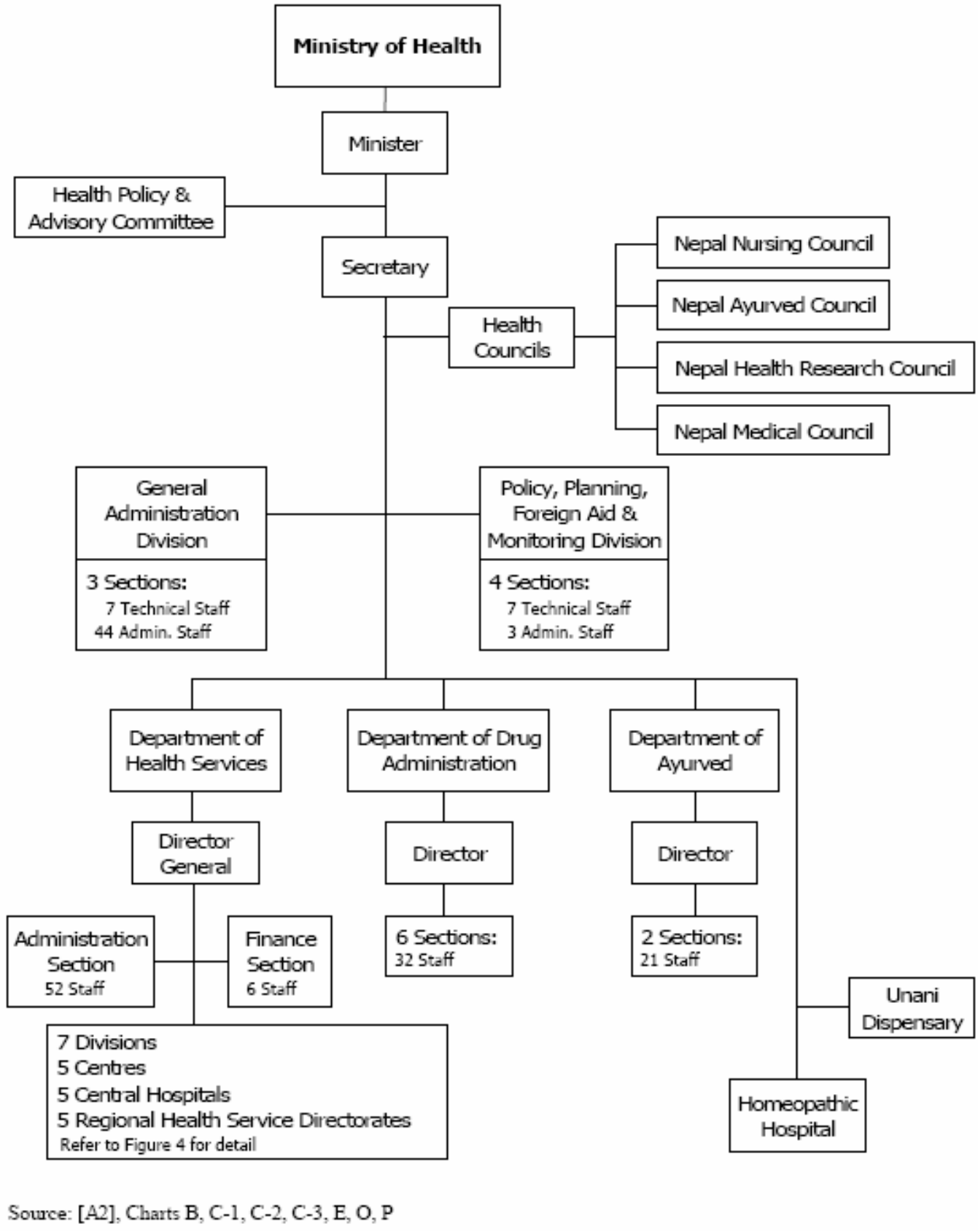
Universalistic, tax-funded systems: No/minimal user fees, no explicit targeting/voluntary self-selection by rich of private sector, emphasis in spending towards hospitals/inpatient care, high density of supply.	Sri Lanka Malaysia Hong Kong
Non-universalistic, tax-funded systems: User fees, means testing, emphasis in spending towards non-hospital care, low density of supply.	Bangladesh Indonesia India Nepal
National health insurance systems: Universal social health insurance, large tax-subsidy for insurance, emphasis in spending towards hospitals/inpatient care	Japan Korea Taiwan (Mongolia/Thailand)
Transition systems: Restricted social health insurance, minimal tax-subsidy for insurance, user charges major mechanism of financing	China Viet Nam

3

Source [10]

3.5 Ministry of Health

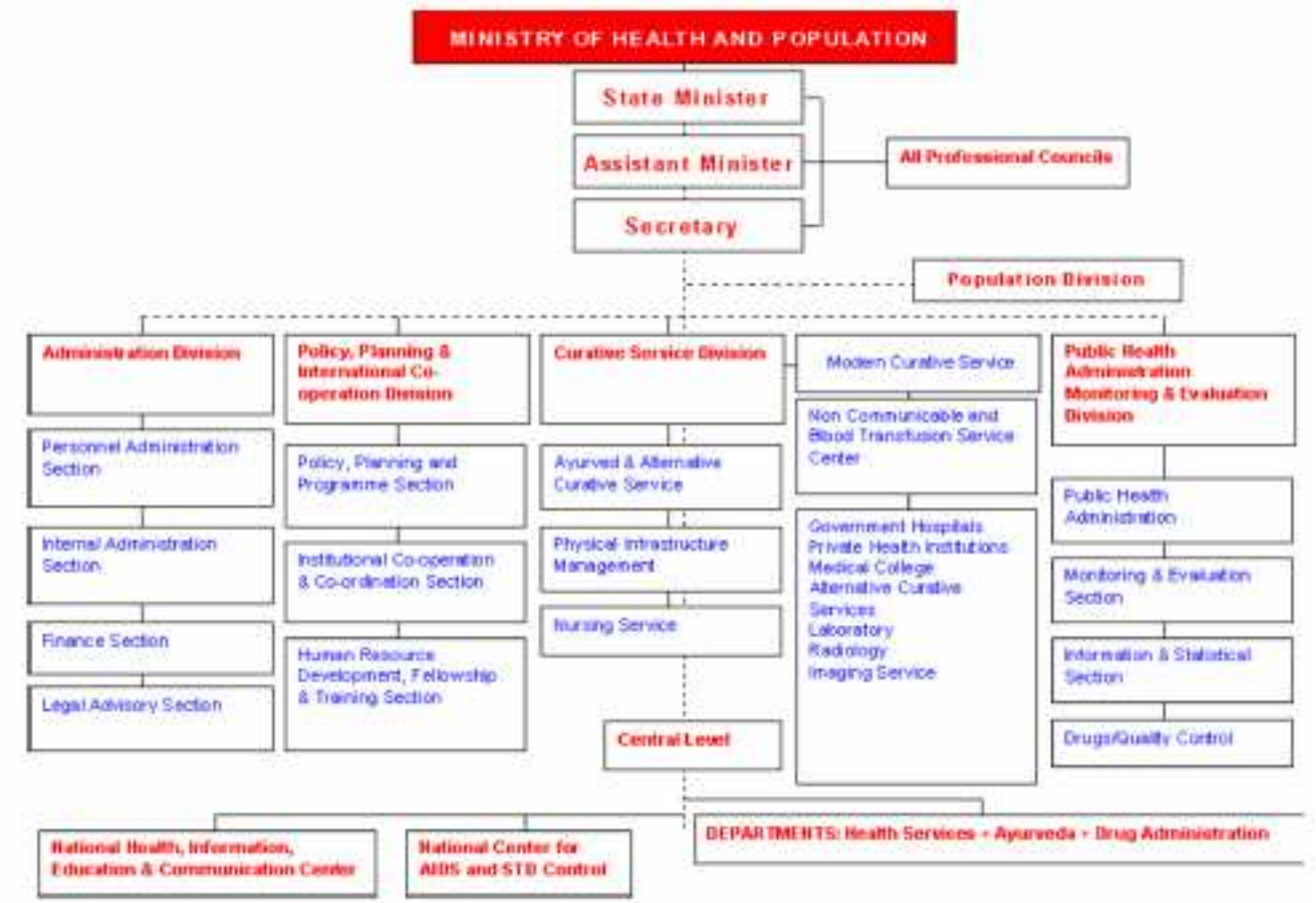
Figure 3 Organisation chart of MoH



Source: [A2], Charts B, C-1, C-2, C-3, E, O, P

Source [139]

Organigram 2009-02-22



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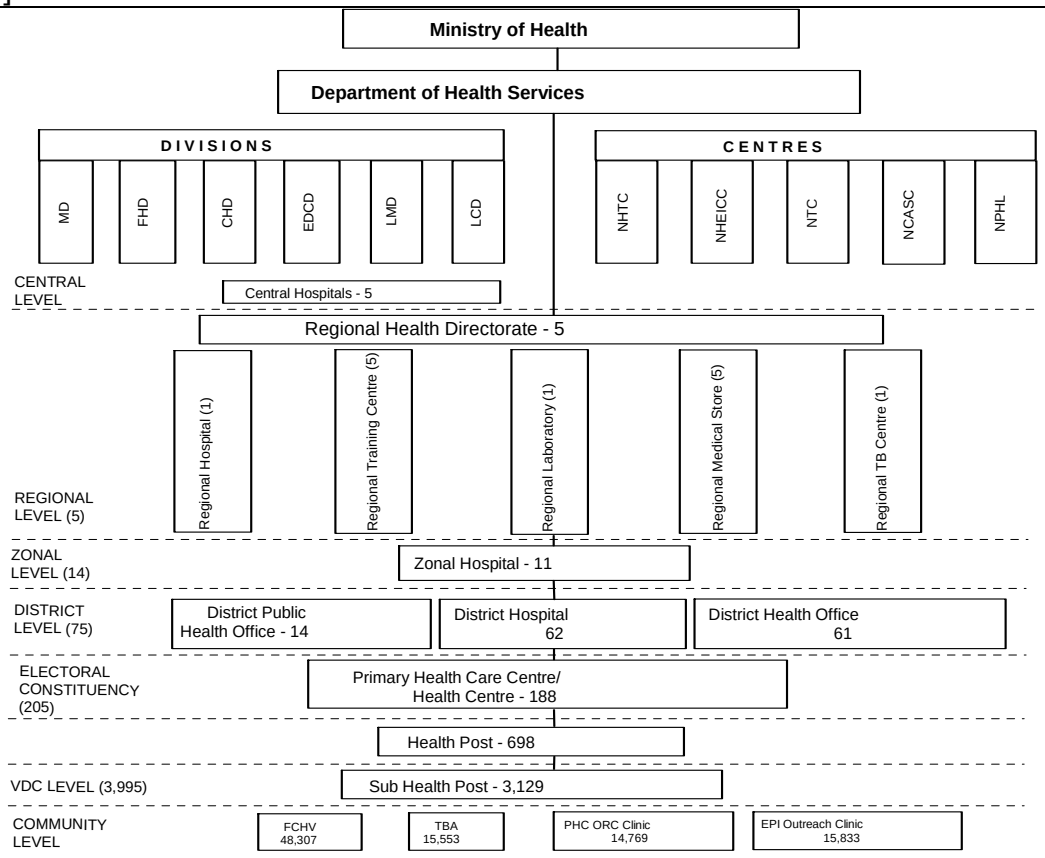
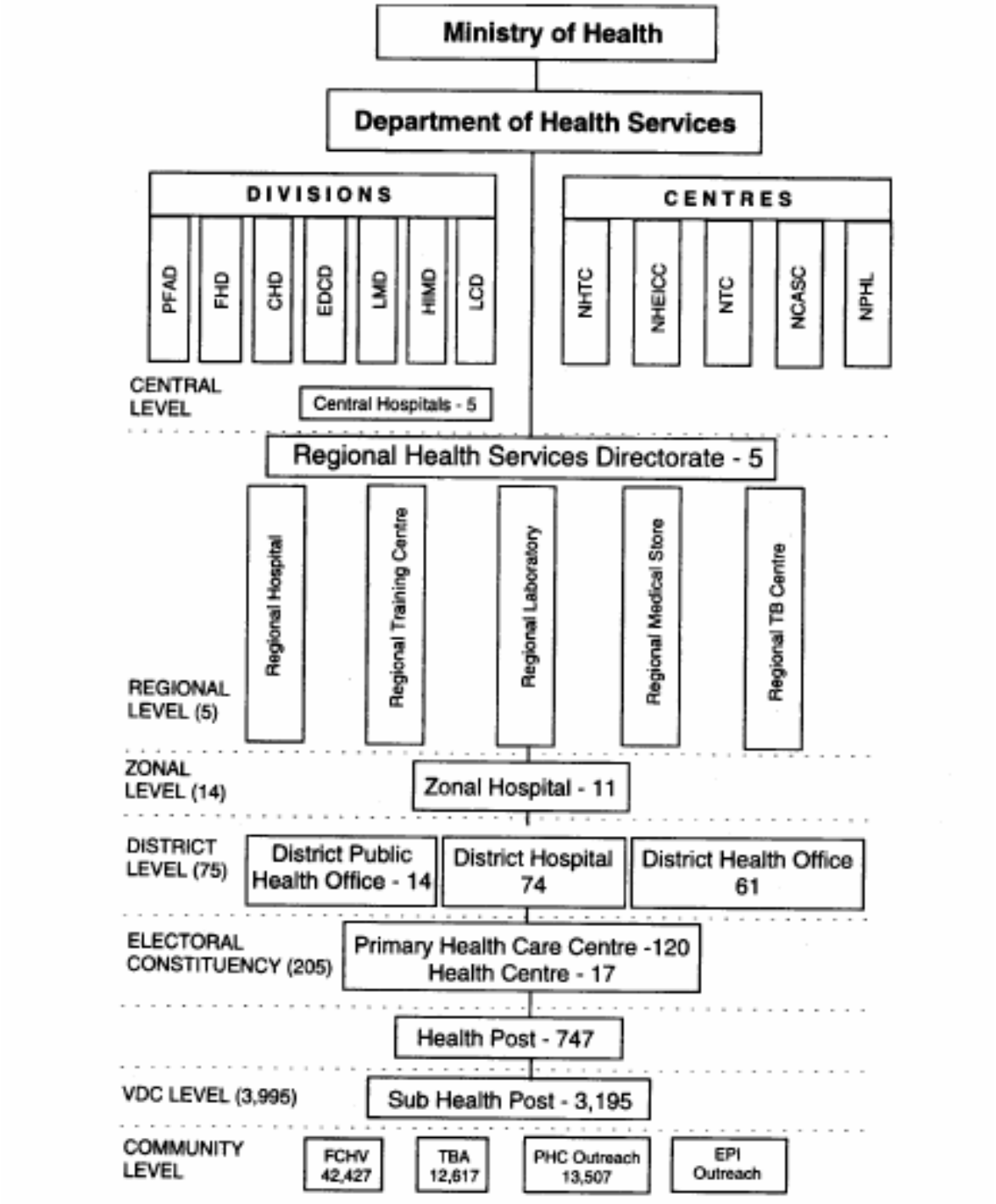


Source [69]

Figure 4 Organisation chart of DoHS



Acronyms

PFAD	*Planning and Foreign Aid Division*	*NHEICC*	*National Health Education, Information and Communication Centre*
FHD	*Family Health Division*		
CHD	*Child Health Division*	*NTC*	*National Tuberculosis Centre*
EDCD	*Epidemiology and Disease Control Division*	*NCASC*	*National Centre for AIDS and STD Control*
LMD	*Logistics Management Division*	*NPHL*	*National Public Health Laboratory*
HIMDD	*Health Institution & Manpower Development Division*	*FCHV*	*Female Community Health Volunteer*
		TBA	*Traditional Birth Attendant*
LCD	*Leprosy Control Division*	*PHC*	*Primary Health Care*
NHTC	*National Health Training Centre*	*EPI*	*Expanded Programme on Immunization*

Source [139]

4 Social security

4.1 Statistics

Table 1. Changing Scenario in Coverage Provisions in Enterprises, %

Provision	1990	1999
Provident fund	41	63
Gratuity benefit	34	50
Accident insurance	12	26
Sick leave	52	86
Maternity leave	23	47
Workmen's compensation	17	28
Housing facilities	37	76

Source: GEFONT, 2001.

Source [179]

68

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
Malawi	...						0	27.7	9.3	0.0	42.7
Malaysia	...							30.8	3.8	0.8	73.8
Mali	2.0						2.0	38	4.8	26.0	89.3
Mauritania	0.3						0.26	23.2	3.7	8.7	100
Mexico	78.6	28.6[51]	47[52]	3[53]				50.5	6.2	66.9	94.2
Moldova, Republic of	78.6		100[54]					43.7	7.2	1.1	96.1
Mongolia	100	57.6[55]	78.5[56]					33	6.7	37.8	91.1
Morocco	41.2		35[57]	0.4	0.5[58]	5.3[58]		50.9	5.1	0.0	76.1
Mozambique	...							14.9	4.7	0.0	38.8
Myanmar	...							80.4	2.8	1.3	99.7
Namibia	22.5		10[59]	12.5[60]				5.8	6.4	1.9	19.2
Nepal	0.1					0.008[61]	0.13	66.6	5.3	0.0	92.2

The General Federation of Nepalese Trade Unions was covering about 2,000 beneficiaries (ILO, 2003a, pp.8,10).

Source [77]

Table 5.1. Summary of Annual Social Protection Expenditure and Indicators

SP Component	Expenditure (NRs'000)	(%)
Labor Market Programs	586,925	6.3
Social Insurance	4,455,893	47.5
Social Assistance	662,352	7.1
Micro/Area-wide Programs	3,151,270	33.6
Child Protection	528,387	5.6
Total	9,384,827	100.0
Indicators of Social Protection Expenditure		
SP Expenditure as% of GDP	2.2%	
SP Expenditure Per Capita (NRs)	NRs408 ($5.5)	

Source: Various.

Table 5.2. Annual Expenditure on Social Protection by Subcomponent*

SP Component /Program	Funding	Annual Cost (NRs'000)	Comment
Labor Market Programs			
Active Labor Market	Government/GTZ/WFP/	254,451	Active labor market programs
Affirmative action	SNV Netherlands	35,448	mainly include income-
Food for Work		297,026	generation programs and
Subtotal		**586,925**	training programs; Funding for Food for Work provided by HMG/N, GTZ, DFID, WFP, SNV, SDC, DANIDA
Social Insurance Programs			
Provident Fund, Citizens' Investment Fund, Poverty Alleviation Fund	Government/ Employees Provident Fund/Citizens'	227,823	Figures for provident fund are disbursements rather than contributions
Health Financing	Investment	226,777	Health financing includes
Pensions	Fund/WB	4,001,293	microinsurance
Subtotal		**4,455,893**	
Social Assistance			
All Social Assistance Programs (mostly targeted at the elderly, widows, and the disabled)	Government/INGO	662,352	Most of the social assistance programs are handled by MWCSW and MLD, HMG/N
Subtotal		**662,352**	
Micro/Area-wide Programs			
All Micro/Area-Wide Programs	Government and several donors	3,151,270	Most of these programs have credit as major
Subtotal		**3,151,270**	component; and most are targeted towards women and disadvantaged groups
Child Protection			
Education-Related Programs	Government/Bilateral	467,581	Other programs include
Other Programs	& Multilateral Donors	60,806	government, NGO and INGO
Subtotal	INGOs	**528,387**	programs for children at risk and children with special needs.
Grand Total		**9,384,827**	

*More disaggregated expenditure figures are provided in Annex 4.
Source: Authors.

Source [96]

Table 5.3. Nepal: Beneficiaries and Target Populations of Major SP Programs, 2002/03

SP Component/Program	Number of Beneficiaries (000s)	Reference Population (Potential Target Group) Definition	Population (000s)	Comments
Labor Market Programs (LMP)				
Training/Employment Promotion	169.0	Unemployed/Underemployed	1,465	Underempl. < 20hrs Underempl. <40hrsGovt./ IFI/INGO projects
Public Works/FFW Programs Targeted at the Poor	303.0	Total Labor Force	2,911	
Other Employment Programs (mostly based on loans, microcredit)	480.0		9,900	
All LMP	**952.0**			
Social Insurance[b] (pensions)	112.1	Elderly population (60 yrs +)	1,504[a]	Persons receiving pensions
Microinsurance[c]	448.6	Total poor population	9,000	
All Social Insurance	560.6			
Health Financing				Scheme membership
Health Benefits: Employees Provident Fund	**Total coverage: 467.5**	Total population	23,000	
Citizens Investment Fund: Senior Citizen Treatment Allowance				
Social Assistance				
Allowances: Senior Citizens/Widows				In 2001, the total females (10+)
Social Welfare Centers/Old Age Homes		Total Senior Citizens (75+)Total elderly people (60+)	301 1,504	were 8.4 million of which 308,451 were widows
Allowances to Conflict-Hit Children		Widows	308	
Under Immediate Relief Program	**Total (SA): 430.5**	Bonded labor	200	

continued next page

Source [96]

Table 5.3. Nepal: Beneficiaries and Target Populations of Major SP Programs, 2002/03 (continued)

SP Component/Program	Number of Beneficiaries (000s)	Reference Population (Potential Target Group) Definition	Population (000s)	Comments
Disability programs				
Allowances and Training to Persons with Disabilities Government	5.6	Disabled population	750	
NGOs/INGOs/Other Organizations	27			
Microcredit		All households	4,000	Govt and NGO programs
All programs	**236 (households)** (1,370 people)			
Child Protection			8,949	Govt and NGO programs
Educational Assistance Programs	623.1	All Children (0-14 years)	6,193	
Programs to Assist Children with Special Needs (CSWN)	100	All Children (5-14 years) Total children in pre-primary	4,573 3,760	
Total Child Protection	723.1	and primary schoolAll CSWN[d]		

[a] Estimated on the basis of the population data of 2001 Census
[b] IIDS 2003
[c] Overview of the Microinsurance Schemes Operational in Asia, Strategies and Tools Against Exclusion and Protection (STEP), ILO, June 2004, Draft.
[d] Includes children not attending school, malnourished, disabled, those in worst forms of child labor (ILO, 2001; NPC/UNICEF 2001; ADB 2004.
Other sources: Ministry of Labor, Ministry of Health, Ministry of Women, Children and Social Welfare, Social Welfare Council, Employees Provident Fund, Citizens' Investment Trust, Ministry of Education, Ministry of Local Development, Nirdhan Utthan Bank.

Source [96]

Table A. 1. Largest SP Programs in terms of Expenditure

Rank	Bangladesh	Indonesia	Mongolia	Nepal	Pakistan	Vietnam
1	Micro-credit (58%)	Pensions for military, government, and formal sector employees. (67%)	Pension Fund (55%)	Pensions for government, and formal sector employees. (43%)	Pensions for military, government, and formal sector employees. (81%)	Social Security (46%)
2	Food security/ aid (17%)	Food security/ aid (15%)	Health insurance (13%)	Micro-credit (34%)	Health insurance (6%)	War invalids and contributors (20%
3	Pensions for government employees (8%)	Health assistance (3%)	Social welfare (7%)	Social assistance (7%)	Zakat (4%)	Health Insurance (8%)
4	SOE retrenchment (6%)	Micro-credit (3%)	Educational assistance (5%)	Educational assistance (5%)	Micro-finance (4%)	Micro-credit (6%)
5	Vulnerable group development (2%)	Health insurance (formal sector) (3%)	Social welfare pensions (4%)	Food for work (3%)	Bait-ul-Mal (3%)	Job creation (subsidised business loans) (5%)
% of total SP Exp.	91%	91%	84%	94%	98%	85%

Source (al tables): Country Reports.

Table A. 2. Largest SP Programs in terms of Beneficiaries

Rank	Bangladesh	Indonesia	Mongolia	Nepal	Pakistan	Vietnam
1	Food security/ aid	Health care assistance	Health insurance	Micro-credit	Health care/ insurance (ESSI and armed forces)	Subsidised health care (incl. schoolchildren)
2	Micro-credit	Food aid/ security	Pensions	Educational assistance	Pension schemes	Formal health insurance
3	Vulnerable group development	Formal Health insurance	Micro-finance	Loan based job creation	Micro-finance	Land tax exemptions
4	School feeding/ educational assistance	Pension schemes	Social welfare pensions	Health care assistance	Bait-ul-Mal (social assistance)	Educational assistance
5	Micro-insurance programs	Educational assistance	Social assistance programs	Social assistance programs	Zakat (social assistance)	War invalids and contributors

Source [3]

Table A. 3. Largest SP Programs in terms of Poor Beneficiaries

Rank	Bangladesh	Indonesia	Mongolia	Nepal	Pakistan	Vietnam
1	Food security/ aid	Food aid/ security	Health insurance	Micro-credit	Bait-ul-Mal (social assistance)	Educational assistance
2	Micro-credit	Health care assistance	Social assistance	Micro-insurance	Micro-credit	Land tax exemptions
3	School feeding/ educational assistance	Educational assistance	Micro-finance	Loans for job creation	Zakat (social assistance)	Various social allowances
4	Micro-insurance programs	Social assistance	Pensions	Food for Work	Health assistance (EDHI)	Health care assistance
5	Food for work	Micro-credit	Disabled programs	Social assistance	na	Pensions
% of all poor beneficiaries	92%*	c. 95%	94%	76%	98%	93%

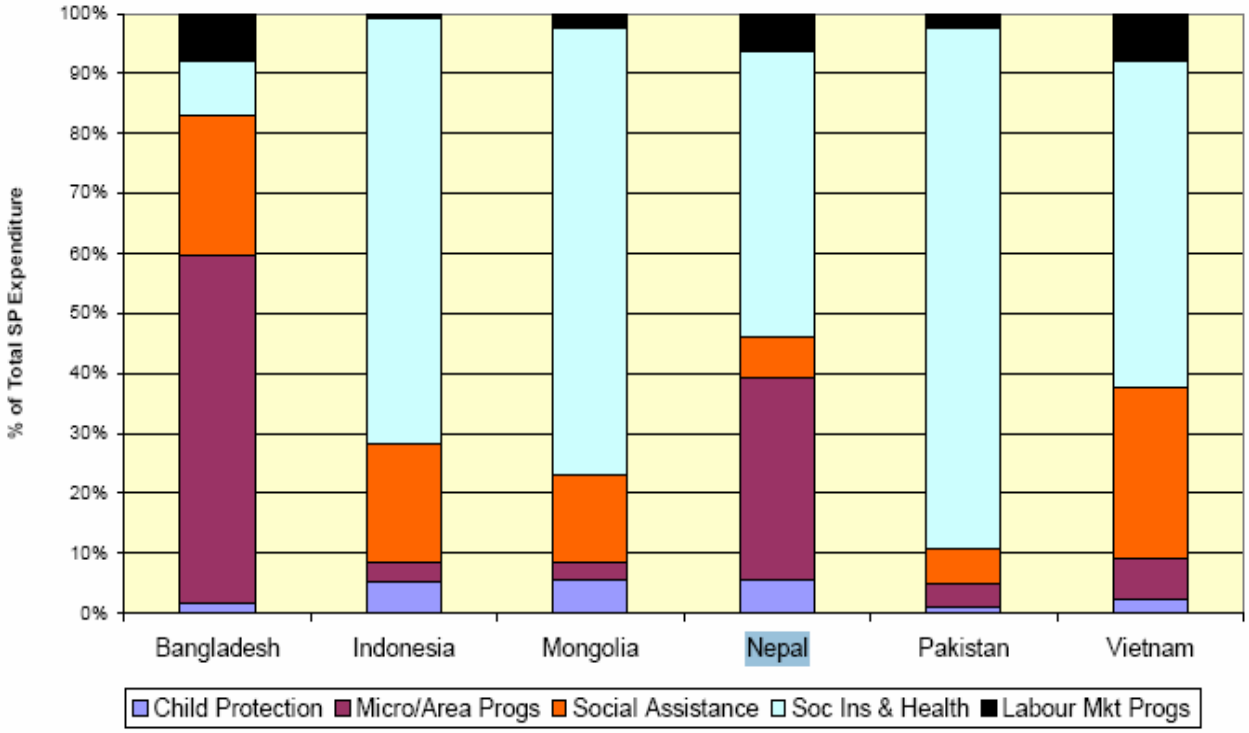
* No allowance for overlaps. These percentages therefore overestimate the number of poor people receiving SP.

Table A. 4. Largest SP Programs in terms of Expenditure on the Poor

Rank	Bangladesh	Indonesia	Mongolia	Nepal	Pakistan	Vietnam
1	Micro-credit (61%)	Food aid/ security (60%)	Pensions (30%)	Micro-credit (71%)	Pensions (39%)	Pensions (30%)
2	Food security/ aid (24%)	Social Assistance (14%)	Social assistance (13%)	Food for Work (8%)	Bait-ul-Mal (social assistance) (24%)	War invalids and contributors (22%)
3	Social assistance (5%)	Health care assistance (8%)	Educational assistance (9%)	Educational assistance (5%)	Zakat (social assistance) (20%)	Micro-credit (15%)
4	SOE retrenchment (2%)	Educational assistance (4%)	SI disability allowances (9%)	Loans for job creation (4%)	Children's programs (3%)	Social Assistance (5%)
5	School feeding/ educational assistance (2%)	Micro-credit / loans (3%)	Formal health insurance (8%)	Allowances for senior citizens (4%)	Khushal (job creation) (3%)	Formal health insurance (5%)
SP EXp. on the poor	94%	89%	69%	92%	90%	77%

Source [3]

Figure 4.1. Social Protection Expenditure by SP Component, 2002-03



Source [2]

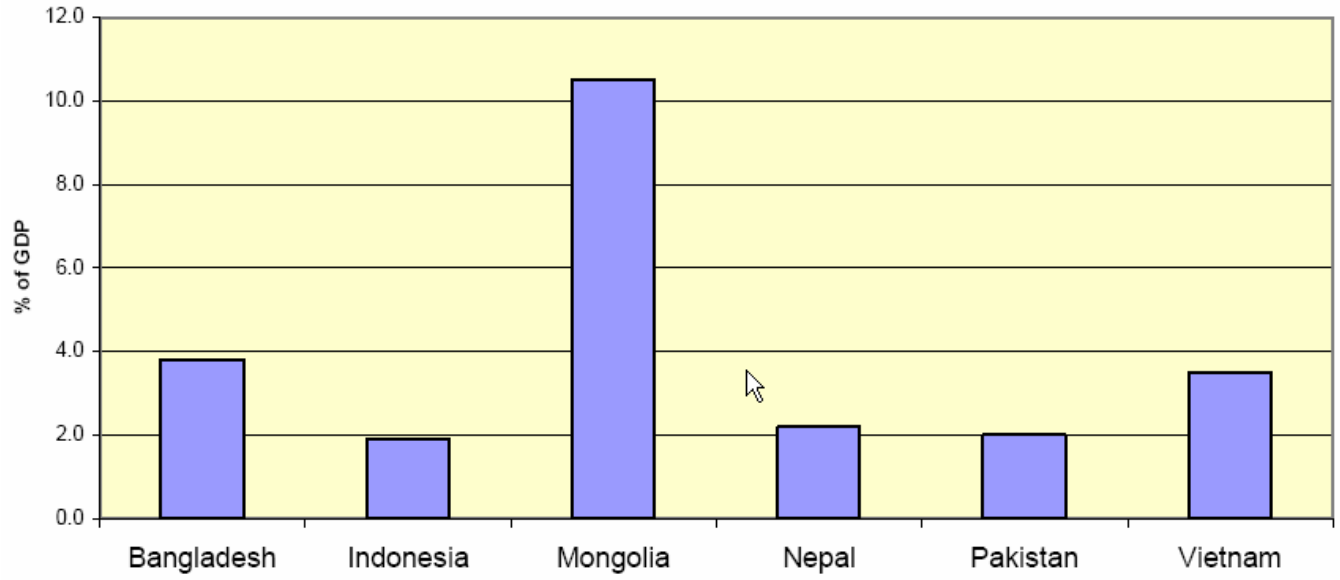
Table 4.1. Social Protection Expenditure as a Percentage of GDP

Country	SP expend. as % of GDP	
	Value (%)	Rank
Bangladesh	3.8	2
Indonesia	1.9	6
Mongolia	10.5	1
Nepal	2.2	4
Pakistan	2.0	5
Vietnam	3.5	3

Source: Country Reports.

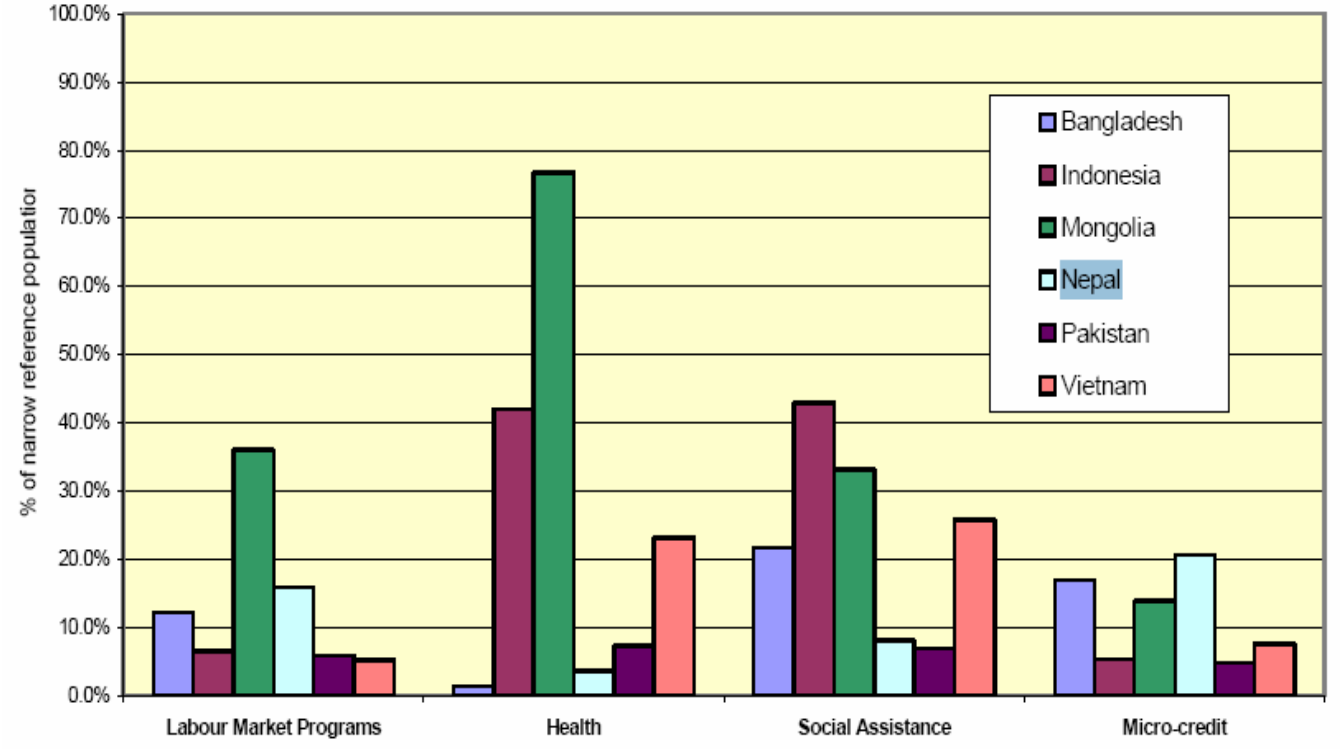
Source [2]

Figure 4.2. Total Social Protection Expenditure (as of GDP)



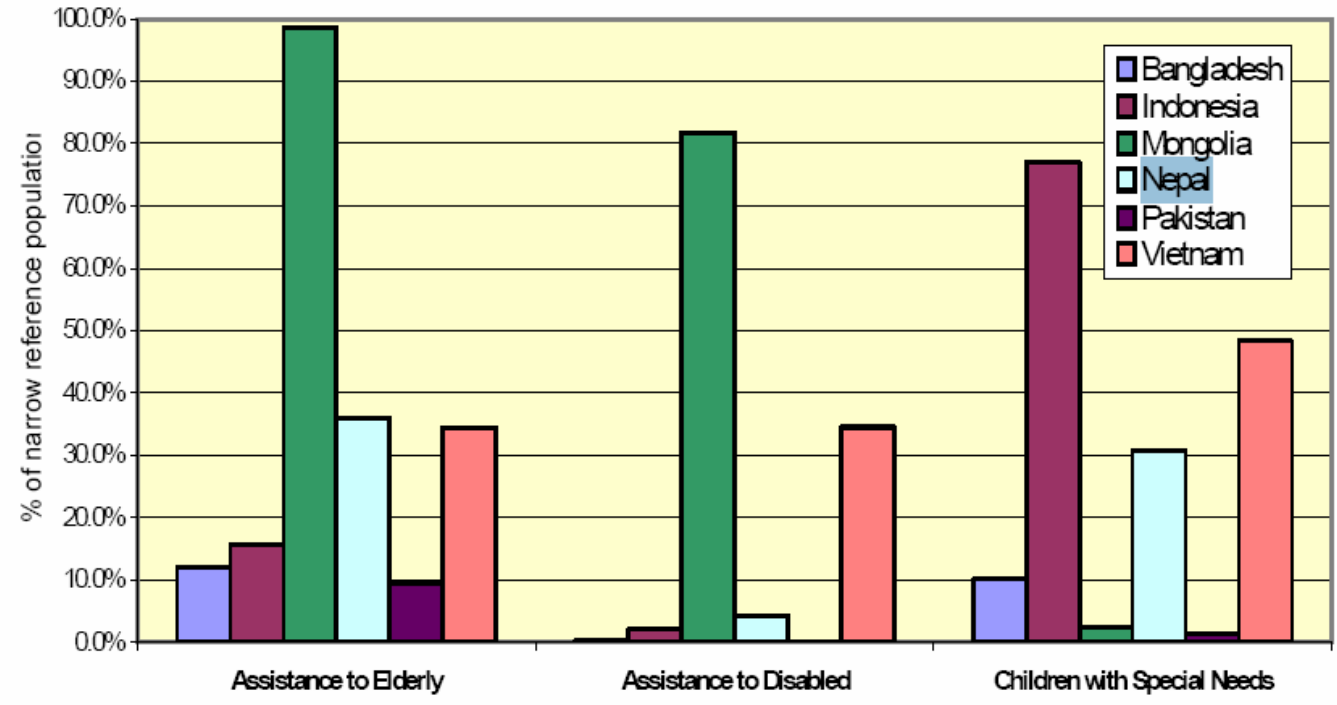
Source [2]

Figure 4.4. Social Protection Coverage Rates (1)



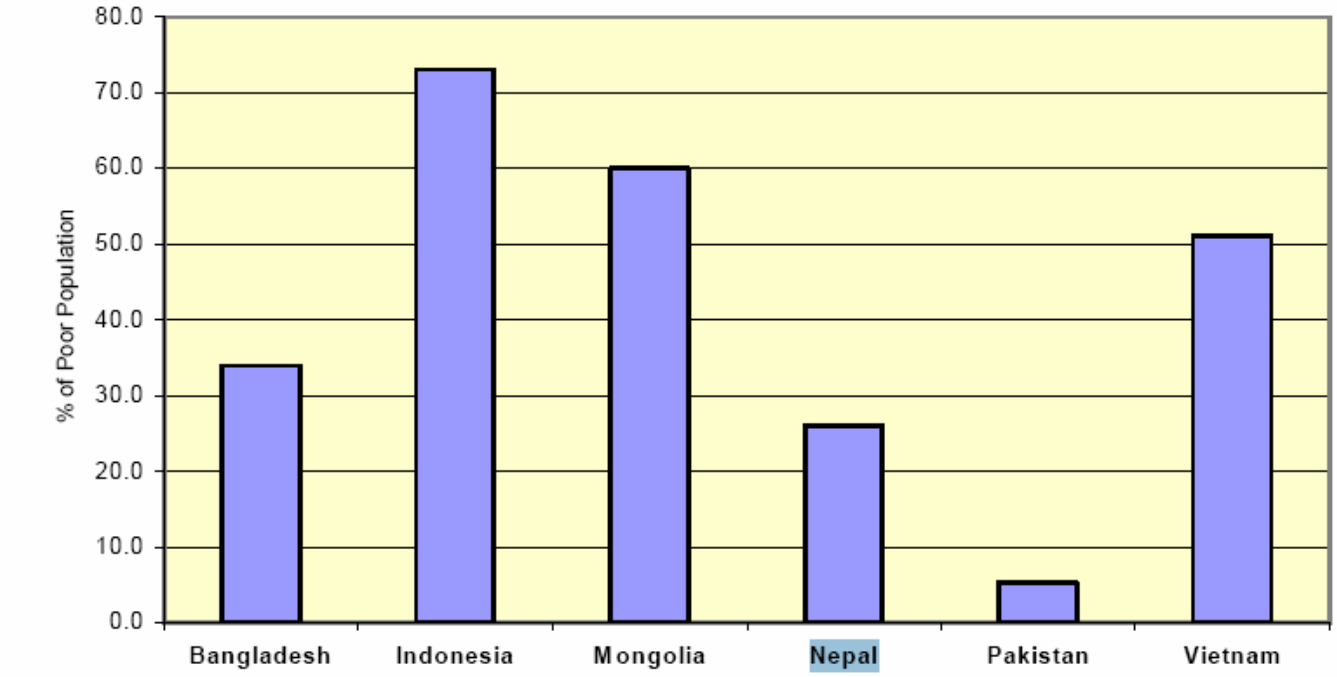
Source [2]

Figure 4.5. Social Protection Coverage Rates (2)



Source [2]

Figure 4.7. Poverty Targeting Rates



Source [2]

Annex 1: Base Data

Table A.1. Social Protection Expenditure by SP Component (percentages)

Country	Labour Market Programs	Social Security/ Insurance	Social Assistance	Micro/ Area Programs	Child Protection	Total
Bangladesh	7.8	9.1	23.3	58.2	1.6	100.0
Indonesia	0.8	70.9	19.7	3.3	5.3	100.0
Mongolia	2.5	74.6	14.4	3.0	5.6	100.0
Nepal	6.3	47.5	7.1	33.6	5.6	100.0
Pakistan	2.4	86.8	5.9	3.9	1.0	100.0
Vietnam	7.8	54.5	28.5	6.8	2.4	100.0

Source [2]

Table A.2. Social Protection Expenditure as percentage of GDP

Country	Expenditure Ratio *		Scaled Values (V_i / V_{max})	
	With MCF	Without MCF	With MCF	Without MCF
Bangladesh	3.8	1.6	0.36	0.16
Indonesia	1.9	2.2	0.18	0.22
Mongolia	10.5	10.1	1.00	1.00
Nepal	2.2	1.5	0.21	0.15
Pakistan	2.0	1.9	0.19	0.19
Vietnam	3.5	3.1	0.33	0.31
Max	10.5	10.1		
Min	1.9	1.5		

* Total SP Expenditure / GDP *100

Source [2]

Table A.5. Coverage Rates - Narrow Reference Population

Country	Labour Market Programs	Assistance to Elderly	Asssistance with health care	Social Assistance	Micro-credit	Assistance to Disabled	Children with Special Needs	Overall Coverage Rate			
								Coverage Rate (%)		Scaled Value (V_i / V_{max})	
								Unweighted	Weighted	Unweighted	Weighted
Reference Population	Unemployed and under-employed	Population aged 60+ years	Total population	Population living below Poverty line		Disabled population	Poor population aged 5-14 years				
Bangladesh	12.2%	12.0%	1.4%	21.7%	17.0%	0.3%	10.2%	10.7%	10.2%	0.22	0.19
Indonesia	6.5%	15.7%	42.0%	42.9%	5.3%	2.0%	77.0%	27.4%	34.6%	0.56	0.65
Mongolia	36.0%	98.6%	76.8%	33.2%	13.9%	81.7%	2.4%	48.9%	53.6%	1.00	1.00
Nepal	15.9%	36.0%	3.6%	8.2%	20.6%	4.4%	30.7%	17.0%	10.5%	0.35	0.20
Pakistan	5.9%	9.4%	7.3%	6.9%	4.9%	0.1%	1.3%	5.1%	6.5%	0.10	0.12
Vietnam	5.2%	34.4%	23.1%	25.9%	7.6%	34.6%	48.3%	25.6%	21.7%	0.52	0.40
Max Value	36%	98.6%	76.8%	42.9%	20.6%	81.7%	77%	48.9%	53.6%		
Min. Value	5.2%	9.4%	1.4%	6.9%	4.9%	0.1%	1.3%	5.1%	6.5%		

Table A.6. Coverage Rates - Wide Reference Population

Country	Labour Market Programs	Assistance to Elderly	Asssistance with health care	Social Assistance	Micro-credit	Assistance to Disabled	Children with Special Needs	Overall Coverage Rate			
								Coverage Rate (%)		Scaled Value (V_i / V_{max})	
								Unweighted	Weighted	Unweighted	Weighted
Reference Population	Labour Force	Population aged 60+ years	Total population	Total population		Disabled population	Total population aged 5-14 years				
Bangladesh	5.0%	12.0%	1.4%	11.0%	8.5%	0.3%	5.0%	6.1%	6.6%	0.15	0.23
Indonesia	1.6%	15.7%	42.0%	7.5%	0.9%	2.0%	17.0%	12.4%	14.8%	0.31	0.51
Mongolia	8.0%	98.6%	76.8%	12.0%	5.0%	81.7%	1.0%	40.4%	28.9%	1.00	1.00
Nepal	3.0%	36.0%	3.6%	3.0%	8.0%	4.4%	12.0%	9.9%	5.7%	0.25	0.20
Pakistan	0.5%	9.4%	7.3%	2.2%	1.6%	0.1%	0.4%	3.1%	3.3%	0.08	0.11
Vietnam	1.7%	34.4%	23.1%	7.5%	2.2%	34.6%	14.0%	16.8%	11.0%	0.41	0.38
Max Value	8.0%	98.6%	76.8%	12.0%	8.55	81.7%	17,0%	40.4%	28.9%		
Min. value	0.5%	9.4%	1.4%	2.2%	0.9%	0.1%	0.4%	3.1%	3.3%		

Source [2]

Annex 2: Calculations using the Poverty Gap

Table A.7. Calculations of Alternative Impact Indicators using the Poverty Gap

Country		Poverty Gap #	Headcount Ratio	Poverty line	Population	Total Income Deficit *	SPEXP POOR	SPIMP2 **
		%	%	Local currency	millions	Local Currency (millions)		
	Year	1	2	3	4	5 = (1/100)*4*(2/100)*3	6	7 = 6/(5+6)
Bangladesh	2000	12.9	50	7,820	134	67,588	79,000	53.9%
Indonesia	2002/03	3.1	18	1,389,000	214	1,658,633	5,681,000	77.4%
Mongolia	2002	11	36	296,600	2.5	29,363	56,661	65.9%
Nepal	1995/96	12.1	42	6,400	23	7,481	3,908	34.3%
Pakistan	1998/99	6.9	32	9,000	149	29,609	7,920	21.1%
Vietnam	2002	6.9	29	1,930,000	80	3,089,544	5,180,000	62.6%

Country	Total Income of the poor ***	Total income before SP Expenditure	SPEXP POOR	SPIMP3
	Local currency			
	8 = (2/100)*3*4-5	9 = 8 - 6	10 = 6	11 = 10 / 9
Bangladesh	456,352	377,352	79,000	20.9%
Indonesia	51,845,647	46,164,647	5,681,000	12.3%
Mongolia	237,577	180,916	56,661	31.3%
Nepal	54,343	50,435	3,908	7.7%
Pakistan	399,511	391,591	7,920	2.0%
Vietnam	41,686,456	36,506,456	5,180,000	14.2%

* Income equivalent of poverty gap aggregated over poor population..

** Ratio of SP Expenditure to poverty gap + SP expenditure.

*** Total income of all poor households.

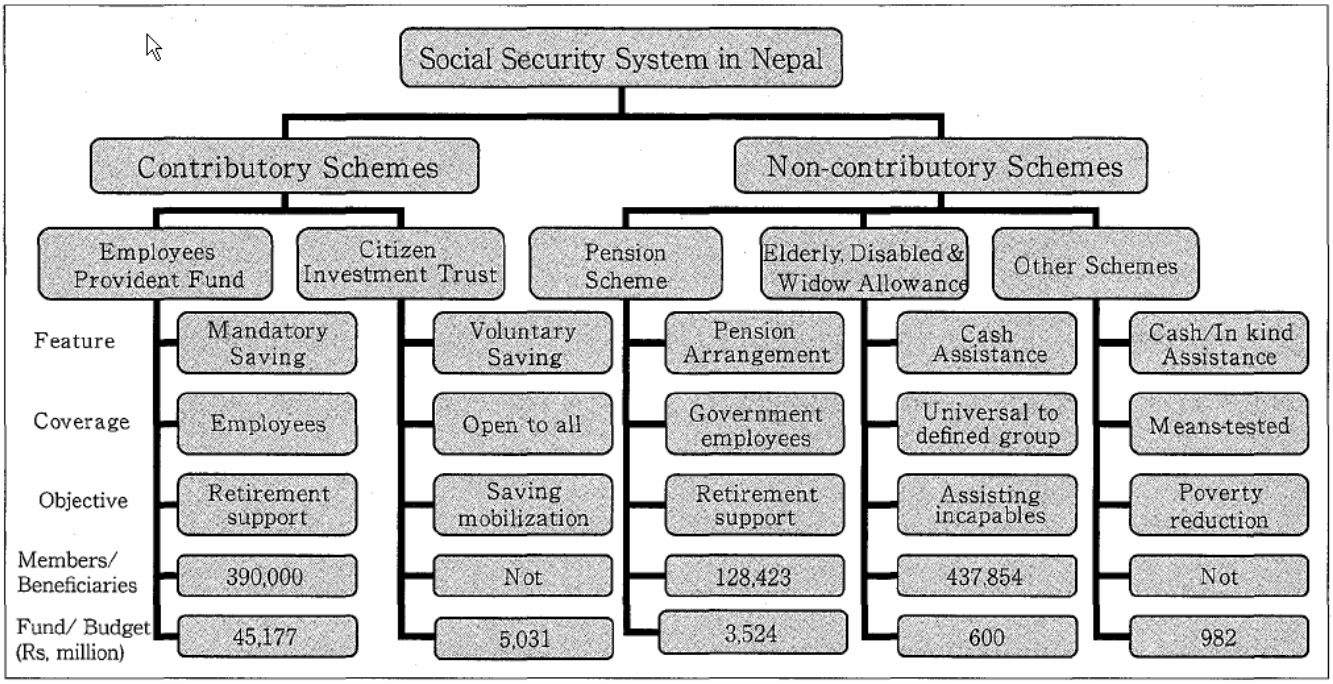
Poverty gaps from country reports except for Pakistan (A.R. Kemal, *Poverty in Pakistan: Trends and Causes*, undated online presentation) and Indonesia (C. Maksum, *Official Poverty measurement in indonesia*, 2004, available online).

Source [2]

4.2

Overview

Chart 1. Summary of Social Security System in Nepal



Source [179]

Social and Health Insurance Programs

1. Work Injury Insurance

Work injury insurance was introduced in Nepal in 1959. Under the Civil Services Act and the Labor Act, it is available to mine workers and employees of enterprises with 10 or more workers. The objective of the insurance program is to provide compensation to workers injured or killed during the course of their work. The scheme is financed by employers through direct payment of insurance premiums to private insurance companies. While the coverage of Civil Servants and other government employees under this framework is automatic, many eligible private sector employees are not covered due to noncompliance on the part their employers. The benefits provided to Civil Servants and other government employees include paid leaves, payment of full medical expenses, lump sum payment of pension, NRs10,000 plus 20% of monthly salary where employment termination is necessary, death benefits, and a NRs700,000 lump sum payment to the families of security personnel killed in the line of duty while fighting the ongoing Maoist insurgency. The benefits for non-Civil Servants include payment of full medical expenses if hospitalized, and half of the expenses if not hospitalized, lump sum payments of up to five years' salary for certain injuries, and death benefits (ADB 2004).

2. Citizens Investment Fund

Introduced in 1990 under the Citizens Investment Fund Act 2056, this program is administered by the Citizens Investment Trust. Participation in this program is voluntary and it provides members with tax-deferred investment opportunities for their retirement savings. Although the program is currently available only to formal sector workers, there are plans to expand the coverage to the

informal sector as well. The investment options offered by the Fund are as follows:
(i) Employees Savings Growth Scheme: employees make a monthly contribution of 5% to 10% of their salary for five to 10 years;
(ii) Gratuity Scheme: employees can take termination payments (gratuities) in place of regular pension payments;
(iii) Investors Account Scheme: investors choose the mix of investment made on their behalf by the Fund, but they cannot access their investments until retirement;
(iv) Company Pension Schemes: the Fund manages the money, but the companies take responsibilities for paying the benefits; and
(v) Flexible Retirement Savings Plan for self-employed people.
At present, approximately, 87,000 members are covered through various schemes provided by the Trust.9

3. Employees Provident Fund
This Fund was introduced in 1962 to provide financial support to the formal sector employees upon retirement. The coverage is compulsory for all government employees and organizations with 10 or more workers also have the option of participating in the scheme. The Fund has around 380,000 members. The Fund is financed by contributions from the employees and the employers and from the returns on its diversified investments.
Lump sump benefit payments are made to members upon retirement or early termination of employment and to survivors in cases of death of the employee contributor. The benefits include the contributions made by the employee and the employers plus interest earnings. The Fund also has provisions for paying a lump sum of NRs50,000 in the case of permanent disability or accidental death of an employee contributor. Another benefit provided by the Fund is borrowing privileges to members—they can borrow up to 90% of their equity at a low interest rate, and can also get loans educational and housing purposes. The total benefits paid by the Fund in 2001/02 were around NRs32 million.

4. Civil Service Pension Scheme
Unlike the Employees Provident Fund, which is available to both the government and nongovernment organizations, the Civil Service Pension Scheme is available only to civil servants, employees of government-owned enterprises, personnel of the armed services, and teachers of government schools and universities. Administered by the MOF, this scheme provides monthly retirement pensions based on the years of service and the salary at retirement. The pension amount increases with the movement of salaries for current employees. In order to qualify for these monthly pension payments, civil servants must have completed at least 20 years of service. For members of the Armed Forces, the minimum number of years of service required is only 16 years. Lump sum gratuity payments are made to retirees who have not completed the minimum years of service. The total annual expenditure on this scheme for 2003/04 was approximately NRs3.15 billion. During 2002/03, approximately 103,125 pensioners received benefits from the Civil Service Pension Scheme.

5. Microinsurance
Lately, some of the major institutions that primarily deal with microfinance (e.g. Nirdhan Utthan Bank and other Rural Development Banks modeled after the Grameen Bank) have started offering microinsurances, particularly in the area of livestock and health. The microinsurance schemes that exist in Nepal currently include livestock insurance, life insurance, and health insurance.
Livestock insurance scheme was introduced in Nepal in 1988 by the Deposit Insurance and Credit Guarantee Corporation. The insurance scheme guarantees a payment of 80% of the insured value of the livestock if they die.

Of the insurance premium, which is set at 6% of the purchase price of the animals, 50% is paid by the government. In spite of this facility, however, the slow process of settlement of losses in this scheme has resulted in limited enrolment of potential participants. Consequently, only 8,000 farmers had purchased livestock insurance by the year 2000. Another livestock insurance scheme, the Small Farmer's Development Program, was launched in Nepal in 1998 by the Agricultural Development Bank. Although the government finances 50% of the premium in this program as well, the premiums are set at a higher level than in the other program (10% of livestock value). This scheme had provided 629 households with livestock insurance. Other smaller insurers in the market are the Swabalamban Bikas Bank and the Nirdhan Utthan Bank. Only a very small fraction of the population in Nepal has access to life insurance. One life insurance scheme targeted at rural laborers and subsistence farmers is the Joint Relief Scheme operated by the Central Regional Grameen Development Bank Ltd. since 1999. Provided on a group insurance bases, this scheme has around 19,000 policyholders. The Center for Micro Finance has also been operating a life insurance scheme since 2000. This program has only 800 subscribers so far.

Health insurance coverage is even more limited than life insurance coverage in Nepal. Adequate access to health care is also still a luxury for most Nepalis, especially for women. One approach to providing low-income people with resources for health care is through microinsurance. Accordingly, the ILO has been supporting government, trade unions, employer organization, NGOs, and health providers to establish gender-sensitive health microinsurance schemes in five districts. The BP Koirala Institute of Health Care also has a health microinsurance scheme that is available to any organized group. The groups serve as intermediaries between the insured group members and the insurer. In order to make the scheme accessible to a maximum number of people, differential premium rates are applied to rural and urban contributors and discounts are provided to families with six or more contributing members. In 2003, around 18,000 individuals (2,500 households) had subscribed to this program.

Several schemes also exist for providing communities and individuals with subsidized pharmaceuticals, health clinic services, and hospital referral services. The Public Health Concern Trust, for example, has established the Kathmandu Model Hospital as a partner institution to provide subsidized services to small communities. It has also partnered with the General Federation of Nepalese Trade Unions (GEFONT) to provide similar services to both union and non-union workers. So far, the take-up of this arrangement has been limited. But GEFONT hopes to increase participation to 50,000 members by expanding the scheme to locations outside Kathmandu. One recent ILO study has compiled information on several schemes of microinsurance in Nepal. Based on this study (which is still ongoing), a total of 448,000 people are benefiting from these various forms of microinsurance schemes operated by nongovernment organizations. These schemes are almost always linked to microcredit programs (ILO 2004).

6. Health Care

Civil servants, police, and army personnel are provided with medical benefits as a condition of service with the value of benefits being capped under a formula related to salary levels (see ADB 2004 for details). For others, health costs are the responsibility of the individuals, but charges in public facilities are generally lower than those applied by private providers. The Ministry of Health estimates that 70-75% of current health costs are met directly by patients. The exception is that needy recipients of Senior Citizens Allowance are entitled to free medical and hospital treatment, financed by earmarking 5% of general purpose block grants to local governments.

Lately, the Government has conceptualized a Community Health Insurance Scheme to be undertaken as a pilot project in eight districts. The scheme will be based on voluntary participation and will be contributions-based, with the Government (and donor support) making up the balance of the cost that is estimated to be NRs10 million a year. The main benefit offered by the arrangements is to be a 20% premium subsidy for the poor. The proposed project aims to cover a

total of almost 70,000 persons in the eight districts (ADB 2004).

7. Road Accident Compensation

The Ministry of Labor and Transport Management/Traffic Police administers some road accident compensation programs in Nepal under the Motor Vehicles and Transportation Act 1997. There are three types of such programs currently in operation: (i) Motor Vehicle Passenger Accident Insurance, (ii) Transport Workers Accident Insurance, and (iii) Third Party Insurance. The objective of the first two insurance programs is to provide compensations to individuals injured in transportation accidents and to the dependents of individuals killed in such accidents. The Motor Vehicle Passenger Accident Insurance covers only the passengers in public transport, while the second insurance scheme covers drivers, handle boys, helpers, cleaners, and others employed in public transportation services. The compensations can range up to NRs50,000 in the case of passengers traveling in public transport vehicles; up to NRs150,000 for drivers; and up to NRs100,000 for other victims of transport accidents. The third program, Third Party Insurance, provides compensation to other people injured or killed in motor accidents and also pays for damages to property.

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2. Area-Based Health Programs

The Community Drug Program, operated in 30 districts, currently provides funds for the initial stocking of community pharmacies where drugs are provided at subsidized rates. Particularly in localities remote from formal treatment services, the Government sponsors the Women's Health Volunteer Program that provides training in basic first aid and healthy lifestyle advice to some 50,000 women volunteers. Arrangements have been established in 13 districts also to provide medical (first aid) kits containing a small range of basic pharmaceuticals for some 250,000 households.

3. Traditional Family and Community Support Systems

The traditional family and community-based support systems are mostly informal in nature and therefore, are not included among the SP programs represented by the different indices being developed in this study. Most of these traditional systems are either getting increasingly marginalized or are proving to be insufficient to support their communities in today's changing times. Nevertheless, they continue to provide some degree of SP to a significant number of people in the country. Hence, it is worthwhile to gain an understanding of the support mechanisms employed by these traditional SP "programs." Brief descriptions of some of the major traditional organizations and institutions of relevance are presented below (ADB 2004).

Guthi. The term Guthi in the Newari language means living together in mutual trust and self-service. The Guthi system has traditionally been practiced by the Newar community of Kathmandu Valley to collectively manage temples and religious institutions, conduct religious and cultural activities, and help each other in times of need. Guthis can be clan-, lineage- or territorybased. They are supported by the physical resources contributed by its members.

Dhikur. Dhikurs are traditional rotating credit associations that are popular among most hill communities of Nepal. They enable members to raise capital for income-generating activities, even where modern credit institutions are able to provide assistance. Typically, each Dhikur has a coordinator, who is responsible for calling meetings, keeping records, collecting contributions and fines, and distributing funds to members.

Parma. Parmas are agricultural labor exchange associations found among the Gurungs of western Nepal and the Limbus of eastern Nepal. Forms of Parma are also practiced by agricultural communities in the Tarai belt. At times, labor exchange in the Parma system is performed for immediate reciprocity as in the case of planting and harvesting seasons. In other cases, labor might be contributed to help others in tasks that might not be reciprocated immediately. It is assumed that each family receiving labor assistance through the Parma system

will contribute the same amount of labor to others in the long run.
Rodhi. Practiced by the Gurungs of western Nepal, Rodhis are community meetings that provide social, cultural, and vocational support for young people. Apart from providing an environment where young girls and boys to socialize in the evening, Rodhis also function as centers where exchange of information about income-generating activities takes place and older community member pass on traditional home industry skills to members of the new generation.
Aama Samuha. Aama Samuhas or mothers' groups originated in the Gurung communities of western Nepal to provide social, cultural, and vocational support to women whose husbands went abroad to serve in the British and Indian Armies. In recent years, many NGOs and donor agencies have utilized the concept of the Aama Samuha to empower women and promote savings and credit programs.
Tiho and Gola. These too are systems practiced by the Gurung community. Tihos are informal village assemblies that function informally to manage natural resources, agriculture and irrigation, and animal husbandry. They also mobilize Gola or voluntary labor for community construction projects.
Bheja. Bhejas are voluntary community associations prevalent among the Magars of western Nepal. They provide support for religious and agricultural activities, resource management, cultural activities, and conflict management.
Pancha Bhaladmi and Dharma Panchayat. These are political self-help groups and local councils found among the Thakalis of western Nepal. They perform political, social, cultural, religious, legal, and judicial functions.
Posang osang and Mirchang. Both these voluntary organizations are unique to the people of the Mustang district in western Nepal. The primary functions of Posangs include supporting cultural and religious activities, dispensing justice, and conducting a population census of the community every three years. Additionally, they also provide support in economic areas such as agriculture, irrigation, and animal husbandry. Mirchangs, on the other hand, are formed to manage natural resources, particularly forests. The Mirchangs made unwritten rules and regulations concerning the use of forest resources like the prohibition of unauthorized entry into forests. Mirchangs have largely been displaced by now by the USAID Resource Conservation and Utilization Project.
Khyal. Khyals are public forums for community discussions and resolution of community issues among the Tharus of the western Terai region.
Chattis Mauja Irrigation System. Originally associated with the Tharu community of Rupandehi district in the Terai, this community irrigation management system has members from many other castes and ethnic groups as well. The system consists of an elected committee that formulates and implements decisions related to water distribution and labor contributions.

Source [96]

Schemes for Civil Servants and Other Public Sector Employees

Contingencies	**Benefits**
Maternity	60 days paid leave, 2 times during service tenure
Work Injury	If overseas treatment is needed, Medicare (mentioned in the last row) + amount decided by a committee formed under regulation based on recommendation of Medical Board + paid leave
Work Accident	Full medical expenses + medical facility mentioned below + paid leaves If job is terminated due to invalidity, payment of Rs 10000 + 20 percent of monthly salary as invalidity pension + normal pension

Death by Work Accident or Life Long Invalidity	Pension + 50 percent of the pension + salary of 3 months **Survivors benefit and family benefits** Pension for 7 years to the spouse as survivors benefit Education allowance of maximum Rs 2400 per year for 2 children up to the age of 18 + maximum 15 percent of basic salary Rs 1800 in case of non-gazetted employees
Voluntary Retirement	**Gratuity based on service years** For 5-10 years of service – ½ month's salary per year For 10– 5 years of service -1 month salary per year For 15-20 years of service –1.5 months salary per year
Old Age	**Provident fund** 10 percent contribution from employee's monthly salary + matching contribution by the employer (HMGN) is deposited to PF account and paid in lump-sum along with compound interest to the respective employee/heir on his retirement/death **Pension** Monthly pension = salary at retirement X service years/50
Death During Job Tenure	Administered through EPF from welfare fund ranging from Rs.40 to 75 thousand Employees in health service Rs 150,000 For Maoist Victim Police Families Rs 700,000
Sickness	12 days paid leave per annum
Medicare	Officers = 12 month's salary in the entire service years Non gazetted I = 18 month's salary Non-gazetted others = 21 month's salary In case of fatal disease, assistance up to Rs. 100,000 in recommendation of Medical Board.

Source [174]

Existing Schemes for Private Sector Employees in the formal sector

Contingencies	**Benefits**
Maternity	A paid leave of 52 days two times during service period 45 days in tea estates
Work Injury	Full medical expenses under certification of Doctor + paid leaves in case of hospitalization, but half-paid leaves if not hospitalized.
Work Accident	Maximum 5 years' salary depending on the quantum of disability Maximum 4 years' salary in tea estates A detail of the quantum of disability and compensation is provisioned in Regulation under Workmen's Compensation.
Death by Work Accident or life long invalidity	Salary of 3 years to the nearest family member + priority in employment to one of the family member

Voluntary Retirement	Gratuity based on service years for tea estates For 4-10 yrs- 10days salary per year For 10-15 yrs-15 days salary per year For 15+years -20 days salary per year Retrenchment benefit For 3-7 years- ½ months salary per year For 7-15 years-20 days salary per year 15+ years- 1 month's salary per year Retrenchment benefit is alternative to gratuity
Old Age	**Provident fund** 10 percent contribution from employee's monthly salary + Equal contribution by the employer to be deposited to PF account Total amount with compound interest pay back to the respective employee/heir on his/her retirement/death 5 percent of monthly salary contribution in the case of tea estates
Death During Job Tenure	Payment depends on practice of the enterprise and strength of the union
Sickness	Half paid leave for 15 days per annum
Medicare	First aid to all Compensation to all from National & local welfare fund created through bonus fund under Bonus Act 1974 (70 % of fund remaining after bonus distribution goes in Local Welfare Fund and 30 % in National Welfare Fund) Immediate relief from welfare fund to family member also in case of accident or sickness.

Source [174]

Labour Law & Social Security in Nepal

by Umesh Upadhyaya

Background

Since Nepal is one of the least developed countries of the world, the process of socio-economic development is far behind in comparison to others. Agriculture is the major occupation in a dominating position, which alone contributes 40.2 per cent of the GDP and provides employment to 81 per cent of the labour force, while industry & services engage 2.7 & 16.3 per cent of the labour force in Nepal. But agriculture is based on traditional technology and the nature of the employment in it is mainly self-employment. Actually, the labour force in wage employment in Nepal is 21 per cent, whereas self- employed labour force is 79 per cent. This dominance of self-employment and informal sector was much more significant in the past. Therefore, the development of labour legislation in Nepal had been very slow. It is only after 1990, particularly after the reinstatement of multiparty democracy in Nepal that the fast growth of trade union organizations and other types of organizations could become possible in the new open environment. As a result, the collective voice for the rejection of the old outdated labour law Factory & Factory Workers' Act 1959 was recognized and has been replaced by the new one, i.e. Labour Act 1992. Similarly, in order to ease and rationalize the organizational activities, Trade Union Act 1992 has also been enacted. Consequently, Labour Regulations 1993 & Trade Union

Regulations1993 have also been brought out to implement the objectives and provisions of the two Acts. Others are Bonus Act 1973 and Foreign Employment Act 1985 in this regard.

Labour law in new perspectives

Although the labour laws in Nepal have been formulated and enacted recently, our socio-economic backwardness is reflected in it in the sense that various essential & progressive provisions are still not included therein. Effort has been cantered to formulate a labour law to include workers of all sectors, but, in reality, it is incomplete for every sector. The Labour Act 1992 is formulated keeping in view only the formal sector workers and hence the huge workforce of the country in unorganized informal sector has been excluded & neglected. Moreover, the weak labour administration & government mechanism has been found ineffective in the implementation and enforcement of a number of provisions of the law. Even the minimum wages determined by the tripartite Minimum Wage Fixation Committee have not been enforced widely & effectively. Clear & complete provisions are still lacking in connection with methods & mechanism for the enforcement of decisions and of collective agreements reached under the law. In the absence of systematic, concrete and dynamic labour policy, labour legislation in Nepal has not been able to address the problems and issues in this regard. Therefore urgent need is to formulate, amend and extend the coverage of the labour laws in a simple, adequate and comprehensive manner.

Because of the increasing speed of liberalization in our country, threat to the interests of the working masses has increased manifold. The job-security & employment-security are heavily endangered. Formal sector, too, is being in formalized through the subcontracting of work and subcontracting of labour. In the name of gaining competitiveness, cost minimization and comparative advantage in international trade, the responsibility of sacrifice and the entire burden is hastily being shifted to the workers. Unfortunately, the government is facilitating the employers and the market instead of shouldering its social responsibility for the working masses. This tendency is mainly visualized in carpet and garment industries, the major export sector in Nepal. But legal provisions do not protect workers in this condition.

With the blind and haphazard privatization of Public Enterprises, both the production and employment have been adversely affected. Though there is no mass retrenchment, slow group retrenchments have been observed. From Privatized public enterprises, 19.8 per cent of the workers have already lost their job and many others are waiting for the same. The extent of permanent workers is gradually going down and the number in contract & casualization is sharply increasing. The vast majority of workers is in informal sector which is unprotected and neglected by the labour laws. Only 10 per cent of the work force under the wage employment is in formal while 90 per cent is in unorganized sectors of the economy. With offensive policies of globalization, this low proportion of the formal sector is endangered to further deterioration pushing new entrants of the labour market to informal sector. The conditions in informal sector are miserable and danger is of further & additional misery. The long working hours, low payment, the widespread use of child labour, existence of bonded labour in the form of Kamaiya system, gender discrimination in wages & terms of employment, no minimum wages in unorganized sectors and non existence of any social security measures are the basic characteristics existing at present in informal sector.

Therefore, the need is to protect formal sector workers from being informalized and to minimize the adversities of the informal sector workers to the possible extent. This requires strong national resistance movement against the adversities of globalization in favour of the entire working population of the country. The building up of the movement is not possible without proper mobilization of informal sector workers, mainly the vast majority of the rural and agricultural workers. Thus, unionization of informal sector with more emphasis to rural and agricultural wage earners simultaneously with the policy intervention by trade union confederation for labour law

revision may give favourable result in this regard.

Social security: existing scenario

In countries like Nepal, where mass poverty has become a common phenomenon, active state intervention is necessary. Without strong, well-determined and committed state intervention, returns of the economic growth & increased productivity never go to the weaker sections of the society. State protection of workers both in formal & informal sectors through labour law, strict enforcement and other socio economic measures is inevitable in Nepal. The most important is the social security system in this connection. Through social security measures and wide network & coverage, government can play vital role in this regard. But the scenario in this respect in Nepal is quite frustrating and while over viewing the situation, we may encounter a gloomy picture.

In Nepal, wage structure is very weak and limited. Incentive earnings are very few and limited to a few enterprises. Fringe benefits like residence facility or allowance, Medicare, educational facilities for the children, transportation, ration, child care centres, entertainment, life insurance, credit facilities etc. are limited to a few establishments and are far from the access of the workers of most of the industries and services. In short, additional to the basic wage/salary are negligible. Wage indexation is also a dream like element in our realities. Therefore, social security system has become more relevant and urgent in our case. A combination of social welfare and social security covering the whole working population can combat the problems created by acute poverty in our country. While reviewing the statistics from 1977 to 1996, we find that poverty is increasing. It was 36.2 per cent in 1977, 42.5 in 1984-85, 40 in 1990 and 45 per cent in 1996. Comparing the situation with our south Asian neighbours, the percentage of poverty is in a declining trend in Bangladesh, India and Pakistan, but not in our case.

A few provisions of social security have been included in the Labour Act 1992. Among them are sick leave, maternity leave of 45 days, workmen's compensation, provident fund & gratuity as the old age benefit, and some OSH provisions. Besides, Childcare centres, canteen and welfare officer in every enterprise are other provisions. But this Act covers the establishments with more than 10 workers & the industrial estates and hence too limited in its coverage. Moreover, the responsibility of these provisions is solely left to the employers. The schemes of social insurance or security based on funds created by the tripartite contributions of workers, employers and the government are non-existent. Thus, we are in a phase of infancy with regard to social security.

An initiative was taken by UNDP/ILO in Nepal to establish and extend social security system under a project 'Social Security Planning & Administrative Reform'. It was a good research producing fair recommendations. As a result, the Ministry of Women & Social Welfare is trying to develop 'National Pension Scheme'.

The present labour law has not visualised the high positive effect of social security in productivity improvement. Outside the organised sector, nothing mentionable can be found in relation with social security or welfare. The single provision through annual budget is the provision of Rs.100 (USD 1.5) per month as the old-age allowance for the senior citizens above the age of 75 years and widows above 65. The Non Government Organisations are active to extend social welfare measures among the disabled persons, but organisations active for the social security of working population are not in existence. Trade unions have raised voices strongly for social security, but most of them have not launched any scheme on their own. General Federation of Nepalese Trade Unions has started an emergency fund scheme which might be considered a milestone in this respect. The scheme has become highly popular among its members. Similarly, Independent Transport Workers' Union of Nepal (one of the GEFONT affiliate) has been able to operate Accident Fund successfully for its members.

Anyway, revision of labour law in order to establish a system of contributory social security fund

and to launch various diverse schemes is extremely necessary. It is important also for the effective alleviation of poverty. The existing labour law has not tried to establish any system for social security. There are no previsions on occupational diseases. The provisions are specified in accordance with the degree of disablement and the injury in connection with workmen's compensation, but these provisions are salary-based, not based on age factor. Loss of earning capacity must not be tied only and strictly with wage/salary, which is a serious lacuna in the existing provisions of Labour Act. Similarly, the present legal provisions treat gratuity and retrenchment compensation as alternatives to one another. It is a wrong understanding and needs to be corrected.

Thus well-organised social security system for us is inevitably important in order to enter 21st Century. For the purpose, a sound labour law structure in combination with labour-friendly socio-economic policies & measures are essential at present.

Finally, it is to be noted that the policies of liberalisation have caused deductions in social expenditures. Even the state expenditure in education and public health is being curtailed, at the same time the burden of the foreign debt has constantly increased. Hence, the hardships and difficulties of the working population have increased tremendously. The major consequences have been observed in the deteriorating living standard. Since the market deregulation has removed restrictions on prices, cost of living has increased. On the contrary, real wages and hence the real incomes have declined. Thus, one-way emphasis to productivity is practically insufficient to solve our problems and redistribution through sound labour legislation & comprehensive social security system is the requirement at present.

(Presented in International Forum on Labour Law and Social Security 26-28 October 1998, Peking University, Beijing, China)

Source [147]

Social Security System in Nepal

by Ramesh Badal

The Labour Act 1992 was enacted by the first parliament in 1992. Before this Act, the Factory and Factory Workers Act 1959 had been in force in factories and other establishments as notified by the government. After the change of polity in 1990, the parliament also enacted the Trade Union Act 1993. In order to complement the Acts, Labour Rules 1993 and Trade Union Rules 1993 were enacted and implemented. Social security issues are dealt with by the Labour Act 1992 and the supplementary Rules.

Application of the labour law

Both the Labour Act and Labour Rules are applicable to those organizations established as per Nepali laws where more than ten workers are employed. This law is not applicable to those companies with less than ten workers. In addition, it is not applicable to the entire informal sector.

Social security applies only to workers with permanent statuses

Of the workers in the formal sector, the provision relating to social security is applicable only to the permanent ones. Otherwise these provisions are not applicable.

Social security benefits: There is no comprehensive social security system under the Nepali labour law. Employees are entitled to receive following benefits as part of social security under the Labour Act and Rules.

Provident fund: Provident fund is a contributory old age benefit under the labour law. According to the provision, the employer should deduct 10 percent of basic salary of the employees and add 10 percent to it, and deposit the amount in any commercial banks or *Karmachari Sanchaya Kosh,* the autonomous provident fund authority in Nepal.

Gratuity: Gratuity is also part of an old age benefit. It is also known as a severance pay. As per the provision in the Labour Rules, the employees serving for three years or more and retiring from the service are entitled to get gratuity at the following rates:

a. For the first seven years of continuous service, gratuity should be paid at the rate of 50 percent of the monthly salary per annum;
b. For seven to fifteen years of continuous service, gratuity should be paid at the rate of the two-thirds of the monthly salary per annum;
c. For service exceeding 15 years gratuity should be paid at the rate of one month's salary per annum.

For gratuity payment, a gratuity fund is to be created to deposit the relevant amount every year. Nowadays, some of commercial banks and Nagarik Lagani Kosh (Citizen's Investment Fund) also administer gratuity funds. The enforcement of the gratuity provision is, however, almost non-existent.

Treatment Expenses: Under the provision of Labour Rules, the employer must pay entire expenses required for treatment, including hospitalization and medical expenses, to an employee who suffers physical injury while on duty.

Salary during treatment: During the period of treatment, employer should pay full salary for the period of their stay in hospital or half of their salary if they have undergone treatment at home. However, if the period of such treatment exceeds a year, the employer is not obliged to pay the salary after one year.

Disability compensation: If an employee is physically disabled as a result of an accident while in employment, the employer must pay a lump sum amount equivalent to the salary of five years of the last drawn salary in case disability is found to be 100 percent. In case disability is less than 100 per cent, the amount of compensation shall be calculated according to the percentage of disability. The percentage of disability should be determined by a doctor recognized by HMG.

Compensation in case of death: In case of death of an employee instantly or in the course of treatment as a result of an accident while in employment, the employer should pay an amount equivalent to three years' salary calculated at the last drawn salary rate to the nearest heir as compensation.

In case an employee dies or becomes physically disabled as a result of a natural calamity, the employee or his/her legal heir shall not be entitled to any compensation.

Insurance and compensation: If an employee is entitled to receive compensation, he/she is entitled to compensation as mentioned above or the compensation under the insurance whichever is higher..

Termination on health ground: In case any employee sustains physical injuries while in employment and does not recover even after a year-long treatment or becomes physically disabled, he/she may be terminated from the service provided that a physician recognized by His Majesty's Government certifies that he/she is incapable of working. In such a case, the employer should pay gratuity and treatment compensation before termination.

Housing Fund: Under the Labour Act, 5 percent of the gross annual profit of an enterprise should be deposited as a housing fund and operated by a joint committee called Labour Relations Committee. However, this provision is almost non-existent in practice.

Welfare Fund: As per the Bonus Act, 1974, 10 per cent of net profit should be deposited for bonus distribution to workers. The Act fixes the maximum upper limit of bonuses to be paid. The amount that is left after bonus distribution will be deposited by every enterprise in the Welfare Fund. Of the amount deposited in the Welfare Fund, 70 percent goes into Local Welfare Fund and 30 percent into National Welfare Fund.

Pension: Pension is limited to government employees in civil services, police and armed forces, including some of public corporations. This provision is not applicable to the workers addressed by the Labour Act.

Retrenchment: If the employer wanted to close the whole or part of an organization, he/she should obtain approval from His Majesty's Government through the Department of Labour before the retrenchment of the employees. This is a legal compulsion on the part of the employer that he/she should provide one-month notice with reasons for retrenchment or pay the salary of one month in lieu of such a notice. Similarly, the employer should pay retrenchment compensation in lump sum equivalent to the amount of thirty days multiplied by the total number of years in service. The labour law has attempted to establish this form of compensation as an unemployment benefit. However, it cannot be practiced properly because gratuity considered by the employers as part of this benefit.

Sick Leaves: All workers or employees who have completed one year of service in the establishment without any interruption shall be granted a sick leave with half-pay for not more than 15 days in a year.

Maternity Leaves: Pregnant women workers or employees shall be granted a maternity leave with full pay for 52 days before or after delivery. Such a leave may be obtained not more than twice during the entire period of service. However, in the event of the death of two children of a woman employee, who has already utilized the maternity leave twice, she may be entitled to a maternity leave for two times more.

Leave is not a right! Under the Labour Rules, no employee can claim a leave as a matter of right. It should only be treated as a facility, which could be permitted by an employer. However, the court has by interpretation established that some kind of leave can be taken by an employee even if it is not authorized by the employer. Maternity and sick leave fall under this category..

Change by collective bargaining: An employee working in the organization has the right to union. Ten or more employees working in an organization can form a Plant Level union. The Plant Level union has the right to submit a charter of demand and bargain collectively with the management. The collective agreement may change social security provisions of a particular organization. This can be settlement shall be valid for up to two years.

On the Informal Sector

There is no concrete social security arrangement for the informal sector. Some of the workers working in the informal sectors are covered partly by the legislation. The Vehicle and Transportation Management Act provides accidental compensation to workers under a compulsory insurance provision. As per this provision, the vehicle owner should have accidental insurance coverage for the driver and helper. It may vary according to the type vehicles and positions of the workers. Normally, the compensation should be 100,000 to 200,000 Nepalese Rupees.

Similarly, the workers in the trekking and mountaineering sectors should also have their accidental insurances covered. The amount of insurance doe the workers in these sectors should not be less than 250,000 rupees. Likewise, employer should have a group insurance policy for accidental injuries for construction workers.

There is no provision for social security benefits for workers in the informal sector. They are treated as a general citizen and are provided with some sort of relief on an ad-hoc basis, such as the senior citizen allowance (Rs. 100 monthly provided to persons above 70 years of age and to widow and helpless women above 65), maternity protection allowances in some DVCs and DDCs, and so on.

Union's Proposal for Social Security Scheme

The government of Nepal is trying to make a new law with more flexibility. The union has proposed a comprehensive social security package to be included in the new law.

Old age benefit: Gratuity should be paid at the rate of 1.5 months salary for each year of service. There should be no time bar for the entitlement of this benefit. Similarly, a provident fund should be established by deducting 10 percent from workers' salary and adding the equal amount by the employer each month.

Workplace injury: In work place related accidents, all hospitalization and medical expenses should be covered by the management. In case of disability, a monitory compensation should be paid with a 5-year equivalent salary for 100 percent disability. For disability of other kinds, compensation amount should be determined taking into consideration the disability ratio as determined by the medical doctor.

Dependant benefit: The employer should pay 3-year equivalent salary compensation to the dependants of a worker in case of his/her death in a workplace accident. In case of his/her mental disorder resulting from the accident, the compensation should be paid with an amount no less than half of the death-compensation.

Sickness benefit: Sick leave should be provided at the rate of 1.5 days for each month of service with full pay in case of the illness of workers and their close relatives, that is spouse, parents and children. Likewise, the employer should establish medical insurance to all workers with an amount equivalent to their one-year salary.

Maternity benefit: Maternity leave and benefit should not be less than as provisioned in the ILO Convention 183 on Maternity Protection. On the basis of this Convention, the union proposed a paid maternity leave of 98 days, 7-week leave with pay in cases of miscarriages and 15-day paternity leave.

Retrenchment: There should be separate compensation for retrenchment. It should not be seen as gratuity.

Proposal of integrated social security fund

The trade union proposed an integrated social security system to administer all benefits as mentioned above. A tripartite board should manage such fund.

Contribution: The workers, employers and the government should contribute at the ratio of 1:2.5:2.5 respectively and 15 percent in the informal sector by all side. For the construction sector, 5 percent of the project amount should be providing to cover social security of the workers in the construction sector.

Once the Integrated Fund comes into operation, the employers will not be liable to pay provident fund, gratuity, injury benefits and compensation as mentioned above.

All workers shall be registered in the Integrated Social Security Fund. The Fund will also have a provision for the compulsory registration of domestic workers.

Social security operated by Union Itself: The Transportation Union and Construction Union of GEFONT have established a social security system for their members. The Transportation Union provides accidental leaves custody compensation in the case of accident. The Union also provides legal assistance to the members.

The Union in the construction sector has established sickness benefits and work injury benefits at the micro level.

GEFONT has also operated a health cooperative for its members. There is a micro health insurance scheme operated for the agricultural labourers in the western part of Nepal. It is trying to introduce such programmes in other areas as well.

(Presented in Social security Seminar in Beijing; November 2005)

Source [177]

Nepal

Exchange rate: US$1.00 equals 73.85 rupees.

Old Age, Disability, and Survivors

Regulatory Framework

First and current laws: 1962 (provident fund); and 1994 (old-age allowance), with 1995, 1996 (widow's allowance and disability pension), and 2002 (eliminating drawdown payment) amendments.

Type of program: Provident fund and social assistance system.

Coverage

Provident fund: Compulsory coverage for government employees.

Voluntary coverage for any organization with 10 or more employees.

Exclusions: Self-employed persons, temporary workers, part-time workers, and domestic servants.

Special system for civil servants.

Social assistance: Nepalese citizens aged 75 or older, aged 60 or older and a widow, or aged 16 or older and assessed as disabled.

Source of Funds

Provident fund

Insured person: 10% of monthly earnings.

Self-employed person: Not applicable.

Employer: 10% of monthly payroll. (Additional voluntary contributions may be made by employers on behalf of employees.)

There are no maximum earnings for additional voluntary contributions.

Government: None.

Social assistance

Insured person: None.

Self-employed person: None.

Employer: None.

Government: The total cost.

Qualifying Conditions

Old-age benefit (provident fund): Paid on retirement or the termination of employment. The legal retirement age is age 55; retirement may be deferred in certain instances until age 60.

Additional benefit scheme: Paid at retirement age.

Loan scheme (provident fund): Loans are provided from the fund member's own account to help finance the cost of housing, education, and other needs. The qualifying conditions vary according to the nature of the loan.

Old-age allowance (social assistance): Paid to Nepalese citizens aged 75 or older.

Personal accident insurance (provident fund): Paid in the event of the partial or permanent disability or the accidental death of the fund member.

Disability pension (social assistance): Paid to disabled Nepalese citizens aged 16 or older. The person must be assessed as blind or having lost the use of feet or hands.

Survivor benefit (provident fund): Paid for the death of the fund member.

Funeral grant (provident fund): Paid for the death of the fund member.

Survivor allowance (social assistance): Paid to Nepalese widows aged 60 or older who satisfy a means test (no personal income, not receiving family support, and not receiving a pension on behalf of a deceased husband).

Old-Age Benefits

Old-age benefit (provident fund): A lump sum is paid equal to employer and employee contributions plus 5.25% interest a year.

Additional benefit scheme: A lump sum calculated on the basis of the value of the old-age lump-sum benefit times 0.75% times the number of years of contributions, up to a maximum.

Loan scheme (provident fund): The maximum amount that may be borrowed and the maximum borrowing period vary according to the nature of the loan.

Government employees also receive a monthly pension, up to a maximum of 100% of basic earnings.

Interest rate adjustment: The Board of Directors of the Provident Fund decides the rate of interest on the basis of the fund's annual income.

Old-age allowance (social assistance): 250 rupees a month is paid.

Permanent Disability Benefits

Personal accident insurance (provident fund): A lump sum of 55,000 rupees is paid for a permanent disability.

Partial disability: A lump sum ranging from 10,000 rupees to 25,000 rupees is paid, according to the assessed degree of disability.

Source [181]

Disability pension (social assistance): 250 rupees a month is paid.

Survivor Benefits

Survivor benefit (provident fund): 100% of the lump sum payable to the deceased is paid to a named survivor or to the deceased's heirs. In the case of more than one named survivor, the amount is split equally.

The surviving spouse of a deceased government employee also receives a pension for up to 7 years, up to a maximum of 100% of basic earnings.

Interest rate adjustment: The Board of Directors of the Provident Fund decides the rate of interest on the basis of the fund's annual income.

Funeral grant (provident fund): A lump sum of 5,000 rupees is paid.

Personal accident insurance (provident fund): A lump sum of 55,000 rupees is paid.

Survivor allowance (social assistance): 150 rupees a month is paid.

Administrative Organization

Provident fund: Employees' Provident Fund is an autonomous body operating under the general supervision of the Ministry of Finance.

Managed by a board of directors, the Employees Provident Fund (http://www.epfnepal.com) administers the program.

Social assistance: Ministry of Local Development administers the program.

Benefits are administered at the local level by Village Development Committees.

Sickness and Maternity

Regulatory Framework

No statutory cash benefits are provided.

The 1993 Labor Code requires private-sector employers to pay 50% of wages for sick leave for up to 15 days each year, provided the employee has been continuously employed by the same employer for at least a year.

The 1992 Civil Servant Act provides for maternity leave to employed women for up to 60 days before or after childbirth, for up to two births.

The 1983 Employment Act requires employers to pay 100% of wages for maternity leave of up to 52 days before or after childbirth. Maternity leave may be paid for up to two births. If both children subsequently die, the woman may take maternity leave for the birth of two more children.

Free medical treatment is provided to older persons through government hospitals.

The 1974 Bonus Act requires private-sector enterprises to provide employees and their dependents with basic medical benefits.

Work Injury

Regulatory Framework

First law: 1959.

Current law: 1992 (work injury), with 1993 amendment.

Type of program: Employer-liability system, involving compulsory insurance with a private carrier.

Coverage

Employees of establishments with 10 or more workers.

Exclusions: Self-employed persons and domestic servants.

Special system for miners.

Source of Funds

Insured person: None.

Self-employed person: Not applicable.

Employer: The total cost is met through the direct provision of benefits or the payment of insurance premiums.

Government: None.

Qualifying Conditions

Work injury benefits: There is no minimum qualifying period.

Temporary Disability Benefits

The benefit is equal to 50% of earnings; 100% of earnings if hospitalized. The benefit is paid from the first day of incapacity for up to a year.

The degree of disability is assessed by a recognized doctor, according to the schedule in law.

Permanent Disability Benefits

For a total disability (100%), a lump sum is paid equal to 5 years' earnings.

Partial disability: A percentage of the total disability lump sum is paid according to the assessed degree of disability.

The degree of disability is assessed by an authorized doctor, according to the schedule in law.

Workers' Medical Benefits

The total cost of necessary treatment.

The nature of necessary treatment is assessed by an authorized doctor, according to the schedule in law.

Source [181]

Nepal

Survivor Benefits

A dependent survivor receives a lump sum equal to 3 years of the deceased's earnings.

Administrative Organization

Labor and Employment Promotion Department enforces the law.

Unemployment

Regulatory Framework

No statutory unemployment benefits are provided.

The 1992 Labor Act requires employers to pay lump-sum severance benefits to laid-off employees equal to 1 month's wages for each year of service in all establishments employing 10 or more workers.

The 1993 Labor Rules require employers in establishments with 10 or more workers to pay a cash benefit to workers with at least 3 years' employment when they retire or resign, as follows: 50% of monthly wages for each of the first 7 years of service, 66% of monthly wages for each year between 7 and 15 years, and 100% of monthly wages for each year of service exceeding 15 years.

The employee may choose to receive the cash benefit or the severance lump sum.

Source [181]

Overview on legal benefit schemes for formal sector in Nepal (first draft)

Coverage / Benefits	Public employees	Private employees
Gratuity (one-time payment after retirement in case of less than 20 years of service)	Claimed by applicant to line office. Validated by Ministry of General Administration and paid from regular budget of Ministry of Finance to accounts on government sector banks	Managed individually by companies.
Pension (monthly payments after retirement after 20 years of service)	Claimed by applicant to line office. Validated by Ministry of General Administration (info system on entitlements) and paid from regular budget of Ministry of Finance to accounts on government sector banks	Not given.
Provident fund (loans during service and one-time payment after retirement)	Offices and line ministries pay monthly to an autonomous body called "Employees Reserve Fund"	Managed individually by companies.
Medical expenses (medical allowances and other provisions) (health insurance)	According to individual request office or line ministry claims money from Ministry of finance. No health insurance asked for in the Civil Services Act	Law stipulates medical allowances, health insurance and other provisions. Funds managed individually by companies.
Remarks	Contracted employees (~2%) are not covered. Non-permanent staff (~8%) get Provident fund benefits	
Applicable laws	Civil service act, health service act, teachers service act, army's service act, etc.	Labour law

Source: Discussion with Raghav Raj Regmi, 13.02.09

4.3

Pensions

Table 2: International Comparison of Universal State Old Age Pensions, 2005

Country	Eligibility	Number of Beneficiaries	Beneficiaries (% of eligible population)	Monthly pension (US$)	Pension % of GDP per capita	Annual Transfer (% of GDP)
Antigua	Citizens from age 60	4,170	100	$281	30.9	1.8
Bolivia	Citizens from age 65	366,000	100	$19	22.6	1.3
Botswana	Citizens from age 65	71,000	167	$38	8.8	2.8
Lesotho	Citizens from age 70	75,000	107	$25	40.5	1.4
Mauritius	Citizens and permanent residents from age 60	112,000	109	$84	19.2	2.0
Namibia	Citizens and permanent residents from age 60	82,000	85	$62	24.9	0.7
Nepal	Citizens from age 75	171,322	60	$2	8.9	0.1
New Zealand	Citizens and permanent residents from age 65	453,400	100	$631	38.7	4.1

Sources: Social Security Programmes throughout the World (2005), Willmore (2004a) and Institute of Southern African Studies – National University of Lesotho (2006). Pension as a % of GDP per capita calculated using GDP data from the World Development Indicators Database of the World Bank. (Note: The data for New Zealand is for 2004.)

Source [207]

Nepal universal pension scheme

B N Sharma Joint Secretary, Ministry of Local Government

A universal pension scheme was introduced in 1994/5 and subsequently expanded. All older people age 75+ receive NRS200 (US$2.8)/month, which covers 245,174 people. There is also a supplementary scheme supporting poor widows age 60+ who receive NRS150 (US$2.1)/month, covering 258,237 older women. The Ministry of Women, Children and Social Welfare formulates policy in this area, while the Ministry of Local Government is responsible for implementation and attempts to ensure distribution at the door step of beneficiaries. The old age pension has an age limit that is too high considering life expectancy and retirement age. It also lacks a satisfactory monitoring and evaluation mechanism, and there has been no impact assessment undertaken to date. Nepal's experience shows that political will is fundamental to initiate old age allowance programmes, support of local government is essential for effective implementation, and impact assessment is necessary for improvement, policy advocacy and programme expansion.

Source [211]

Table 8.1: Social pensions in low- and middle-income countries

Country	Age eligibility (years)	Universal (U) or means tested (M)	Amount paid monthly (US$/ local currency)	% of population 60+ years	% of people 60+ receiving a social pension	Cost as % of GDP	Low- (L) or middle-income (M) country
Argentina	70+	M	US$ 88 273 pesos	14%	6%	0.23%	M
Bangladesh	57+	M	US$ 2 165 taka	6%	16%*	0.03%	L
Bolivia**	65+	U	US$ 18 150 bolivianos	7%	69%	1.3%	M
Botswana	65+	U	US$ 27 166 pula	5%	85%	0.4%	M
Brazil (Beneficio de Prestacao Continuada)	67+	M	US$ 140 300 reais	9%	5%	0.2%	M
Brazil (Previdencia Rural)	60+ men 55+ women	M	US$ 140 300 reais	9%	27%***	0.7%	M
Chile	65+	M	US$ 75 40 556 pesos	12%	51%	0.38%	M
Costa Rica	65+	M	US$ 26 13 800 colones	8%	20%	0.18%	M
India	65+	M	US$ 4 250 rupees	8%	13%	0.01%	L
Lesotho	70+	U****	US$ 21 150 loti	8%	53%	1.43%	L
Mauritius	60+	U	US$ 60 1978 rupees	10%	100%	2%	M
Moldova	62+ men 57+ women	M	US$5 63 lei	14%	12%	0.08%	L
Namibia	60+	M	US$ 28 200 dollars	5%	87%	0.8%	M
Nepal	75+	U	US$ 2 150 rupees	6%	12%	unknown	L
South Africa	65+ men 58+ women	M	US$ 109 780 rand	7%	60%	1.4%	M
Tajikistan	63+ men 58+ women	M	US$ 4 12 somoni	5%	unknown	unknown	L
Thailand	60+	M	US$ 8 300 baht	11%	16%	0.00582%	M
Uruguay	70+	M	US$ 100 2499 pesos	17%	10%	0.62%	M
Viet Nam	60+	M	US$ 6 100 000 dong	7%	2%	0.022%	L
Viet Nam	90+	U	US$ 6 100 000 dong	7%	0.5%	0.0005%	L

*Percentage of people aged 57+ years receiving a social pension; **paid annually; ***includes women 55+; ****universal with a few exceptions, primarily people who are already receiving a substantial government pension (about 4% of those who would otherwise be eligible).

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Source [56]

4.4 Groups

3.2. Additional Benefits for Army Personnel

There are some additional schemes for military people and their families. Such schemes are like education of army children, medical coverage for soldiers and their families, housing schemes, legal assistance, micro-insurance, special programs for widows and family members and interest-free loan facilities. Large part of the fund accumulated by partial deduction of the benefits army personnel receive in returns to their service under the UN Peace Keeping Mission. There is blame on non-transparency of the fund and details of the fund was made public in 2006 for the first time. Various schemes have helped army people via financial as well as moral upliftment without burdening much to the government. Under the scheme of health support, parents and children of army personnel, either service holder or retired, will be treated free of charge in selected hospitals. Currently, all the army people are compulsorily insured in retirement benefit insurance, accident insurance, residential insurance though the benefit amounts are not so high.

Source [179]

Social protection for the informal sector in Nepal according to ILO

"1. Nepal's deteriorating economy, its political infrastructure, and the continued impact of neoliberal economic policies, has left very few options for the provision of effective social and health security. The authors of this study are of the opinion that a broader perspective on social protection, one that aims at extending security mechanisms to include the entire working population, and particularly the informal economy, is fast becoming essential.

2. This study is intended to provide a) an analysis of the scope of various social protection schemes which address the needs of vulnerable and excluded groups of people; and b) recommendations for the development of more effective social protection mechanisms with a specific focus on unprotected workers in the informal economy.

3. The study locates an assessment of social protection mechanisms in the specific social, political and economic context of contemporary Nepal (Chapter 1). And it gives a conceptual overview of social security and social protection in relation to current debates in the international policy arena; and attempts an analysis of risk and vulnerability in Nepal's informal economy (Chapter 2).

4. To this end, the authors identify 15 vulnerable, socially and economically excluded, groups that are considered to be in most urgent need of enhanced protection. They include landless agricultural workers; home based workers and women workers in the informal economy, migrant workers and people at high risk from HIV/AIDS, workers in the construction industry, the disabled, and child labourers. The study outlines the demographic and economic characteristics of each group, gives an indication of their basic needs, and the impact of existing social protection provisions.

5. Nepal's existing social protection mechanisms are documented on three levels:

• The social security and social protection provisions within Nepal's legislative framework (Chapter 3);

• The institutional initiatives run by the State, I/NGOs and civil society groups, micro finance institutions and trade unions, with a particular emphasis on micro-insurance schemes for health, life, and livestock (Chapter 4); and

• The community initiatives covering non-formal, indigenous community based social systems that manage mutual aid, share risks and provide assistance to vulnerable families. These include mechanisms for the exchange of labour at peak harvest times, community food stores, contributions to the construction of public facilities, and membership based welfare funds (Chapter 5).

6. In their concluding comments (Chapter 6), the authors suggest specific roles for the ILO, its tripartite social partners, and other national or non-national organisations that can support an enabling environment for the implementation of social protection systems in Nepal? The authors then propose a set of specific initiatives:

• The urgent promotion and design of micro-insurance schemes and community based financing schemes, targeted at vulnerable groups of workers in the informal economy, as an immediate priority.

• The introduction of a registration system for workers,

• The introduction of sector based tripartite social protection funds;

• A comprehensive review of the existing National Welfare Fund; and

• 'Action research' into existing, community based assistance mechanisms.

7. The study does not claim to document all the needs of vulnerable workers in the informal economy and their families. Instead it begins to highlight some of the areas, issues, and existing protective practices that should be considered when designing further social protection mechanisms for the informal economy.

Source [316]

4.5 Assessment

Patchwork

In Nepal much of the social protection effort is a patchwork of aid donor and NGO projects.

Source [219]

Social protection study of Asian Development Bank 2004, Executive Summary

Situation Analysis

Demography

At the time of the 2001 Population Census Nepal had a total population of some 23.2 million residing in 4.2 million households, with 84% of the total population living in rural areas. Relatively high population growth rates (2.24%) and low average life expectancy means that Nepal's

population is a young one with a median age of around 20 years. However, the demographic scenario is changing as improving sanitation, health and nutrition are extending longevity and reducing traditionally high maternal and infant mortality rates.

In social protection terms, demographic trends are of interest in Nepal's case on three levels. The first is that extending longevity indicates a need to consider longer term policies designed to deal with the future income security and health care needs of an ageing population. Nepal has a good measure of flexibility in this respect as existing social protection arrangements for the aged are so limited that the political constraints that are evident in many other countries are not a significant factor. The second is that the absence of adequate support mechanisms for the existing cohort of aged people requires the urgent introduction of more immediate income security measures based on social assistance principles. The third is that despite a range of family planning measures, Nepal's aggregate population remains on a steep growth path rendering even existing population levels unsustainable in terms of the financial capabilities of Government and the capacity of the labour market to adequately support the numbers involved.

While the seeds of this adverse demographic scenario are based in religious and societal norms, the more influential, underlying factors appear to be poverty stemming from the absence of secure wage based employment opportunities and the absence of old age income security provisions that buttress the widely held view that old age security rests primarily on the procreation of male children. Oversized families in poorer households also promote highly adverse practices such as the supply of exploitative child labour and the suppression of women.

Economy

Nepal's economy relies heavily on agriculture (39.6% of GDP in 2003) and the sector is plagued by low productivity, high levels of disguised unemployment, acute rural indebtedness and a high incidence of poverty with only modest prospects for improvement. The manufacturing sector is also poorly performed and contributes less than 10% to GDP. Prospects in the services sector are brighter particularly in the areas of largely untapped hydropower potential and Nepal's natural advantage in terms of time zone compatibility with major European and North American markets. The vulnerability of the Nepali economy is exposed also through its heavy dependence on foreign sourced income, with the international community funding more than 60% of Nepal's development budget and more than 28% of total budget outlays.

Prospects for reversing an adverse trade balance appear limited because of the economy's narrow base and the worsening security situation that is sapping international confidence. Accession to the WTO and South Asia Free Trade Association offer the prospect of improvements but many local commentators believe that potential gains will prove elusive. Vulnerabilities are evident also in terms of low GNI per capita (around US$ 240 in 2002) and a lack of commercially viable natural resources. Internal resources are extremely limited to spur economic growth and alleviate poverty while tax evasion is endemic and the Government appears to have no structured plan for addressing the situation.

Labour Market

The Nepali labour force of some 9.5 million persons is dominated by the agricultural sector where over three quarters of the labour force is situated. In addition, an estimated 2 million (just over 40%) of children are child labourers. Labour force participation rates are high (around 86% in aggregate) reflecting high participation rates among women (81%) and the aged (47%) and low participation rates in education generally and for teenagers in secondary education in particular. In part, high labour force participation rates reflect the absence of social protection systems particularly in respect of old age income security and child support payments for poorer households.

Over half of the workforce has only minimal levels of cash income from employment, derived

mainly from intermittent daily wage rate labour. The oversupply of labour produces high unemployment/underemployment and significant rates of Government supported out-migration of largely unskilled Nepali workers seeking foreign employment. Excess labour, fragile labour market opportunities, poverty, high household debt levels and customary practice rooted in the Hindu hierarchical caste system have given rise to highly exploitative labour market practices for informal sector workers, particularly those in poorer households. The two worst forms of these are the practice of bonded labour and the widespread use of child labour. While efforts are being made to reduce both bonded and child labour conditions, progress has proved difficult and the incidence of both may be rising.

Because Nepal's population is concentrated in rural areas both poverty and informal sector employment are highly correlated with agricultural activities. However, neither poverty nor informal sector employment are rural phenomena with many of the occupations of most concern located in the industry and services sectors that are urban based, as are the worst forms of exploitative child labour and the disturbing increase in the incidence of street children.

The composition of the informal sector workforce in rural areas is changing. With the increasing fragmentation of landholdings, subsistence farming for those with land is becoming increasingly inadequate to meet the basic needs of households. Combining subsistence farming with day wage labour is increasingly the norm. The number of landlessness rural households is growing and that also is adding to the number of households dependent on wage-based income. At the same time, the demography of the agricultural workforce is changing and women and children are taking a greater hand in farm activities with the outflow of men seeking work opportunities in urban areas and abroad and the increasing drain on male labour occasioned by continuing conflict conditions.

Opportunities to gain employment under formal sector conditions is diminishing as employers seek to cut costs through a greater reliance on subcontracting and homebased workers. This development, apart from degrading labour standards and employee benefit guarantees, is also having the effect of dispersing the workforce in ways that make it more difficult to implement organised social protection activities for such groups.

Poverty

Owing to data deficiencies there are no reliable measures of the incidence of poverty in Nepal but it is not contentious to state that poverty is both widespread and intractable and the most significant issue facing policy makers. Moreover, in Nepal's case poverty is exacerbated by other aspects of social exclusion related to caste, ethnicity and gender based discrimination.

Official estimates based on the official poverty line of NR's 4404 per capita showed some 42% of the Nepali population was poor in 1996 and 38% in 2000. Poverty incidence was lower in urban areas – 23% of households compared to 44% in rural areas. Other estimates place the poverty incidence higher. The UNDP Human Development Index ranks Nepal lowest in South Asia. In headcount terms this means that between 9 and 10 million Nepalis are living below the poverty line, and that number is almost certainly growing as a result of the worsening security situation

Women

In general terms, women in Nepal are suppressed, exploited, neglected and forced to live insecure lives due to illiteracy, ill health, poverty, orthodox traditions and a discriminatory legal system. While the Constitution of Nepal guarantees equality to women in all walks of life, in practice women do not enjoy equal benefits to men in respect of their civil, political, social and economic advancement. In terms of empowerment, women lag far behind their male counterparts. Women are significantly underrepresented in public employment at all three levels of Government, in the judiciary and in Parliament.

While more than 85% of women are engaged in agriculture less than 11% of women own land. Similarly women have lower access to paid work, and of those who do earnings are generally lower than for men. Lack of economic status in turn severely constrains access by women to credit facilities further increasing already high social and economic vulnerability.

Vulnerabilities and Risks

Vulnerabilities and risks in Nepal are broadly based affecting large numbers of the population. Most rural households rely on a combination of subsistence farming and daily wage labour for their livelihood. For the one million rural people who are landless the situation is even more tenuous as they depend entirely on low paid daily wage labour that is generally available in the peak agricultural seasons only. As a consequence, the economic security of rural households generally is in an extremely fragile state and highly susceptible to both covariant and idiosyncratic shocks. Structural fragility has been significantly heightened by civil unrest that increasingly is manifesting in armed conflict between the security forces and Maoist insurgents who have extended their influence across all areas of rural Nepal to a point where few rural households are immune from the consequences on a daily basis.

The SPS analysis reveals that the three key determinants of vulnerability are socio/economic factors, discrimination and armed conflict, while the three principal risks impacting across vulnerable households are poverty, unemployment and health loss. Socio/economic factors and discrimination also constitute the root causes of the enduring armed conflict in Nepal. Removing vulnerabilities arising from the conflict therefore relies on adequately addressing these two factors. Given that the country appears to be sliding further towards anarchy, making substantive progress in these these terms, quick gains in the areas of poverty alleviation and reducing unemployment would be possible if there is political will to proceed and expenditure priorities are shifted in these directions.

Conflict

Conflict conditions in Nepal date from 1996 when the Communist Party of Nepal (Maoist) opted for extra-constitutional means to transform Nepal into a “proletariat state”. Two declared ceasefires since that time have failed to resolve matters. Since the breakdown of the latest ceasefire in 2003, violence and counter-violence have continued to be daily occurrences with arbitrary arrests, human rights abuses and intimidation of citizens by both sides increasingly the norm.

On the Government side, there are some 65,000 military and police in the unified command, compared to some 20,000 to 25,000 Maoists regulars and militias. The Maoists are able to make up the deficit through tactical refinement, using hit and run guerrilla tactics and spontaneous strikes. Thus far over 8,000 people have been killed in the conflict, 70% of whom were civilians. Military spending continues to escalate having doubled in the past three years to its present level of 15% of total national budget outlays.

The causes of the conflict can be viewed in terms of primary, secondary and collateral factors. Primary factors are the underlying conditions or root causes of conflict. These include the interrelated factors of economic, social and political exclusion. Social inequalities that translate to economic inequality on the basis of gender and between Hindu castes, regions, ethnic groups have been a major source of grievances. Maoists recruit largely from oppressed minorities seeking an alternative to their marginalised and deprived conditions. Maoists also recruit a significant number of disaffected women into their ranks, including in senior command positions.

Secondary factors largely revolve around conflict over how primary factors should be addressed and the associated struggle for political dominance. That struggle has reached a now long standing stalemate and turned the debate away from primary factors to a focus on power sharing.

For many, the resultant disunity within and between political parties has cast a shadow across the value of constitutional monarchy and brought the Maoist alternative more sharply into focus. Collateral factors are direct products of armed conflict and in Nepal's case include a large number of internally displaced persons, casualties, destruction of infrastructures, incapacity of the State to deliver services nation-wide and increased unemployment and poverty.

Secondary and collateral factors feed into the primary factors to create a cycle of escalating tension. The challenge for Nepal is to find ways of breaking the cycle and social protection initiatives can play an important role in this process.

Existing Social Protection Arrangements

Nepal has a broadly based but shallow set of social protection programmes. That is, a reasonably comprehensive framework but one that does not assist significant numbers of people.

In the ***labour markets*** area Nepal has passed extensive and enlightened legislation for the protection and advancement of formal sector workers but these provisions have only weak support from private sector employers. For over 80% of the labour force that is situated in the informal sector employment is unregulated and there is a need to address this situation with a fresh approach.

Nepal pursues a range of active labour market programmes as part of its poverty alleviation and human resource development strategies. These include income generating activities, including the formation of micro-enterprise, job creation programmes as part of public works infrastructure projects, social funds, vocational education and training initiatives and assisted economic migration. There is no question that active labour market programmes are a key strategy for poverty alleviation in Nepal and that existing levels of investment could be substantially increased with good effect. Similarly, given that unemployment/underemployment in rural areas is heavily implicated in prevailing poverty levels, greater priority could be given to direct job creation as part of national infrastructure development activities. Languishing poverty levels in rural areas are also clearly a primary factor feeding the escalating level of civil disorder.

The Nepali labour market is characterised by foreign labour transfers with up to 10% of the workforce in foreign employment currently. The Government actively encourages economic migration by providing low cost loans to facilitate entry to the market to boost the already considerable level of remittances that is a major source of foreign exchange. While almost all of these are unskilled workers, highly qualified individuals are also said to be deserting the country ("brain drain"). Concurrently, a large number of Indian workers are transiting into Nepal as part of the open border arrangements to take up mainly skilled and semi-skilled jobs. Trade Unions and employer representative groups In Nepal believe that the main explanation for these labour transfers is the inability of local education and training institutions to provide relevant qualifications that are actually in demand in the domestic economy.

HMG Nepal supports a range of affirmative action programmes for those who for economic, social and cultural reasons suffer discrimination and exclusion in employment and decision making processes. The main groups targeted in this way are women, lower Hindu castes and ethnic minorities. However, affirmative action needs to be better supported by substantive programmes of economic empowerment to yield significant benefits for the most vulnerable.

Social insurance arrangements in Nepal are confined to age, disability and survivor pensions, maternity and work injury schemes that benefit only formal sector workers, most of whom are Government employees. The remainder, virtually all Nepalis, is highly vulnerable to lifecycle risks associated with old age, disability, death, sickness and injury, maternity and unemployment. Similarly, the absence of family allowance type arrangements seriously threatens the welfare of children. The prospects of this situation changing in other than the long term seem remote owing to the limited financial capacity of most Nepalis to support contributory social security

arrangements and limited financing capabilities on the part of the Government. However, Trade Union federations with the support of the ILO are promoting the possibility of a *National Social Security Fund,* and the ILO is working with the Government on a *National Master Plan* for the provision of broadly based health insurance. Because lack of access to adequate health services is a pervasive risk for vulnerable households in Nepal, finding the means for supporting potential health insurance initiatives should be given a high priority.

Social assistance instruments have not attracted significant support in Nepal and at the moment, the only budget financed poverty alleviation income transfer that exists is the non-means tested *Senior Citizen's Allowance* paid to the advanced aged, indigent aged widows and small numbers of severely disabled people. The only social assistance programme of significance – the *Food-for-Work Programme* is designed to be self-targeting to the poor by holding down the value of in-kind food transfers to make them unattractive for other than the poor. The combined annual budgetary commitment to these two programmes is a mere NRs 1.2 billion or some NRs 50 per capita. A detailed outline of how a more extensive social assistance approach might be successfully employed in Nepal is outlined at Part 6 of the report concerned with the possible establishment of *District Welfare Funds*.

Nepalis have long supported arrangements that promote ***community solidarity and mutual support mechanisms*** in tandem with strong joint and extended family support. Curiously, traditional forms of solidarity have not attracted active and practical support from government and others and, as a consequence, are rapidly disappearing. The disposition towards mutual support, however, has been exploited in other ways. For example, widespread reliance on community *user groups* in forestry management and other areas. Support for *Welfare Funds* and *microfinance* arrangements of various kinds is also consistent with this observation. However, the success of these measures has been mixed. Microfinance initiatives in Nepal have been pursued since 1956 but coverage of remains relatively limited, with perhaps no more than a quarter to one third of rural communities having at least some access to cooperative, communitybased savings and credit instruments. Coverage of urban populations where microfinance options are more readily available is higher.

Microinsurance arrangements in the form of livestock, group life and health insurance have been part of the microfinance landscape in Nepal for some twenty years but have struggled to capture a significant market even where premium costs have been heavily subsidised by government. Recent efforts by government, international organisations, NGO's, and the trade union movement in Nepal are attempting to revitalise interest in microinsurance.

At the heart of ***child protection*** issues in Nepal is a traditional cultural disposition that tends to subordinate the needs of children and the fact that most live in poor households, which in tandem seriously obstruct conformity with international norms of child development. Moreover, poor households are driven by economic necessity to view children as an economic resource. Consequently, perhaps as many as 40% of children in Nepal are child labourers, a significant but unknown number are victim to human trafficking while the incidence of street children in Kathmandu has reached epidemic proportions. Elaborate policy frameworks have been developed to address the issues of child labour and trafficking but little progress has been achieved by reason of low investment in remedial strategies. The work of the SPS suggests strongly that at the promotion of children's welfare depends in significant part on supporting poor households in practical ways that provide financial capacity to meet the basic educational, health and nutrition needs of children. Only then will child specific initiatives in areas such as child labour be positioned to succeed. To achieve this, social protection initiatives that boost household income in ways that create both direct and indirect synergies for child welfare are required.

Financing Social Protection Nepal's national Budget is heavily subsidised by the international

community that currently finances 60% of the development budget and some 28% of total budget outlays. In the area of social protection, and including outlays on health, the SPS estimates that just under 14% of total budget outlays (0.3% of GDP) are directed at social protection interests currently (8.4% if commitments in respect of employment benefits for civil servants and allied public sector employment are excluded). If voluntary sector and independent donor activities concerned with social protection and private sector contributions to pension schemes are included, perhaps 1% of GDP currently is directed to social protection. Given the breath of the ADB classification of social protection, and the scale of social protection needs in Nepal, this level of investment is very modest indeed.

Those who take the position that HMGN has no budgetary capacity for additional social protection measures need to be challenged for three reasons. The first is that there is considerable potential to boost low tax revenue yields through improving tax compliance, but this seems not to be an active priority for the Government. The second is that as recent history demonstrates significant shifts in expenditure priorities are possible where there is a political will. The most recent example is the doubling of military expenditure to its present level of 15% of aggregate budget outlays. The third is that the conventional view that social and economic spending priorities are in competition with one another, when the more correct view is that if the right choices are made synergies between social and economic objectives are possible.

Future Measures

Because of the overwhelming size of, and higher poverty incidence in, the informal sector in Nepal future social protection policy interest is drawn intuitively to the informal sector. However, there is not consensus among local stakeholders on how informal sector social protection needs should be approached. Formal sector interests tend to think of informal sector priorities in terms of how formal sector approaches can be extended to the informal sector (for example, the extension of existing social security and *Labour Act* guarantees to informal sector workers) and argue that some formal sector issues (for example, vulnerabilities in respect of foreign workers) deserve attention in the policy dialogue. The SPS analysis focuses at a more generic level in terms of vulnerabilities and risks facing the informal sector and seeks to explore what synergies are possible in improved social protection outcomes and broader economic and social objectives. These different positions are not in conflict but do present different possibilities in terms of policy choices.

A central thesis of the SPS is that social protection and economic development should be seen as mutually supporting poverty alleviation strategies. For the economically active it is also possible to integrate the two to produce synergies in crosscutting areas of concern. Importantly in Nepal's case, both policies have the potential to reduce conflict and promote social stability as both ameliorate the root causes of conflict that stem from economic inequality, poverty and social exclusion. The utility of social protection instruments compared to economic development in these terms is that social protection impacts are more immediate while much of the economic development agenda is concerned with conditions in the medium to long term.

At a more generic level, achieving progress with social protection in Nepal will be determined by financing, service delivery and programme monitoring and evaluation capabilities. As noted above, financing capability issues need to be linked to wider budgetary management issues. Unless and until that view is adopted, finding financial capacity for sustainable social protection will remain elusive. In service delivery, Nepal is pursuing a policy of decentralisation based on local government machinery. While for the moment local government is increasingly dysfunctional at the grassroots (Village) level because of conflict conditions in rural areas there is no question that it can ultimately provide an effective service delivery platform for social protection and other Government programmes. Social protection planning therefore needs to support capacity building in local government. Existing programme monitoring and evaluation, and policy research and

review capabilities generally, are of a poor standard and greater investment in both central Ministry and local government in these terms is required.

The unorganised nature of most informal sector activities provides few reliable entry points for mobilising social protection target populations or understanding an optimal design for achieving the most appropriate targeting methods. In Nepal's case, there are a number of possibilities. The first and most obvious entry point is geography. In Nepal, some of the poorest people are concentrated in reasonably well defined geographical areas such as the far western areas of the country. Similarly, there are potential entry points based on industry or occupational status in urban areas where trade unions and INGO/NGO actors are potentially important partners. In addition, targeting by social grouping (e.g. lower Hindu castes) and by characteristics, for example old age, are also reasonably efficient indicators of need in Nepal.

The prospect of Nepal becoming a modern economy based on a strong services and manufacturing sector in the medium term seems remote. Agricultural activities therefore will remain central to the livelihoods of most informal sector workers. As subsistence farming is insufficient to meet the needs of most rural households, improving small farm productivity and opportunities for cash crops, and boosting supplementary wage based employment through public works programmes should be seen as important strategies. Facilitating greater access to microcredit as supplementary support for these initiatives would be desirable also. Apart from addressing the social protection needs of rural people, investment in these areas should be seen as important strategies for addressing crosscutting issues concerned with meeting local infrastructure needs, creating local market opportunities in rural areas, low participation by children in education, the prevalence of child labour and reducing the strains on urban infrastructure occasioned by out-migration from rural areas.

Similarly, finding greater employment opportunities for over 12% of youth who are unemployed should be seen as important, not only in terms of labour market objectives but in respect of the deepening conflict in Nepal. Youth are one recruiting ground for the Maoist movement, and student unions in Nepal are in the forefront of violent political protests. As part of conflict resolution, the government could consider a number of special employment generation initiatives for youth, particularly tertiary level graduates.

For those who are outside the labour force and who are destitute, direct transfers from government either in cash or in kind are required. Similarly, special measures are required to protect children and women from exploitative child labour conditions and human trafficking.

Urban economies like rural economies are dominated by informal sector employment and the trend is that this dominance is increasing except in the case of civil service employment and related employment in the military, the constabulary and the teaching profession. However, the composition and orientation of the urban informal sector workforce is fundamentally different to its rural counterpart in that economic activities centre on the industry and service sectors and in terms of geography are compressed in Kathmandu, the composition of employment is more diverse, labour rewards are almost invariably in the form of cash income, there are fewer constraints on access to markets and financial services, and opportunities for labour to organise are greater and more transparent. A policy reform agenda for urban areas requires an extensive suite of approaches to address the diversity of conditions that exist. Sectoral reform is one possible approach that could be followed and has some attractions as it would maintain focus in both designing and implementing reforms. Initiatives in some sectors are within the province of government to resolve, for example the regulation of street vendors and porters. Other sectors, and home based workers and domestic helpers in particular, however, are far more intractable as there is no transparency in the employer/employee relationship. Fully understanding the local dynamics of these activities before intervening would be important to ensure that any measures taken would be effective.

Of course, the distinction between the rural and urban workforces is often an artificial one. For individual workers, mobility between the two sectors is a matter of both choice and necessity. Large numbers of agricultural workers for example routinely take up day labour employment in the construction industry in the agricultural off-season. Others are driven to the cities by reason of unemployment and increasingly by reason of displacement due to the ongoing conflict between the security forces and the Maoists. Many younger males are also abandoning rural areas to escape the possibility of forced recruitment to the conflict. One facet of broad based improvement in social protection arrangements, especially those designed to address unemployment, is the possibility of incorporating more orderly labour flows between rural and urban areas as a supplementary objective.

Women in the informal economy tend to be in unskilled manual and repetitive jobs, lack education and training opportunities and have low labour and social mobility. Although equal pay provisions have been legislated women typically receive less. Health care, especially maternity care is not available to most. Contrary to experience elsewhere, women in Nepal have a low take up of subsidised microenterprise initiatives. Quick gains for women lie in affirmative action that involves economic empowerment. Accordingly, setting priorities in broader based social protection arrangements should reflect a conscious policy of positive discrimination in favour of women. To be effective, positive discrimination approaches need to be accompanied by well researched strategies to build the self-confidence of women, particularly rural women, to participate in the opportunities on offer. This would be especially important in relation to participation in income generating activities and micro-enterprise. Similarly, participatory policy design and decision making processes capable of accurately reflecting women's needs and preferences in these terms need to be strengthened and extended.

An important issue that appears not to have received detailed attention in the policy debate in Nepal is the degree of reliance to be placed on cash transfers in social protection arrangements. The *Senior Citizens Allowance* is the only major example of the cash transfer approach presently and the programme appears to have been introduced for mainly political rather than welfare utility reasons. The major advantages of a greater reliance on cash transfers in social protection arrangements is that they provide choice in resource utilisation for households to meet actual rather than the assumed needs, improved capacity for household savings and contingency planning and that by boosting the local cash economy in rural and remote areas economic opportunities for local producers and entrepreneurs could be significantly improved. In addition, providing adequate social assistance cash transfers to poor women would be most effective in terms of women's empowerment.

Up to one million Nepalese are in foreign employment. By reason of its significance to foreign exchange earnings, its employment generating potential and the flow of remittance income to poor households, the Government is an active facilitator of foreign employment opportunities. There is little question that in Nepal's case government support for these arrangements can be considered as an important social protection programme. The issue in terms of this Report is how to locate it in terms of priority against other social protection approaches. The positive elements of the programme are its direct employment effects and the inflow of cash resources into poor households. However, the arrangements also act to denude rural communities of its more able bodied workforce with consequent pressures on women, the aged and children to take a greater hand in farming activities in particular.

An important issue for Nepal is how to approach social protection reform in a situation of continuing conflict conditions. At one level there is a danger that implementing a reform agenda under these conditions has the potential to frustrate objectives and undermine outcomes. On the other hand, as the analysis of the conflict in Nepal contained in this Report shows clearly, social protection has the potential to contribute in a significant way to reducing tensions in terms of the

primary causes of the conflict and addressing collateral conflict factors. An important question to consider therefore is how social protection measures might be formally integrated into peace processes and, in the medium to longer term, how a more coherent broadly based social protection framework can assist in establishing a platform for lasting peace by removing some of the root causes of conflict concerned with poverty and economic and social exclusion.

Recommendations

Nepal's current state of economic development and medium term prospects means that achieving an effective and comprehensive social protection framework will not be possible in other than in the long term. What is most concerning in this scenario is that the past pattern of economic development has not been pro poor and is unlikely to become so if current strategies are maintained.

For those elements of current budgetary investments that are focused on immediate benefits for the poor, the approach to date has been to proceed on a wide front with the result that the existing social protection framework is broadly based but lacking depth both in terms of coverage of the population and in terms of the adequacy of assistance provided. In other words, within the social protection reform agenda little attention appears to have been paid to the sequencing of reforms across the various sectors. In turn, this has created entrenched and competitive positions in the various sectors making consensus on sequencing issues more difficult.

A central criterion for assessing future social protection priorities should be that initiatives have multiple utilities not only in terms of cross cutting benefits across social protection sectors, but also in terms of supporting economic development. Policy makers in Nepal must refocus if synergies of this kind are to be achieved. In terms of the ADB's five social protection sectors, there are many outstanding social protection issues to be addressed and setting relative priorities both within and between the five sectors is at best problematic. In respect of labour markets, local stakeholders are divided on the issue of the relative weight to give to formal and informal sector labour market issues. All agree that informal sector issues need to be given greater emphasis but the means for achieving this are not agreed. In broad terms, stakeholder interests see the central issue as being how to extend formal sector worker guarantees and associated social security benefits to informal sector workers. On the basis of the SPS analysis, the central priority issues are seen as rural and youth unemployment and providing adequate assistance for the destitute. These positions are not necessarily inconsistent as the former seeks to establish a longer term participatory social security framework and the latter is focused on immediate poverty impact initiatives.

In respect of social insurance, the most pressing issue is how to provision improved health services. There is active interest within the Government currently in considering possible health insurance measures. This interest needs to be encouraged and the ADB should consider how it might support initiatives in this area in cooperation with the ILO that is providing technical and other support to the Government in its efforts to implement reforms.

Because of budget requirements, social assistance arrangements have not found much favour in Nepal. A major priority in terms of SPS findings is to look for sustainable possibilities for introducing more adequate social assistance cash transfers for the destitute aged, disabled people and widows. A detailed proposal in this respect is presented later in the Report (*District Welfare Funds*).

Micro and area based schemes in the case of Nepal are a useful approach for addressing the immediate needs of poor and marginalised households because Nepal's cultural traditions are empathetic with community solidarity approaches. Microfinance based initiatives in particular have the potential for improving the financial situation of households if existing approaches can be adapted to resolve a range of obstacles that are present. These include lifting credit limits to

enable more meaningful economic activities and providing adequate training and marketing support for income generation and microenterprise activities. An opportunity for the ADB to consider providing support in this area is outlined in the Report as part of the recommendation for establishing a *National Employment Programme.*

Immediate Social Protection Possibilities

To date, Government and international investment has centered on building the necessary infrastructure to position the country to achieve modern economy status at some time in the future. Hence, the emphasis has been to focus more on national capacity building in physical infrastructure, education, productive capacity, building a modern and efficient financial sector, providing basic public services to assure clean water and sanitation and institutional strengthening and good governance. Social concerns connected with high levels of poverty and social exclusion have been given prominence in the policy planning process but they have not been supported with sufficient resources to make significant inroads on the problems that exist.

One consequence of this is that the sense of grievance with prevailing social and economic inequalities has manifested itself in growing social unrest and instability culminating in open and violent conflict between the government and the self-styled people's war lead by the Maoist insurgents. Unless lasting peace is restored, progress with economic and social objectives will become increasingly difficult and at some point untenable. Taking active steps now to avert this outcome by creating conditions that are empathetic with social stability should be moved to the centre of the planning agenda. Improved social protection instruments can be part of that formula if the right choices are made.

The economic benefits of certain social protection arrangements are readily transparent. For example, investment in microfinance and microenterprise has direct employment effects by creating income generating opportunities with beneficial flow on effects for economic growth. For Nepal, however, such initiatives are constrained by limited marketing opportunities in rural areas. In sequencing terms therefore creating improved markets for small rural producers and entrepreneurs should precede attempts to extend the availability of credit, particularly for non-agricultural households. A major constraint in the rural economy is weak domestic demand stemming from high poverty and unemployment levels that severely constrain domestic consumption. Social protection initiatives involving cash transfers can provide a partial solution to this problem by boosting local consumption levels and demand for locally produced goods and services. Growth in rural micro-markets in turn can be expected to generate local employment and improve local economic opportunities more generally. Cash transfers that support the rural poor therefore can promote economic growth and should not be seen as deadweight expenditure.

Connectivity between social protection objectives and improved economic performance can be achieved in other ways also if the right choices are made. Nepal is well placed to address the issue of reducing unemployment through labour intensive local infrastructure projects. Connecting infrastructure needs and unemployment relief is not a contentious strategy and has been used successfully in both developed and developing countries. Local infrastructure needs in Nepal are both manifest and urgent.

Apart from the positive impact in terms of rural poverty, increasing wage opportunities and supporting the destitute would bring the twin benefits of improved micro-markets and improved infrastructure that would operate in mutually supportive ways. The approach would also serve other crosscutting objectives. For example, improved financial capability in poor households could be expected to reduce the incidence of child labour, human trafficking and bonded labour practices, while improving school attendance by children (as a design feature if desired by setting conditionalities in these respects). In the process, the root causes of conflict in the country would be ameliorated.

Choice of Social Protection Instruments

The summary profile of vulnerabilities and risks in Nepal highlights thirteen vulnerable groups of most concern to stakeholders. The profile reveals three overarching areas of concern – unemployment, socio/economic discrimination/exploitation and financial deprivation. The unifying characteristic of all three is poverty.

The utility of social protection approaches compared with the wider development agenda in these terms is that social protection instruments can deliver both poverty reduction outcomes and economic benefits immediately if the right strategies are chosen. In consultation with Ministry representatives on the Social Protection Study Steering Committee two broad schemes of approach that conform to these requirements have been identified.

National Employment Programme

The first of the two recommended approaches would be to establish a *National Employment Programme* (NEP). The NEP would have three elements: □□Wage based employment guarantees on a household basis in labour intensive local level infrastructure projects;

□□Follow-up support that capitalises on improved local market conditions created by increased liquidity stemming from employment guarantee arrangements through the provision of microcredit for target groups to promote longer term income generating activities; and

□□Special employment programmes for young unemployed who have completed tertiary level education.

The programme would target four of the identified SPS priority vulnerable groups - landless day labourers, smaller subsistence farmers and poor *Dalit* and indigenous households - in aggregate, an estimated 2 million households nationally. One third of employment guarantees would be reserved for women. The programme would operate for a period of up to five years as a form of temporary social safety net to assist poor, conflict affected rural households in ways that promote economic development while providing much needed and market opportunities for rural producers and entrepreneurs.

District Welfare Funds

The second of the two recommended approaches would be to establish *District Welfare Funds* in all 75 Districts. The purpose of the *District Welfare Funds* would be to provide adequate financial support to destitute aged, widows and people with disabilities on an ongoing basis. Some 650,000 persons who would be eligible for payments on this basis.

Apart from meeting the income security needs of these people, the arrangements would achieve two outcomes in conflict resolution terms. Firstly, they would address the perception that existing policies are indifferent to human suffering – a key marker of Maoist ideology - and secondly, provide an opportunity to address the needs of the casualties of conflict. In addition, as would be the case with the recommended National Employment Programme, a significant increase in cash transfers to the poor in rural areas would have beneficial spin-offs in terms of support for rural micro-markets.

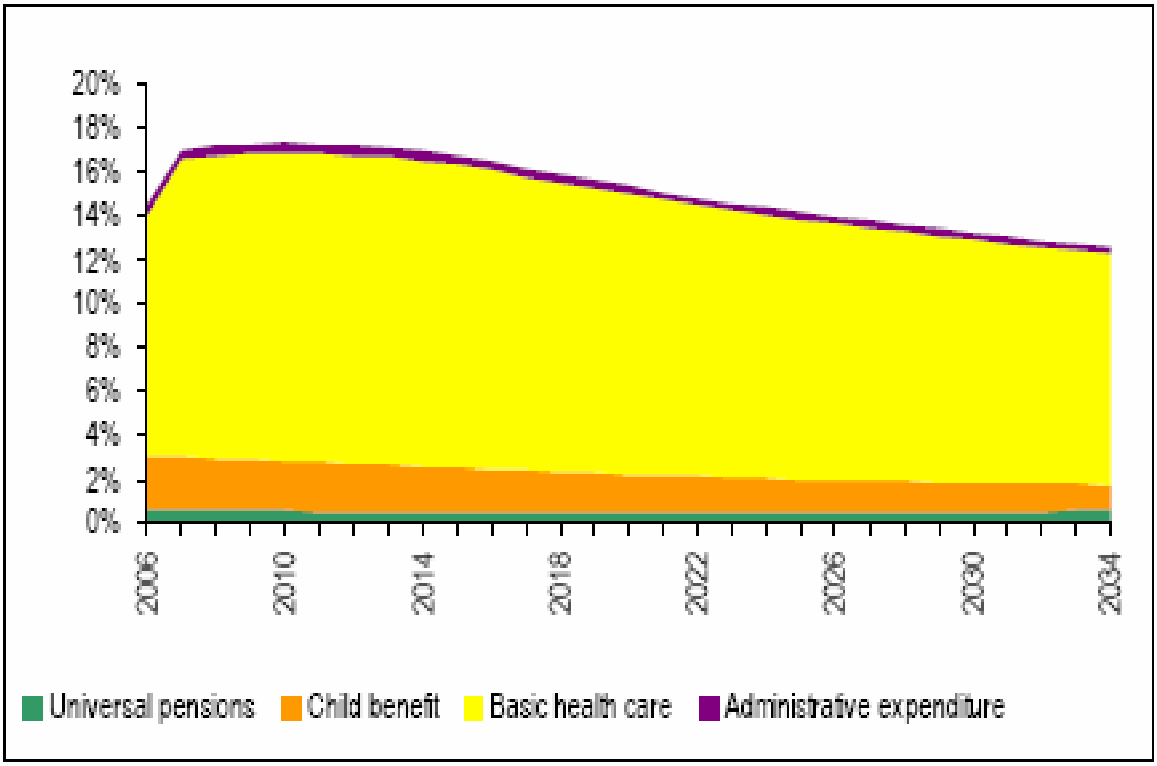
Source [282]

4.6 Scenarios

Nepal

The results of the base case scenario for Nepal show that a universal old-age and disability pension would require 0.5 per cent to 0.6 per cent of GDP over the entire projection period (Figure 5). The cost of a child benefit estimated at 2.5 per cent of GDP in 2006 is projected to decrease to 1.2 per cent by 2034. The cost of health care is estimated to amount to 11.0 per cent of GDP in 2006, rise to a peak of 14.0 per cent in 2012, and decrease slowly thereafter to a level of 10.5 per cent of GDP by 2034. Administration costs are estimated to start at 0.5 per cent of GDP, and decrease to 0.3 per cent by 2034. Total expenditure for basic social protection is estimated at 14.5 per cent of GDP in 2006, it is projected to reach its peak of 17.3 per cent in 2010, and thereafter decrease to 12.5 per cent by 2034.

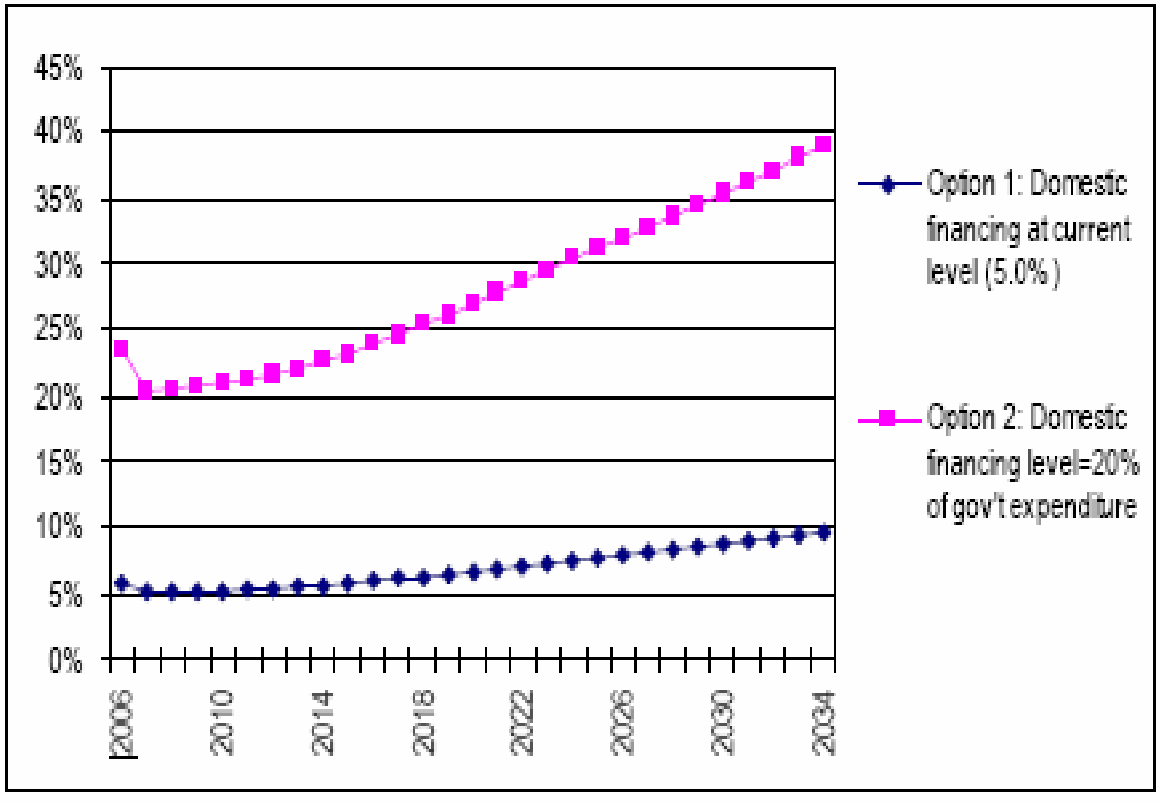
Figure 5. **Cost of basic social protection benefits package for Nepal, 2006-2034** (in per cent of GDP)



Source [29]

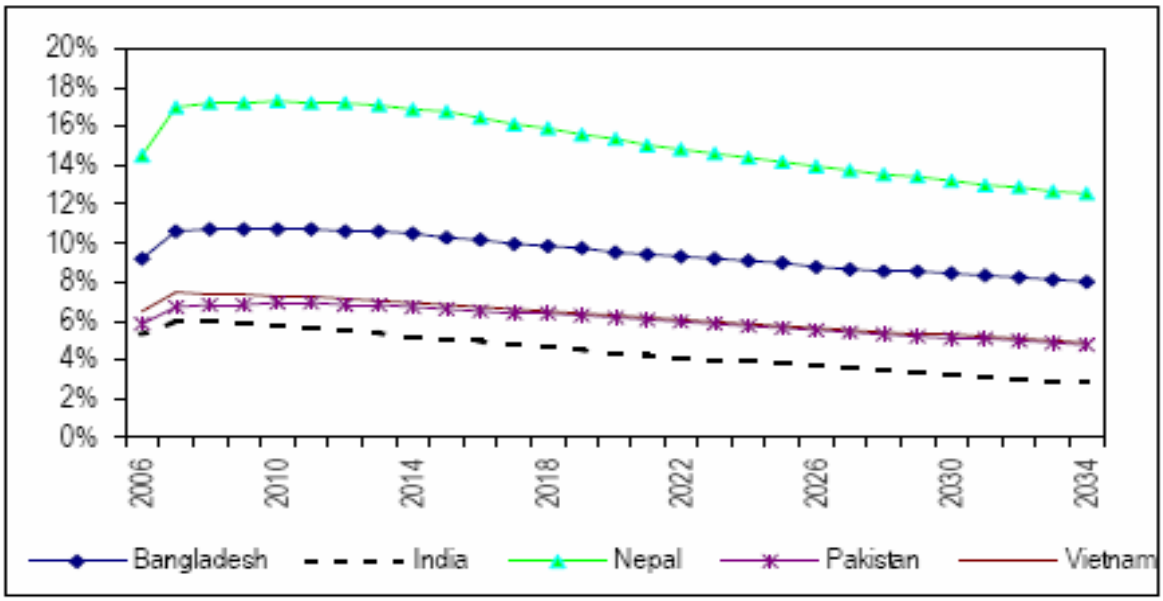
Figure 6 represents the capacity of the Government of Nepal to finance basic social protection out of domestic resources from 2006 to 2034. Under Option 1, it was assumed that government expenditure on basic social protection would remain at its current level (5.0 per cent of total government expenditure), and under Option 2, it was assumed that the government of Nepal would allocate 20 per cent of total expenditure to basic social protection. Under Option 1, it was estimated that the Government would be able to finance 6 per cent of total basic social protection expenditure in 2006. This ratio would subsequently increase to about 10 per cent by 2034. Under Option 2, the Government would be able to finance 20 per cent in 2007, and this ratio would increase to 39 per cent by 2034. Under Scenario I, these results suggest that provision of basic social protection in Nepal would require both increasing government's financial allocation to the social protection sector, and external financial support.

Figure 6. **Domestic financing of basic social protection benefits package under two options for Nepal, 2006-2034** (in per cent of total costs)



Source [29]

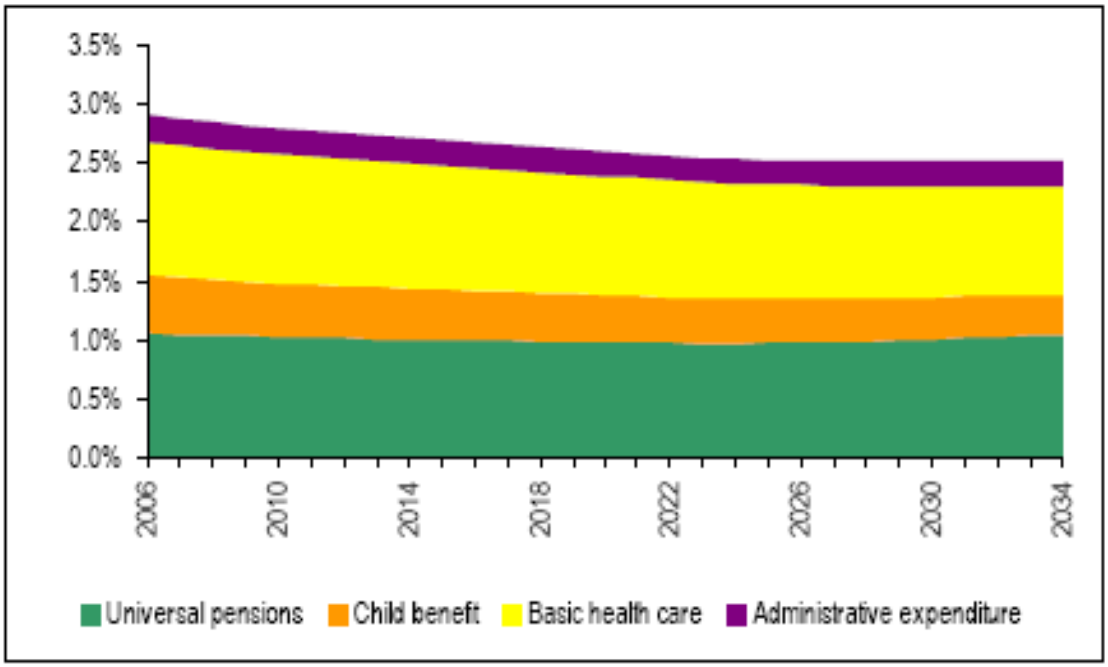
Figure 11. **Cost of social protection benefits package of Scenario I** (in per cent of GDP)



Source [29]

Figure 18 represents the cost of basic social protection under Scenario II in Nepal is estimated at 2.9 per cent of GDP in 2006, including 1.1 per cent for the universal old-age and disability pension, another 1.1 per cent for essential health care, 0.5 per cent for the orphan benefit, and 0.2 per cent for administration costs. The overall costs are projected to slowly decline to 2.5 per cent of GDP by 2034.

Figure 18. **Cost of basic social protection benefits package of Scenario II for Nepal, 2006-2034** (in per cent of GDP)

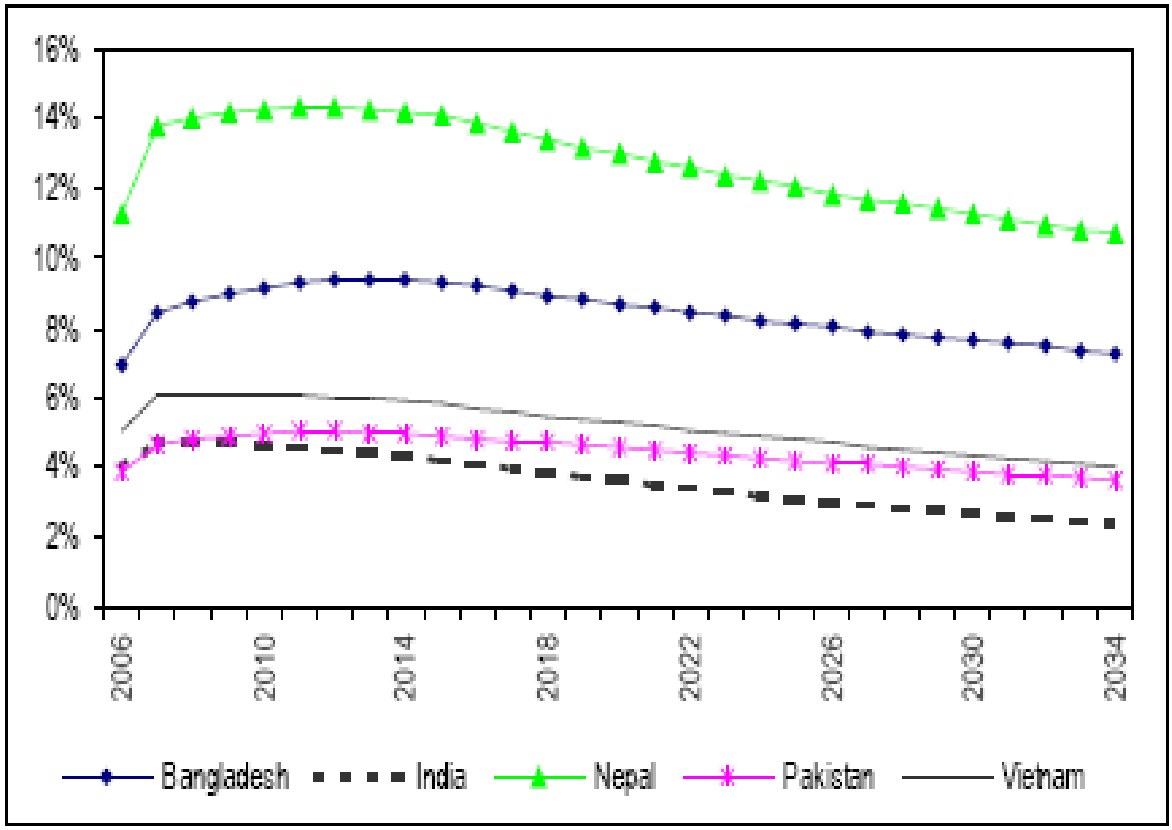


Source [29]

Cost of basic social protection

Figure 21 summarizes the cost of the basic social protection benefit package of Scenario III in terms of the percentage of GDP for the five Asian countries considered until 2034. The country with the highest cost would be Nepal where the basic social protection benefit package would require 14.3 per cent at its peak in 2011, but slowly decrease to 10.7 per cent of GDP by 2034. In Bangladesh, the total cost would increase to 9.3 per cent of GDP at its peak in 2013, and decline to 7.3 per cent by the end of the projection period. The remaining three countries find themselves within a narrow band of similar developments. The basic social protection package for India is projected to increase up to a maximum of 4.9 per cent of GDP by 2007 before declining to 2.4 per cent by 2034. For Pakistan, the package would rise to a peak of 5.0 per cent of GDP by 2011, and subsequently gradually decrease to 3.6 per cent of GDP by 2034. In Vietnam, the total costs are projected to attain a maximum of 6.1 per cent of GDP in 2009, but would decrease to 4.0 per cent of GDP by 2034.

Figure 21. **Cost of social protection benefits package of Scenario III for five Asian countries, 2006-2034** (in per cent of GDP)



Source [29]

6. Conclusions

Table 7 summarizes the costs of various social protection benefits as calculated in Scenarios I, II, and III, and shows the range of different policy options considered.

Table 7. **Summary of costs of basic social protection benefits, including administration costs for cash benefits** (in per cent of GDP)

Benefit		Old-age & disability pension		Child benefit		Health care		Targeted cash transfer
Benefit level		US$0.5 (PPP)/day	30% of GDP/capita	US$0.25 (PPP)	15% of GDP per capita	Per capita health cost of US$38 by 2015	300 health workers per 100,000 pop	US$13.71 (PPP) per month
Eligibility		Elderly, 65 or older		All children aged 0-14	Orphans aged 0-14	Universal	Universal	10% poorest
Scenario		I	II	I	II	I and III	II	III
Bangladesh	2010	0.4	0.7	1.5	0.4	8.6	0.4	0.2
	2020	0.4	0.8	1.1	0.4	7.8	0.4	0.2
	2030	0.5	0.9	0.9	0.3	6.9	0.4	0.2
India	2010	0.3	0.6	0.7	0.4	4.6	0.9	0.1
	2020	0.3	0.6	0.5	0.4	3.5	0.7	0.1
	2030	0.3	0.5	0.3	0.3	2.6	0.6	0.1
Nepal	2010	0.5	1.0	2.3	0.5	14.0	1.1	0.3
	2020	0.5	1.0	1.7	0.5	12.7	1.0	0.2
	2030	0.5	1.0	1.3	0.4	11.0	0.9	0.2
Pakistan	2010	0.3	0.6	1.4	0.3	4.8	0.6	0.1
	2020	0.3	0.6	1.1	0.3	4.4	0.6	0.1
	2030	0.3	0.6	0.9	0.2	3.8	0.6	0.1
Vietnam	2010	0.4	0.7	0.8	0.2	5.9	0.8	0.2
	2020	0.4	0.7	0.6	0.2	5.1	0.8	0.2
	2030	0.5	0.9	0.4	0.2	4.2	0.8	0.1

Source [29]

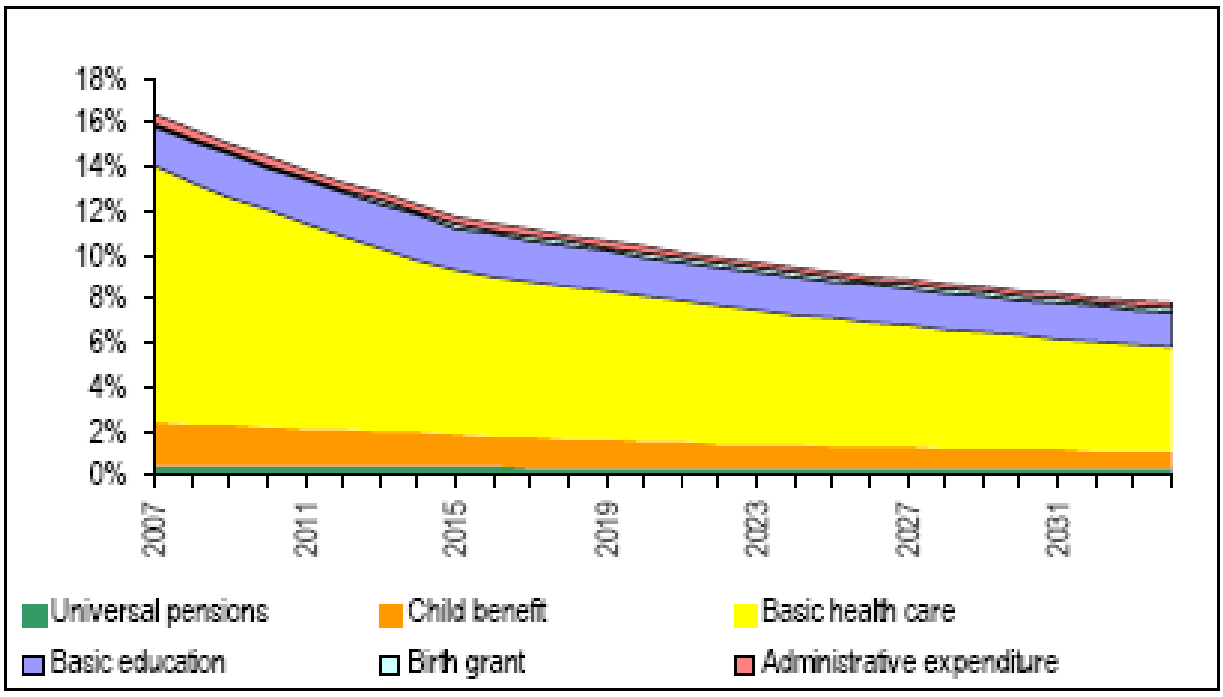
Updated scenarios published by: International Labour Office 2008

Scenario I estimates the costs of a basic social protection benefits package based on the following main assumptions:

- Universal old-age and disability pension of Rupees 200 per month, to older persons aged 65 and over and the disabled (assumed to be 1 per cent of population).
- Basic health care costs based on Commission on Macroeconomics and Health estimates of US$34 per year on average in low-income countries by 2007, and US$38 in 2015.
- Universal child benefit at 50 per cent of old-age and disability pension per child (Rupees 100 monthly) for all children aged 0-14;
- Universal access to primary education based on per unit UNESCO estimate; children aged 6-11 years of age; net enrolment ratio in primary education reaching 100 per cent by 2015; 10 per cent of children in primary in private schools by 2015; 15 per cent capital cost.
- Birth grant of Rupees 5,336 paid to all women who deliver in health facilities based on starting assumption that 15 per cent deliver in 2007 in a health facility.
- Administration costs of delivering cash benefits equal to 15 per cent of cash benefit expenditure.

Source [430]

Costs of basic social protection benefits package for Nepal, Scenario I, 2007-2034 (in per cent of GDP)



Source [430]

5 Health insurance

5.1 Statistics

Table 2: Voluntary Health Insurance in Low-income Countries, World Health Survey, 2003

	Number of respondents with health insurance	Number of respondents with voluntary health insurance	Percentage of insured respondents with voluntary health insurance	Q1 lowest income	Q2	Q3	Q4	Q5 highest income
			Percentage of insured respondents with voluntary health insurance					
Burkina Faso	40	10	25.0	0.00	0.00	0.00	0.00	100.00
Chad	194	17	8.8	0.00	0.00	0.00	10.90	89.10
Comoros	272	164	60.3	4.70	8.20	9.90	29.60	47.60
Cote D'Ivoire	1244	885	71.1	0.30	0.90	3.80	21.10	74.00
Ethiopia	23	4	17.4	0.00	0.00	0.00	0.00	100.00
Ghana	359	310	86.4	12.40	11.20	15.10	41.30	20.10
India	709	146	20.6	3.10	3.90	6.70	23.30	63.00
Kenya	1891	1758	93.0	0.30	3.40	10.20	24.60	61.50
Malawi	151	121	80.1	0.00	1.50	5.90	15.70	76.80
Mali	172	131	76.2	0.80	17.20	18.80	27.60	35.70
Mauritania	208	35	16.8	0.00	0.00	0.00	0.00	100.00
Nepal	140	127	90.7	0.00	0.00	0.00	2.00	98.00
Pakistan	132	1	0.8	0.00	0.00	0.00	0.00	100.00
Senegal	843	320	38.0	0.00	23.70	10.30	26.10	39.90
Vietnam	5195	3260	62.8	11.10	16.00	20.60	23.30	29.00
Zambia	565	269	47.6	2.70	6.50	14.60	19.70	56.60
Zimbabwe	1210	639	52.8	0.70	2.60	3.50	11.60	81.60
Average	**785**	**482**	**61.4**	**2.12**	**5.59**	**7.02**	**16.28**	**68.99**

Source [37] [38]

Voluntary health insurance

Of those respondents reporting insurance, 61.4% on average were enrolled in voluntary health insurance programs, ranging from 0.8% of insured persons in Pakistan to 90.7% of those insured in Nepal.
Source [37]

5.2

Overview

Regional Overview in South-East Asia

Table 1. *Health Insurance Models Existing in Nepal*

No.	Insurance Model
1.	*Hospital based micro-social health insurance scheme*: Initiated in 2000, the BP Koirala Institute of Health Sciences offers services to rural and urban household members through linkage with Village Development Committees (VDC), co-operatives, business associations, educational institutions etc. The premium for urban areas is four times higher than rural areas and the scheme covers 2 400 members from 565 households. The service package includes free consultations and investigations in Out- and In-patient Departments, free hospital beds and medicines and operation charges beyond certain limit. The entire premium, contributions from VDC etc. go to hospital. The income shows surplus, but does not include expenditures borne for manpower, equipment costs etc.
2.	*Community, Health Post-Based Insurance model*: Initiated in 1976 as Lalitpur Medical Insurance Scheme; this scheme has a coverage of 19 to 52 per cent rural population in six health posts. The premium varies and is set up by the local committee with the drug subsidy coming from the government. Registration fee-based and free clinical service is provided in the clinic, although for the referred cases in Patan Hospital, the charges are discounted. There is no surplus revenue over the expenditure. It is observed that sustainability may be a problem with existing premium.
3.	*Health Cooperative Model:* A Nongovernmental Organization (NGO), PHECT (Public Health Concern Trust) Nepal, offers health service through Cooperative Society with the members maintaining a daily savings of nominal amount to contribute for health, both in rural and urban areas. Community clinics provide primary services and referrals for Kathmandu Model Hospital (KMH). Fifty per cent of total collections go to KMH. Subsidy is provided to the poor on referral cases. There is coverage for 2 038 persons from 438 households. The General Federation of Nepal Trade Union (GEFONT) supports another cooperative scheme for transport and industrial workers. A monthly premium is paid by workers to establish a Health Cooperative Fund, which runs a clinic for primary service and the referred cases go to KMH as above. For the poor, PHECT Nepal provides financial support as solidarity. It covers only 500 families (2 members from each family) out of 300 000 GEFONT members.[123]

Source: British Council; DFID/District Health Strengthening Project, Teku, Kathmandu; and The ILO/STEP programme in Nepal, 2003.

Source [124]

5.3

Communities

Table 1: Characteristics of Selected Community Based Health Insurance Schemes

Characteristic/Scheme	Fandene Mutual Health Organization	Micro-Care	UCGM Sirarou	SEWA Integrated Social Security Scheme	Public Health Concern Trust
Country	Senegal	Uganda	Benin	India	Nepal
Services Offered Starting	1990	2000	1995	1992	1992
Size	287 persons	776	3,075 (1996)	32,000 (1999/2000)	35,000 (1999)
Community Participation	Democratically governed through general assembly, control committee, and governing body meet frequently. Managed by 5 volunteers.	Microcare Uganda Ltd is a non-profit organisation that establishes managed care arrangements between client groups (especially MFIs) and service providers. Groups negotiate managed care contracts.	Democratic participation in mutual health organizations general assembly. Members can participate in monthly meeting conducted at the village and communal levels. Scheme developed with the assistance of CIDR.	Program designed in response to members request. Premiums and benefits copied from United India Insurance when SEWA took over insuring their members. Community members participate in claims committee which review each claim, together with SEWA staff and a doctor.	Scheme was first established as a cooperative. Managed through voluntary services of local coordination committees, one-quarter of whom must be women, who collect premiums, and facilitate the use of services. Frequent meetings reinforce democratic management.
Membership	Rural families	Open to families – family considered as a minimum of four and part of a group of over 15 people.	Open to individuals and to families	Must be a member of SEWA (Women's Informal Sector Trade Union)	Families, with no ethnic, race of caste restrictions.
Premium	1,000 CFA Franc and 200 CFA Franc monthly fee per person. 3 month waiting period after first premiums are paid before insurance is effective.	Family of four pays annual lump sum fee of Ush.108,000 ($62) or six monthly fee of Ush.67,000 ($38). Additional family members over 16 pay Ush.36,450 ($21) annually or Ush.19,238 ($11) every 6 months. Children (Under 16) pay annual fee of Ush.17,550 ($10) or Ush.9,263 ($5) every 6 months. 2 week processing period before insurance is effective.	Annual premium (1997) was CFA 1,300 per person, CFA 3,700 for a family of 2-5 persons, CFA 7,500 for a family of 6-10 persons, CFA 12,400 for a family of 11-15 persons and CFA 18,000 for a family of 16 or more. Premiums are collected during the cotton selling period. Premiums can be paid on a credit basis for members who cannot afford to pay at once.	$1.65 per year for member only. To get additional coverage for Husband's natural death, an additional $0.51, to have husbands health covered, adds $0.45. Premium can be paid using earnings from fixed deposits, annual payment or monthly payment.	Members must deposit between 25 to 50 paisa per day (equivalent of $1.20 to $2.40 per year). May be paid in one lump-sum or in two installments. Families with less than 5 members must deposit Rs. 100 ($1.40) per year, and those with more than 5 members must deposit Rs. 200 ($2.80) per year. Half of total premiums deposited at Katmandu Hospital
Benefit Plan	100% out-patient urgent consultation, 10 days hospitalization, 50% surgery costs, 75% of mid-wife and delivery costs, 50% discount given by local hospital to all services not covered.	All members can access the provider hospitals, including Nsambya, Rubaga, Kibuli, Kisubi, and Metro-Med Medical Clinic.. Casualty and outpatient services; In-patient services. Referrals to specialists within the hospital. Surgery, X-rays and laboratory procedures, Prescription drugs, Maternity. Dental care, Optical consultation. Excludes dental surgery, some elements of optics, intentional self-injury, mental illness, infertility, alcoholism and chronic illness, long-term care and medication of chronic illness. Microcare has set up check-in desk terminals at the scheme hospital where computer terminals monitor client details and service utilization data.	Covers 100% of hospitalization, deliveries and snake bite. Members must use the community health center and health post for deliveries and snake bites. Hospitalization provided through designated hospital. Part of a network of 9 Mutual Organizations that are serviced by a common hospital.	Medical coverage for hospitalization of at least one day, except for injuries. In-patient care with related medications and tests, plus grant for: Maternity, Cataracts, Dentures, Hearing aids, Single premium also provides death, widowhood, and property coverage). Excludes Pre-existing and chronic illnesses. Covers only expenses related to illness or accident that requires more than 24 hours hospitalization ($27.27 annually). Maternity ($6.82 grant), cataracts ($27.27), dentures ($13.64), and hearing aids ($22.72) only covered for 'lifetime insurees'. Certain procedures (maternity, dental) only covered after one year.	Covers pre-defined set of general medicine, hospitalization, surgery, gynecological and obstetric services. A set of generic drugs are also covered. Members may use PHECT community clinics and the Katmandu Model Hospital. Services are provided by health assistants and doctors from Katmandu Hospital who visit twice a week at the community clinics. Patients with complex cases are referred to Katmandu Model Hospital if required. A referral sheet signed by a doctor of health assistant is required to use services at the Katmandu Hospital. Radiology and pharmacy services are excluded. Primary health care services are excluded from the insurance since these are covered by Government.
Co-Payment	50% of surgery and 25% of mid-wife and delivery costs.	Registration fee of Ush.1,000 ($0.57) - Ush.1,500 ($0.86) per visit. Coverage up to a Limit of $195 per 8 months for in-patient treatment per patient.	None---all routine health services and drug costs are borne by households.	None (but restricted coverage tends to offset an average of 22% of members annual medical costs)	Members pay 50% of the cost of each treatment. 80% of the cost of a general annual medical check-up is covered.
Other	Linked to Mission Hopital Saint Jean de Dieu	Each member gets ID card. It is not transferable. Charge for replacement if lost.	Two funds maintained to provide loans to members for premiums and to pay premiums for indigent.	One-third of premium is government subsidy and one-third comes from GTZ endowment interest. .	Village development committees receive donations from donors and govt. to supplement premiums.

Source [22]

Source [22]

Box 1: Characteristics of Different Community Health Insurance Scheme

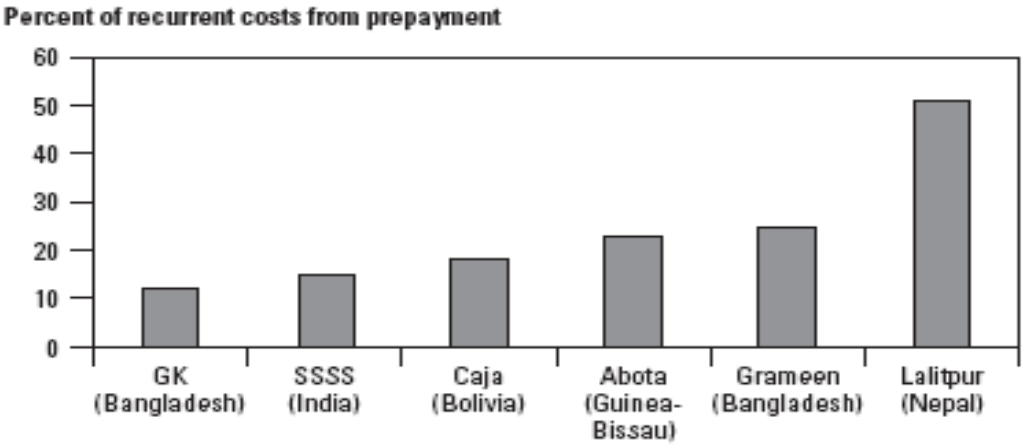
Particulars	BPKHIS	GEFONT	LMIS	PHECT-Nepal
Coverage (Size)	2,383 from 565 households)	500 families (2 members from each family)	19 to 52 percent population in six district	2,038 (from 438 households)
Targeting	Rural and Urban	Transport group and industrial workers	Rural	Rural and Urban
Safety net provisions	Rural	Less cost a priority for the poor	Charity service for the selected poor, if hospitalized	Special subsidy for the poor on referral cases
Health Service Provider	BP Memorial Hospital	Community clinic for primary services and Kathmandu model hospital as a referral unit for complex problems	Community clinic for primary services and Patan hospital as a referral unit for complex problems	Community clinic for primary services and Kathmandu model hospital as a referral unit for complex problems
Membership	Household organized through the institutions (Cooperative, Clubs, VDC)	Household (annual service entitled to first two persons from the family throughout the year)	Household	Household
Premium Rates	Urban Rs 600 – per person per year Rural Rs 180 – per person per year	Rs 30 per person per month	Rs 100 – 200 per family	Rs 0.25 to Rs 0.50 paisa per member per day
Revenue Sharing	100% premium transferred to BP Memorial Hospital	No revenue sharing because of partial cost reimbursement	User fee applied Annual drug subsidies from government and CDHP	50% of the total collections forwarded to Kathmandu Model Hospital
Cost sharing provisions	Free of charge service from the BP Memorial Hospital	GEFONT – 23% PHECT-Nepal – 2e% Patient – 54 %	- Registration fee based free Clinical service. - In case of referral services Rs 200 discount on hospital admission fee Rs 30 – discount on other costs	50 to 80 percent subsidy on community clinic and referral services

Source: Lokendra Prasad Poudel/Babu Ram Shrestha, Alternate Health Care Financing: Synthesis of Existing Experience in Nepal submitted to DFID/District Health Strengthening Project, Teku, Kathmandu, February 2003.

Source [463]

BOX 1.1 REVENUE MOBILIZATION

Based on data from Bennett, Creese, and Monasch (1998), this graph shows the cost recovery from prepayment of six Modality II schemes. The range is from 12 percent to 51 percent of recurrent expenditure. This shows that, for these schemes, the resources collected contribute significantly to the full recurrent costs but do not fully cover them, thereby necessitating other sources of funding, such as out-of-pocket spending, government subsidies, and donor grants.



Source [59]

Cost-recovery from pre-paid premiums from Bennett et al (1998) (p. 40)

No.	Scheme	Country	Cost recovery from prepayment *last date available*
42	SWRC	India	10% of recurrent expenditure
25	RAHA	India	10-20% off community costs & 100% referral costs[a]
24	SSSS	India	15% of recurrent expenditure[b]
18	Caja-Tiwanaku	Bolivia	18% of recurrent expenditure[c]
31	Abota	Guinea Bissau	23% of recurrent expenditure[d]
64	Bajada	Philippines	30% of recurrent expenditure
58	CAM	Burundi	34% of outpatient drug costs[e]
17	GK	Bangladesh	12% of recurrent expenditure[f]
14	Grameen	Bangladesh	24.7% of recurrent expenditure[g]
41	BRAC	Bangladesh	50% of recurrent expenditure
62	Health Card	Thailand	50.0%[h]
67	Bwamanda	former Zaire	65-70% recurrent excluding personal allowances
79	SWHI	Thailand	50-60%[l]
59	Lalitpur	Nepal	51% of recurrent expenditure[j]
21	Kisiizi	Uganda	72% of recurrent expenditure[k]
46	KSSS	India	88% of recurrent expenditure

60	Boboye	Niger	89% of drug and management costs[l]
26	Sewagram	India	96% of community health program costs
32	Medicare II	Philippines	100% of recurrent expenditure[m]
33	PHACOM	Madagascar	100% of drug costs[n]
61	UMASIDA	Tanzania	100% of costs
2	ORT	Philippines	100% excluding professional salaries
66	Nsalasani	Congo-Brazzaville	100%
29	Bao Hiem Y Te	Viet Nam	130%[o]

Notes

[a] Non member fee collections cover roughly 60% of community cost

[b] Copayments cover 31% of costs and balance is financed from fund raising activities

[c] Without the costs associated with expatriate assistance the caja contribution would have been 48% of budget

[d] In a study of 18 village schemes the cost recovery ranges from 3%-123% based on assumption that all communities consume a given amount of drugs estimated by government.

[E] There is no link between prepayment revenues collected and financing of services as revenues revert to government. A study in Muyinga province showed that the revenue from premiums was sufficient to fund approximately 34% of drug costs.

[f] The remaining was covered by user fees (24%), subsidies from GK commercial ventures (14%) and international solidarity (50%).

[g] The remaining was covered by user fees (41.3% members and non-members) and a long-term loan from Grameen Bank (34%).

[h] The scheme is currently half financed by government budget and half by cardholders, this is a relatively recent reform, and previous estimates show recovery of approximately 35% of recurrent costs.

[I] Balance from cross-subsidy from richer households.

[J] Cost recovery from prepayment ranges from 30% to 56.6%.

[k] Average cost recovery for the hospital as a whole is 48%.

[l] 149% of drug costs only.

[m] Fund utilization is relatively low, ranging from 38-78% of total collections. Only in 1992 after a large drop of membership disbursement exceeded collection in Unisan, Quezon pilot scheme.

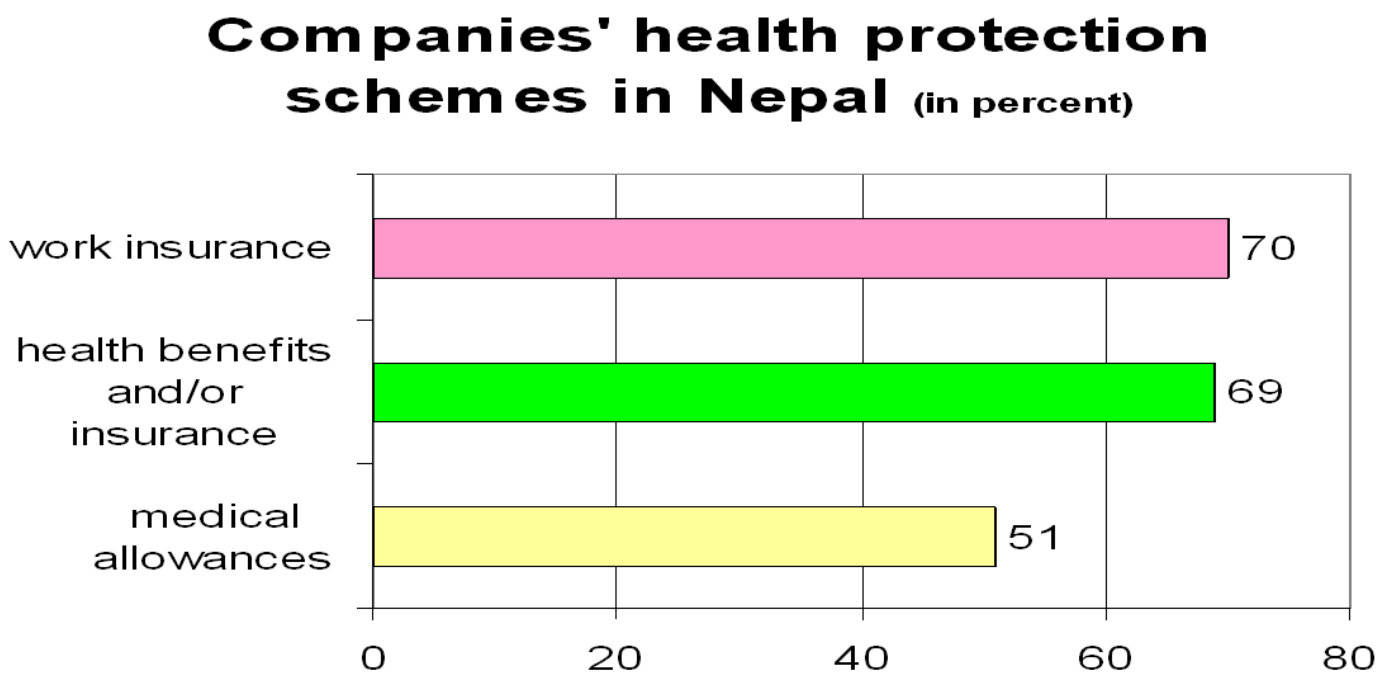
[n] Drugs are bought with membership fees but often only last three months of the year.

[o] The 130% includes a cross-subsidy from formal sector workers to non-formal sector workers.

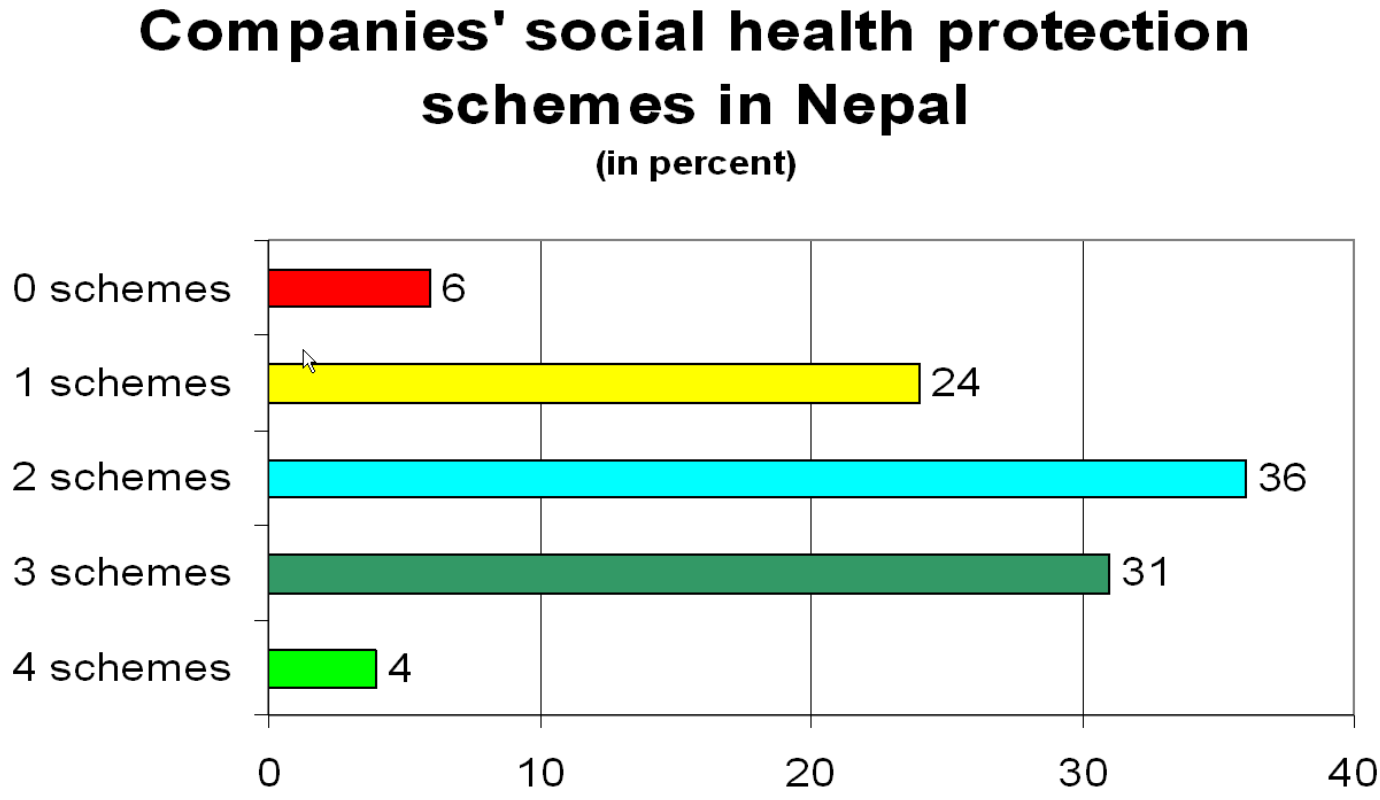
Source [26]

5.4

Companies



Source [466]

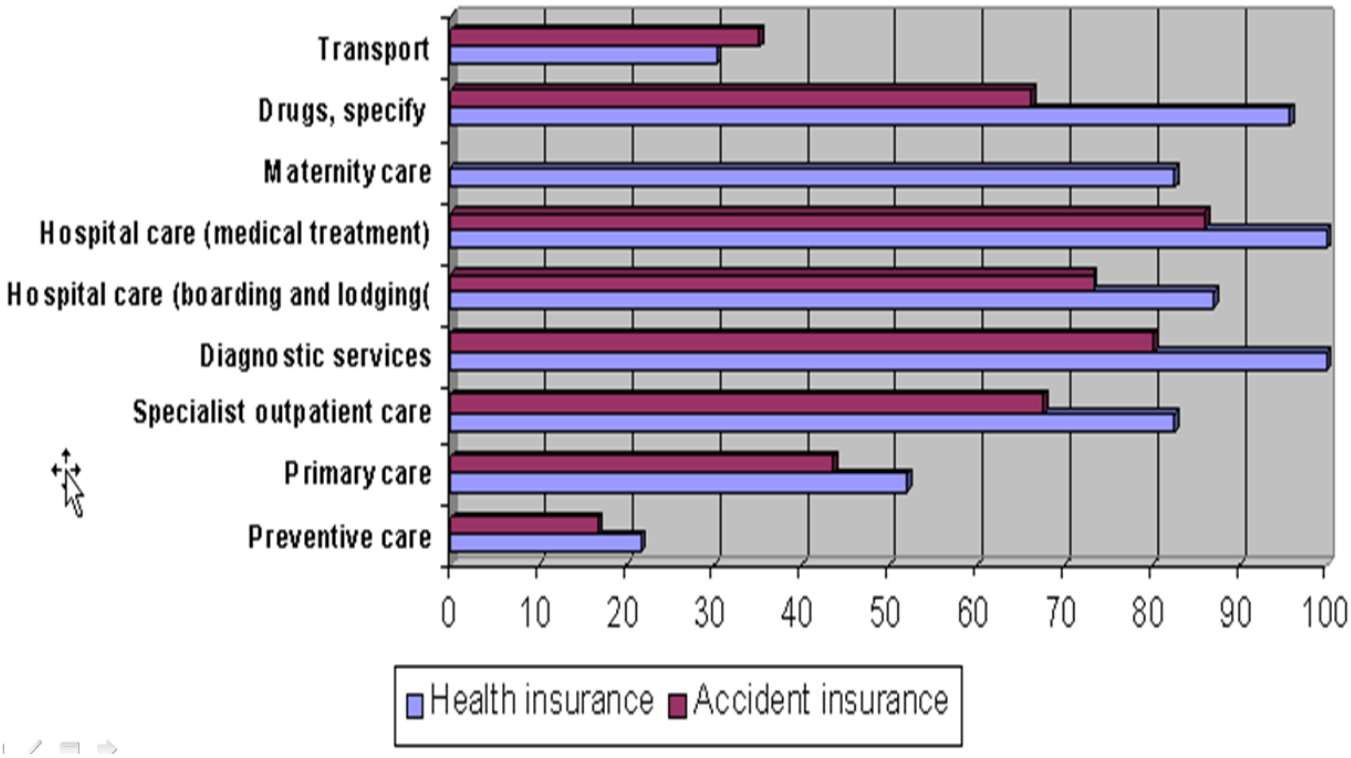


Source [466]

- 26% of companies provide health insurance
- 52% give HI to all employees
- 48% give HI to permanent employees, only
- 96% cover family members

Source [466]

Figure 05. Distribution of the Benefits Received by Employees from Health and Accident Insurance, Nepal 2009



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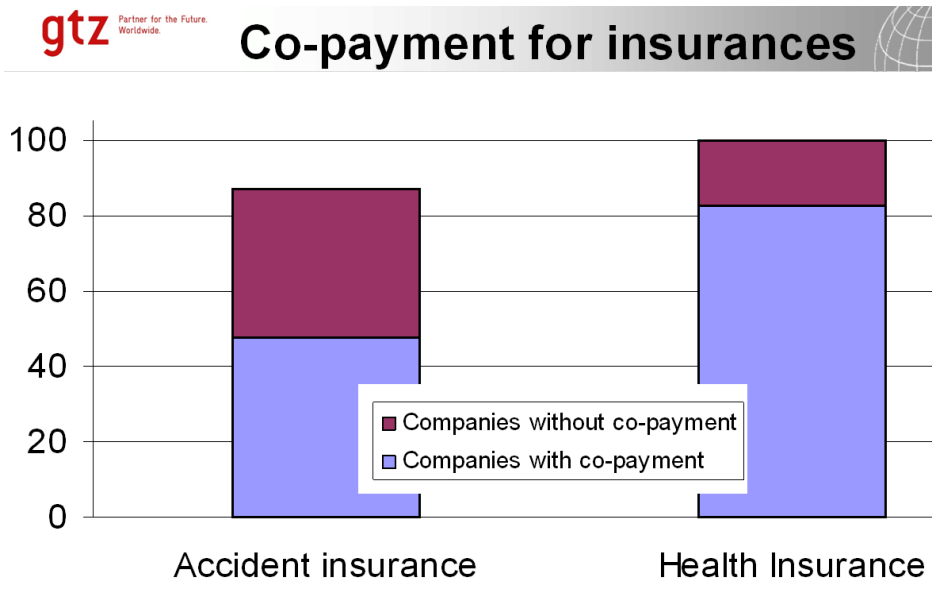
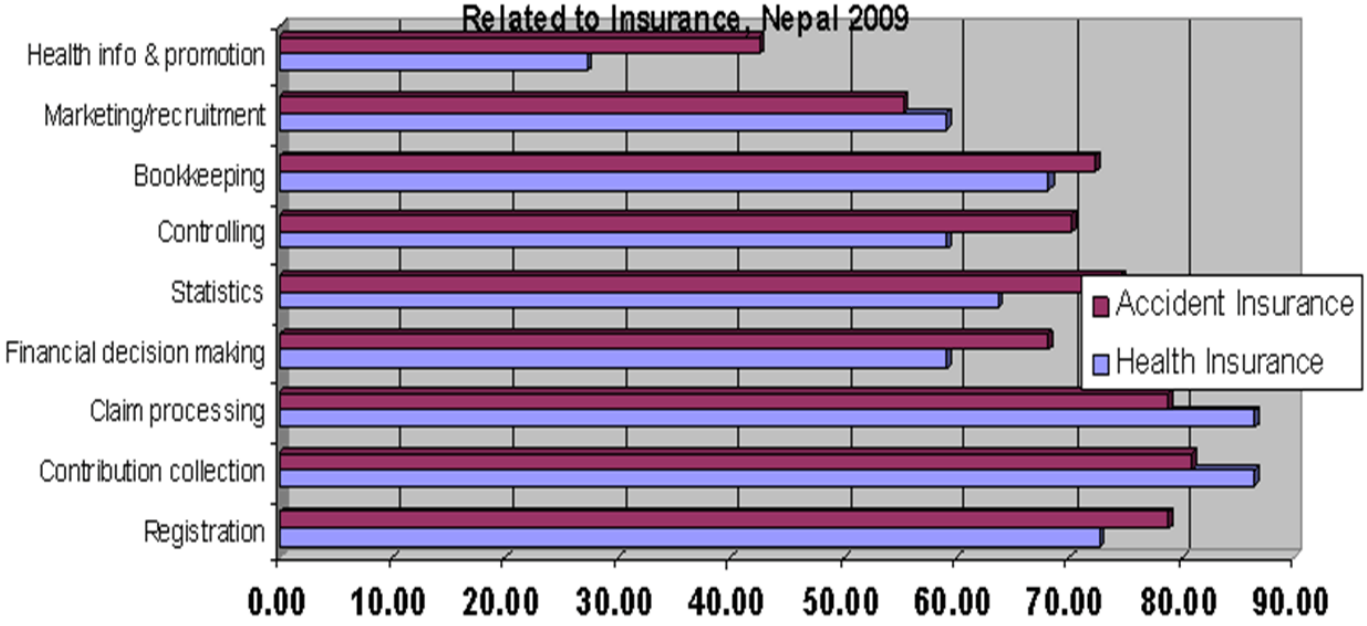


Source [467]

gtz Partner for the Future. Worldwide.

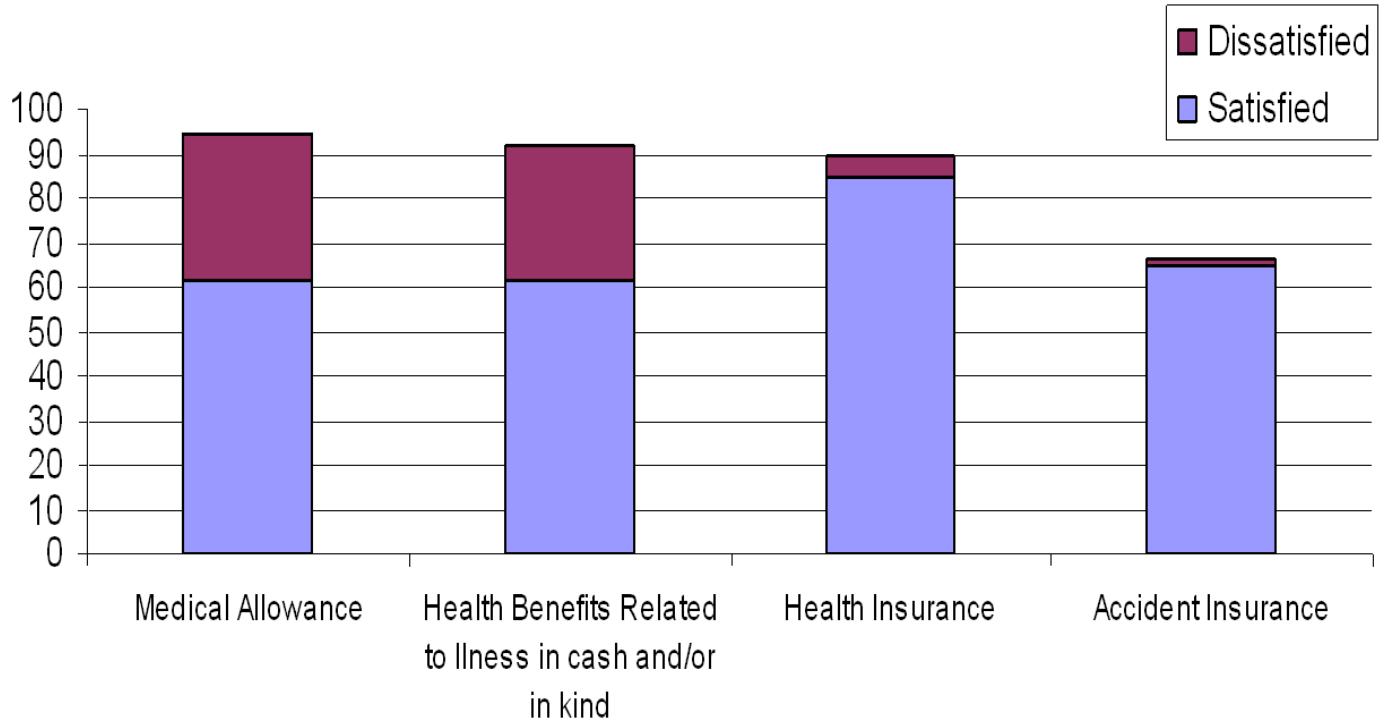
Insurances' management

Figure 08. Distribution of Companies Performing the Administrative Tasks Related to Insurance, Nepal 2009



Source [467]

Satisfaction with protection



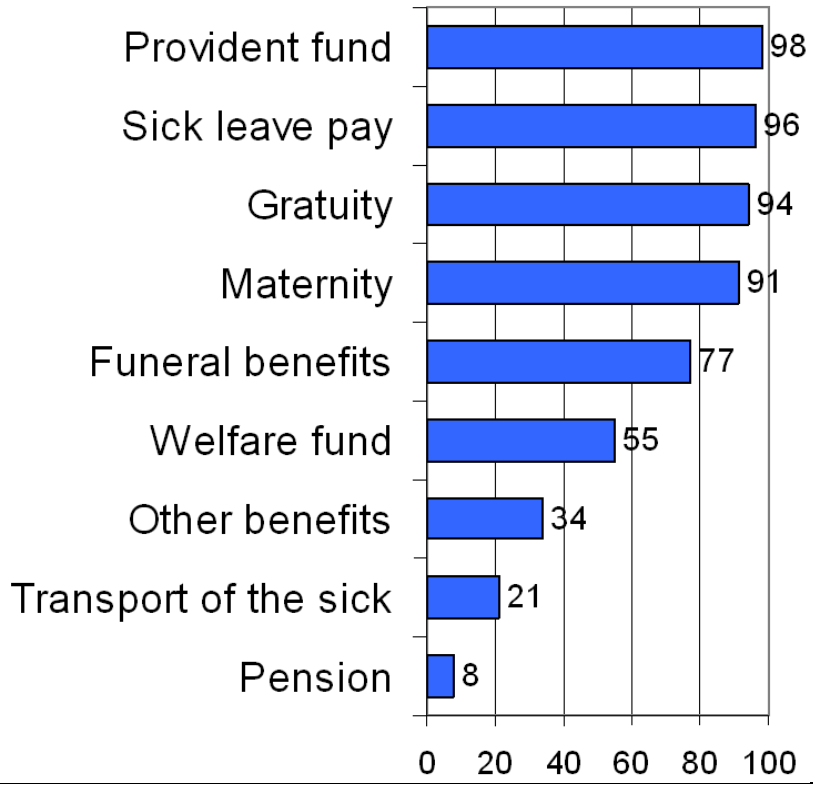
Source [467]

- Opinion leaders have a mixed feeling on the free health care policy
- Reintroduction of user fees is advocated by some but all favour health insurance
- Mandatory pre-payments are asked for with exemptions for the poorest 30%
- Health financing should be shared by people, employers, national and local governments
- Opinion leaders are divided on the question of leadership for health insurance
- They assume that an autonomous national health insurance institution could be trusted
- A smart division of labour between government and health insurance has to be designed
- Government should concentrate on what the market fails to provide sufficiently
- Prevention, health education – e.g. – should be the mandate of the government
- Government would mainly concentrate on regulatory tasks – management and health care provision could be set apart
- This would be a drive towards a sustainable and efficient health financing
- Many companies in Nepal are providing already health benefit and insurance schemes
- Most employees are accustomed to share through contributions and co-payments
- There is quite some expertise in various companies on how to manage such schemes
- The satisfaction of employers and employees with such schemes is quite high
- Government and best companies should discuss on options of cooperation
- Financial contributions from national and local government would be needed
- There is willingness and capability for a more sustainable health financing in Nepal

Source [466]

Other social benefit schemes of companies in Nepal

(in percent)



Source [466]

5.5 Assessments

Health insurance schemes

In ***Nepal*** and ***Bangladesh***, social health insurance schemes are almost nonexistent or, if present, cover a few people in limited geographical areas. Most schemes rely on external funding and are on some contributions. There are a small number of private health insurance and community-based insurance schemes with limited coverage.

Source [292]

Kathmandu University Medical Journal (2007), Vol. 5, No. 2, Issue 18, 268-272

Personal Viewpoint

Social health insurance: A knowledge-do gap in eastern Nepal

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Abstract
Health care costs, and those for inpatient care in particular, pose a barrier to seeking health care, and cost be a major cause of indebtedness and impoverishment, particularly among the poor. The Ministry of Health in Nepal intends to initiate alternative financing schemes such as community and social health insurance schemes as a means to supplement the government health sector financing source. Social Health Insurance (SHI) is a mechanism for financing and purchasing / delivering health care to workers in the formal sector regulated by the government. Considering all these facts BP Koirala Institute of Health Sciences (BPKIHS) has introduced SHI scheme in 2000 as an alternative health care financing mechanism to the community people of Sunsari and Morang districts. In the beginning small area was elected as a pilot project to launch the scheme. A major objective of SHI is to reduce poverty caused by paying for health care and to prevent already vulnerable families from falling into deeper poverty when facing health problems. A total of 26 organizations with 19799 populations are at present in SHI scheme. Sixteen rural based organizations with 14,047 populations and 10 urban based organizations with 5752 people are the beneficiaries in this scheme. BPKIHS SHI Scheme is the outcome of the visionary thinking on social solidarity and as an alternative health care financing mechanism to the community. BPKIHS is mobilizing people's organizations and is offering health services through its health insurance scheme at subsidized expenses. This has helped people to avail with health facilities who otherwise would have been left vulnerable because of their penetrating health needs. There is huge gap between premium collection and expenditures. The expenditures are more and this may be due to knowledge – do gap in the program. If conditions are unsuitable, SHI can lead to higher costs of care, inefficient allocation of health care resources, inequitable provision and dissatisfied patients. It can also be more difficult to realize the potential advantages of SHI in future. The future challenges confronting the scheme are to give the continuity and sustainability of the program to its catchments areas. This might entail a shift in its program operation mechanism. People's active involvement is required, which will further provide a sense of ownership in the scheme amongst the people.

Source [126]

Prerequisites for health insurance in Nepal

- Stocktaking Survey
- Declaration of Health Insurance Policy
- Act and regulation for the policy implementation
- Insurance agency and its network throughout the country
- Hospital pharmacy set-up
- Per patient (average) treatment cost estimation
- Listing of countrywide/total number households
- Identification of poor household
- Listing of health service providers
- Statistics of formal sectors employees/workers

Source [349]

6 Social health protection in international perspective

6.1 Definitions

Definition of social health protection by GTZ WHO ILO consortium

“Extension of social protection in health is the key strategy to reduce financial barriers to access health care and moving towards universal coverage (i.e. universal health protection). Social protection in health comprises a variety of financing mechanisms. Besides tax-funded health financing, social health insurance in a broad sense is one important option for countries to ensure social protection in health thereby contributing to universal coverage. Community-based and employer schemes are complementing options. Within each of these broad categories identified in terms of financing sources lies a range of options for organizing arrangements for pooling funds and purchasing services. Further options lie in mixed arrangements that use these different sources of funds in an explicitly complementary manner.

Irrespective of the financing mechanisms employed, social protection in health involves a shift towards enhanced risk-sharing and risk-pooling, i.e. increasing the share of prepayment in total health expenditure and reducing the reliance on out-of-pocket-payments. The strategy also involves subsidies and cross subsidies within or between risk-pools.”

http://www.socialhealthprotection.org/social_protection_health.php

Source [250]

GTZ definition of social health protection in Berlin declaration:

“**Social Protection in Health**

The conference acknowledged that the extension of social protection in health is the key strategy to reduce financial barriers to access health care and moving towards universal coverage (i.e.

universal health protection). Social protection in health comprises a variety of financing mechanisms. Besides tax-funded health financing, social health insurance in a broad sense is one important option for countries to ensure social protection in health thereby contributing to universal coverage. Community-based and employer schemes are complementing options. Within each of these broad categories identified in terms of financing sources lies a range of options for organizing arrangements for pooling funds and purchasing services. Further options lie in mixed arrangements that use these different sources of funds in an explicitly complementary manner.

Irrespective of the financing mechanisms employed, social protection in health involves a shift towards enhanced risk-sharing and risk-pooling, i.e. increasing the share of prepayment in total health expenditure and reducing the reliance on out-of-pocket-payments. The strategy also involves subsidies and cross subsidies within or between risk-pools.

Social protection in health is essentially a matter of shared societal values and procedures towards an overall more equitable distribution of wealth and resources. Important underlying values include equity and solidarity, which in turn can contribute to social justice. According to the principle of solidarity everyone should have access to an adequate package of healthcare and no family should be catastrophically burdened by the cost of illness. The principle of solidarity is directly related to equity in financing and financial risk-protection. The former means that people should contribute on the basis of their ability to pay rather than according to whether they fall ill. Achieving the latter ensures that the cost of care does not put people at risk of financial catastrophe.

While progress towards increased social protection in health based on these principles and values can be made in systems funded from general revenues, payroll tax revenues, or a combination, social health insurance is generally based on the additional principle of responsibility and participatory governance by social partners and insured. In many systems, governance includes the delegation of functions from the state to public, non-state institutions, such as independent or quasi-autonomous health insurance organisations, ruled by public law and civil society groups (e.g. mutual health organisations, co-operatives), professional associations (e.g. medical doctors), workers' and employers' organizations and the private sector (e.g. private providers). It often involves a wide range of actors, thereby strengthening participation and decentralization in social protection as well as reducing the burden on governments (though of course accountability relations between the insurance fund(s) and the government with regard to the use of public funds must be clear). In this context regulations based on social dialogue are crucial for defining policies, assigning roles and responsibilities.“
Source [285]

ILOs definition of social health protection

“**What is social health protection?**
Based on the core values of equity, solidarity and social justice, the ILO defines *social health protection* as a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health.
Equity, solidarity and social justice are understood here as basic characteristics of universal access to social health protection founded on burden sharing, risk pooling, empowerment and participation. It is up to national governments and institutions to put these values into practice.
Achieving universal social health protection coverage - defined as effective access to affordable quality health care and financial protection in case of sickness - is a central objective for the ILO. In this context, coverage refers to social protection in health, taking into account the:

- size of the population covered;
- financial and geographical accessibility of covered services;
- extent to which costs of a benefit package are covered; and
- quality and adequacy of services covered.

Social health protection consists of various financing and organizational options intended to provide adequate benefit packages for protection against the risk of ill health and related financial burden and catastrophe.

There are various mechanisms to finance health services. These range from tax-funded national health services, vouchers and conditional cash benefits, to contribution-based mandatory social health insurance and mandated or regulated private non-profit health insurance schemes (with a clearly defined role in a pluralistic national health financing system comprising a number of different subsystems), as well as mutual and communitybased non-profit health insurance schemes. These mechanisms normally involve the pooling of risks between covered persons - and many of them explicitly include cross subsidizations between the rich and the poor. Some form of cross subsidization between the rich and the poor exists in all social health protection systems, otherwise the goal of universal access could not be pursued or attained.

Social health protection *is a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health.*

Source [389]

6.2

Glossary

Glossary of affiliated terms:

Equity:

Equity is often confused with ***equality***. *Equity* refers to a system of justice based on conscience and fairness. *Equality* is 'the state of being equal' (Longman New Universal Dictionary, in Donaldson, C. 1993). *Equality* may be considered as a particular interpretation of *equity*. *Equity* is different through its incorporation of the idea of social justice. It may be judged fair to be unequal. A variety of definitions of equity exist, including:

Equal health,
Equal access to health care,
Equal utilisation of health care,
Equal access to health care according to need, and
Equal utilisation of health care according to need.

Given the importance of social justice in the concept of equity, it seems fair to suggest that the last two definitions come closest to European thinking. These definitions comprise two important dimensions of equity: financial equity (access) and equity of opportunity to use health care resources.

The different interpretations and definitions of equity may give rise to conflicting health care equity objectives. Moreover, it seems that there is no universal equity measure. In consequence, each health care system has to decide upon its own equity objective(s), and to confront and resolve any potential conflict between equity objectives, and to monitor achievement of objective(s) (Green, A., 1992, Donaldson, C., 1993).

The World Health Report 2000 proposes an index of fairness regarding health care financing,

however, argues that this index cannot discriminate between health financing systems that are regressive and those that are progressive. Moreover, the WHO index cannot discriminate between horizontal inequity and progressivity/regressivity of a financing system. Therefore, he suggests the use of an approach developed in the income redistribution literature used in the late 1990s to study the fairness of various OECD countries' health care financing systems. He argues that policymakers should not be concerned as much about the distribution of health care payments *per se* (and, in consequence, de-link payments and health care utilisation). They should rather ensure that the distribution of health care payments does not lead to an unduly adverse effect on the distribution of disposable income of households (to buy other goods and services). This argument is favoured by most European health care financing systems.

Poverty:
Extreme poverty is defined as a purchasing power of less than one US dollar per capita per day. According to this definition over a billion people world wide live in extreme poverty. The majority of them are females. While two thirds of the poor in developing countries live in rural areas, urban poverty is also on the increase.
Poverty does not only mean that people have low incomes but also that they have to face limited opportunities and inadequate means of taking part in political and economic life and therefore are excluded from decision making. Simultaneously, their human dignity is not respected, their human rights are abused, they lack access to resources and they are particularly exposed to risks and burdens of disease, independent of the respective country and society.

Social Protection:
Social protection includes the entire system of tools to protect citizens against the risks of sickness, natural disaster, accident, old age, unemployment and occupational hazards. Forms of social protection comprise traditional, informal and formal arrangements. These include families, solidarity-based groups (voluntary membership and/or self-help), co-operatives, (compulsory) membership-based systems of social security (such as social health insurance), private insurance (for-profit, or not-for-profit), and government-based forms of social security as well as social assistance.

Social Security:
Defined as systems of formal social protection, they are run either by public, private or by state-owned carriers or as systems combining different forms. All social security systems are ruled by (mostly public) law, and/or controlled by the state, or public organisations. Social security includes tax-financed national health services, social health insurance schemes, pension funds, unemployment funds, occupational accident funds (occupational hazards), long-term care insurance, and social assistance. They are designed to effect a distribution of income considered desirable, and to prevent poverty of affected individuals or households. Benefits are either provided in kind or in cash. In many instances, the term social security schemes is used for member- and contribution-based social insurance systems only, excluding tax-based systems (such as national health services).

Solidarity:
As understood in Germany and, more generally, in Europe, is the ethical platform of joint efforts among people of economically different positions directed so as to achieve a common socio-economic goal to reduce social friction. Everyone in the solidarity system should have access to the same quality of care and the same comprehensive benefit package, on equal terms. No family should be financially burdened by illness, and a family's contribution should be based strictly on the family's ability to pay and be completely unrelated to the size of the family or its health status.

Subsidiarity:

This concept implies that tasks and obligations should always be fulfilled by the lowest possible level within society that is capable to shoulder the burden and/or to solve the problem. This principle foresees that the government should step in as a regulator of private affairs only if the private system fails to reach shared social goals. [2] It also implies that government should direct its monetary subsidies and other form of assistance mainly to those individuals in society who cannot help themselves (Reinhardt, 1993).

6.3 Benchmarks

Social health protection in Europe

The First Asset: Solidarity is the First Step to Stability
The Second Asset: Universal Coverage – Health for All
The Third Asset: Responsibility, Self-Reliance and Self-Governance
The Fourth Asset: Competitive Markets and Social Protection
The Fifth Asset: There is more than Public-Private-Mix
The Sixth Asset: Sustainability
The Seventh Asset: Variety, Coordination, Convergence
The Eighth Asset: Tradition and Innovation

Source [287]

6.4 Policies

P4H: What is intended to be achieved ?

- SHP incorporated in national health plans and programmes
- Enhanced harmonisation of external assistance for SHP in alignment with national policies, plans and strategies
- Increased and improved utilisation of domestic and international resources (e.g. vertical funds, SWAps) for the development of equitable and sustainable SHP structures
- Increased awareness and cross-country learning on SHP among countries, development partners and the public
- Enhanced capacity in partner countries for evidence-based decisions and strategic orientations in SHP

Source [305]

[2] Federal Ministry for Economic Cooperation and Development (2001): Poverty Reduction – a Global Responsibility. Program of Action 2015: The German Government's Contribution Towards Halving Extreme Poverty Worldwide

Providing for Health (P4H)

Initiative on Social Health Protection

Background

The large majority of people in developing countries do not have access to effective and affordable health care. Often governments are unable to raise the funds required to finance their health systems and to meet basic health care needs. This prevents many people from seeking health services or continuing their treatment. Building up the capacities of health systems and increasing social health coverage are top priorities to ensure the effective, efficient and equitable use of scarce resources.

Strengthening health systems through social health protection

Increased international funding for health has frequently focused on specific diseases or selected interventions. However, improving health outcomes also calls for long-term strengthening of health systems that include sustainable and equitable social health protection.

Thus there is considerable scope for improvement. How can targeted international interventions effectively contribute to setting up appropriate social health protection mechanisms with a view to achieving universal coverage? How can global initiatives best be aligned with existing social health protection systems? How can they effectively be integrated and combined with country-led strategic and innovative solutions for the reduction of out-of-pocket spending and the enhancement of financial risk protection?

Providing for Health (P4H) – Tackling Social Health Protection

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

Objective of P4H

P4H aims to support countries with the development of social health protection systems by increasing financial protection against out-of-pocket payments, and thus to facilitate the utilisation of health services.

Key areas of P4H work

- Contributing to harmonisation and coherence of global initiatives
- Facilitating international and regional collaboration and exchange (South-South learning)
- Networking and alliance building
- Mobilising additional financial and technical resources for social health protection
- Supporting capacity development, e.g. for social health protection and health financing strategies that promote equity, efficiency and social inclusion; sustainable country level systems for social health protection; informed choices of people and demand-side support
- Provision of technical support for the design and implementation of social health protection strategies
- Research and innovation for insurance- and tax-based social health protection systems
- Advocating for the right of access to quality health care and social health protection
- Facilitating stakeholder participation and change processes

There is no 'one-size-fits-all' solution for social health protection. P4H will be country-focused. Its support for capacity development and the facilitation of change processes will be shaped by country demand, building on existing social protection mechanisms and strategies. Careful adaptation of regional and international experience, as well as sensitivity to stakeholders' values and interests at various levels will be pre-requisites for success.

The added value of P4H is based on the combination of international commitment and partnership and high level technical and local expertise.

How does P4H work?

The current core group comprises Germany, France, ILO, WHO and the World Bank. New members are welcome to join.

P4H works with a lean management structure and draws on the regional and country structures of its members.

Contact: info@providingforhealth.org

Federal Ministry for Economic Cooperation and Development

World Health Organization

afd

gtz

kfw

Source [401]

Analytical framework of P4H

Executive Summary

This analytical framework will be used by P4H to assess the status of Social Health Protection in a partner country and to identify country-driven support options. It will enable researchers, policy designers, advisers, planners and political decision-makers to refine and sharpen their thinking and suggestions related to the design and implementation of financial protection for health, and to this extent, should be comprehensive, actionable and identify potential constraints to the conceptualization and execution of policies designed to enhance Social Health Protection, especially in low and middle income countries.

The agenda for country assessments includes various phases and steps:
Phase 1: Preliminary data analysis and preparation of in-country
Phase 2: Country missions
Phase 3: Preparation and distribution of the assessment report
Phase 4: Collection of views and comments on the report and agreement on reform agenda.

The assessment is guided by a series of key questions, which are outlined in chapter V. These questions raise the main issues country assessments have to look into. There are various tools that can be use for country assessments, which are outlined in chapter VII of this framework. They include qualitative and quantitative tools as well as mixtures of both. The analysis will be based on a series of indicators and benchmarks, which are outlined in chapter IIX. Finally, the framework discusses what is the follow-up and what are the consequences from country assessments.

This framework gives some elements and processes for country assessments. It has the character of a methodology but still is open enough to allow organizations experts and countries that follow it to take into account specific situations, interests and experiences. The P4H partners agree to work on the basis of this framework and to work on its further development.

Source [326]

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