Overview of Public-Private Mix in Health Care Service Delivery in Nepal

June 2010

care

RTI INTERNATIONAL

HSRSP Report No. 2.24-06-10

Overview of Public-Private Mix in Health Care Service Delivery in Nepal

Ministry of Health and Population

Government of Nepal

June 2010

Health Sector Reform Support Programme

RTI INTERNATIONAL

Previous HSRSP Publications

The Sector-Wide Approach in the Health Sector – May 2010
Assessing Health Care Performance in Nepal – May 2010
Health Care Financing in Nepal – May 2010
Management of Lamjung District Community Hospital – April 2010
Pro-Poor Health Care Policy Monitoring: Household Survey from 13 Districts – April 2010

Assessing Implementation of Nepal's Free Health Care Policy: Third Trimester Health Facility Survey - December 2009
Overview of Public-Private Health Care Service Delivery in Nepal – November 2009
Health System Performance – November 2009
Examining the Impact of Nepal's Free Health Care Policy: Second Facility Survey Report – June 2009
Examining the Impact of Nepal's Free Health Care Policy: First Facility Survey Report – April 2009
Cost and Equity Implications of Public Financing for Health Services at District Hospitals– April 2009
Human Resource Strategy Options for Safe Delivery – January 2009

Ministry of Health and Population Budget Analysis 2008-09 – December 2008
National Competitive Bidding Process for the Procurement of Goods – November 2008
International Competitive Bidding Process for the Procurement of Goods – November 2008
Health Sector Strategy (translated into Nepali) – October 2008
Costing Study on Incentives Packages for Nepal's Health Care Professionals – August 2008
Equity Analysis of Health Care Utilization and Outcomes – August 2008
Financing Pro-poor Health Care in Nepal – August 2008
State-Nonstate Partnerships in the Health Sector – June 2008
Monitoring Strategy and Toolkit for Pro-poor Essential Health Care Services – February 2008
Rapid Costing of the Government of Nepal's Free Health Care Policy – January 2008
Bottleneck Study for Timely Disbursement of Funds – January 2008

Rapid Costing of Delivery and Emergency Obstetric Care – November 2007
Operationalising Social Inclusion in the Health Sector – September 2007
Ministry of Health and Population Budget Analysis 2007-08 – August 2007
Nepal's Experience of Advocacy and Lobbying to Increase the Health Sector Budget – July 2007
Implications of the Government of Nepal's Free Health Care Policy – June 2007
Equity Analysis in Resource Allocation to Districts – June 2007

Please note that all of our publications may be downloaded from our website:

www.hsrsp.org

This paper looks at the roles played by public and private health care providers, looking specifically at utilization, inputs, human resources, and provision of services. Funding was provided by the U.K. Department for International Development (DFID) through the Health Sector Reform Support Programme. RTI International provided technical assistance. The opinions expressed herein are those of the author and do not necessarily reflect the views of DFID.

The Health Sector Reform Support Programme (HSRSP) aims to provide policy and strategy support to the Ministry of Health and Population (MoHP) in implementing its sector reform agenda. Additional information on HSRSP is available by contacting: Dr. Damodar Adhikari, Team Leader, or Mr. Devi Prasad Prasai, Health Economist, at: HSRSP, Ministry of Health and Population, P.O. Box 8975, EPC 535, Kathmandu, Nepal (telephone: 977-1-426-6180; fax: 977-1-426-6184; e-mail: hsrsp@np-hsr.rti.org).

Suggested citation:

RTI International, 2010. *Overview of Public-Private Mix in Health Care Service Delivery in Nepal.* Research Triangle Park, NC, USA.

Contents

List of Acronyms ii
I. Introduction 1
II. Objectives 1
2.1 Polices and strategies on public-private mix 1
III. Public-Private Mix in Inputs 2
3.1 Public and private health care facilities 2
3.2 Human resources for health by public and private 4
4.3 Expenditure by private and public sources 5
IV. Public-Private Mix in Health Care Services 6
4.1 Public-private mix in family planning services 6
4.2 Public-private mix in maternal health care 8
4.3 Public-private mix in abortion care 9
4.4 Public-private mix in curative care 9
References 11

List of Acronyms

AIN	Association of International NGOs
CAC	Comprehensive Abortion Care
CB-IMCI	Community-Based Integrated Management of Childhood Illness
CDP	Community Drug Programme
DoHS	Department of Health Services
DOTS	Directly Observed Treatment, Short course
EDP	External Development Partner
EHCS	Essential Health Care Services
FP	Family Planning
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
INGO	International Non-Governmental Organization
MoF	Ministry of Finance
MoH	Ministry of Health
MoHP	Ministry of Health and Population
NGO	Non-Governmental Organization
NHSP-IP	Nepal Health Sector Programme – Implementation Plan
NMC	Nepal Medical Council
NNHA	Nepal National Health Accounts
NPC	National Planning Commission
PHCC	Primary Health Care Centre
SHP	Sub-Health Post
SWC	Social Welfare Council
TB	Tuberculosis
UMN	United Mission to Nepal
VCT	Voluntary Counselling and Testing
VSC	Voluntary Surgical Contraception

I. Introduction

Modern medical services in Nepal started with the establishment of Bir Hospital in 1889. Until then, the country had relied on the traditional system of medicine. Modern health care evolved from basic medical care and disease-specific vertical programmes to a more integrated approach culminating in Primary Health Care and the global movement of "Health for All" in 1978. Following the restoration of democracy, the newly-elected government introduced a national health policy in 1991 which opened to door to the private sector.

But various humanitarian and faith-based organization started service delivery long before the introduction of the new health care policy. The United Mission to Nepal (UMN) began health work in the Kathmandu Valley and Tansen where it established a hospital 1954, and the Nepal Family Planning Association along with Nepal Paropkar Prasuti Griha (now known as the Maternity Hospital) were both established in 1959. But until the liberalization of the health care policy in the early 1990s, there were virtually no private, for-profit institutions related to health care.

The national health policy not only brought in for-profit and not-for-profit organizations, but also developed standards for establishing private hospitals. A large number of health institutions were established by the private sector to train health care professionals, and the number of private hospitals grew quickly, thereby greatly expanding secondary and tertiary care in urban areas. Nepal's pharmaceutical industry has also grown in the last twenty years and now produces one-third of the national requirement for medicines.

II. Objectives

The objective of this background paper is to gather and present information on the public-private mix in terms of inputs and health care services.

2.1 Policies and strategies on public-private mix

The Health Sector Strategy states that the 'public sector will develop a major new role in working with the private/NGO sector,' and identifies four areas of operation: sustainable financing, providing an integrated approach to EHCS delivery, quality assurance by the government, and pharmaceuticals, other consumables, and new technology.

The NHSP-IP recognizes the role of the private sector and their expected contribution to health care provision. Various agreements and operating modalities exist between the MoHP, NGOs, and private providers, and in many cases these are vital for supporting EHCS programmes and directly providing curative care which cannot be covered by public expenditure. The NGO (and EDP project staff) contribution includes middle level management support for specific EHCS programmes (e.g. child health, reproductive health,

tuberculosis, and leprosy), co-ordinated planning and supervision with the district level (all EHCS programmes), trainings (e.g. CB-IMCI, tuberculosis, leprosy, and CDPs), evaluation of programmes (e.g. vitamin A, iodine, and CB-IMCI), and direct provision of services, especially in reproductive health and HIV control.

NGO-provided support often has important advantages over public services in terms of flexibility, accountability, innovations, and a strong sense of mission. Most curative care visits, even in rural areas, occur at drug shops and private provider offices (who are often public providers during government working hours) rather than in government health facilities. A substantial proportion of reproductive health services and HIV prevention activities also occur through private providers and social marketing.

In urban areas there has been a rapid expansion of private speciality providers and hospitals. The Government of Nepal intends to develop this contribution further (MoHP, 2004). The Three Year Interim Plan states that the role of the government is in stewardship, facilitating, and regulating (NPC, 2007).

III. Public-Private Mix in Inputs

The private sector has started establishing private hospitals, nursing homes, and private clinics in urban areas of Nepal. Since 1991, the private sector has been complementing and supplementing public health care services through facilities, human resources, and expenditures.

3.1 Public and private health care facilities

The private sector has grown quickly in the last fourteen years, leading to many more hospitals. Prior to 1991, there were only two private hospitals in Nepal, but growth proceeded quickly following liberalization; from 1995 to 2008, private hospitals grew from composing 23 percent of total hospitals to 78 percent. Similarly, in 1994 only 47 health-related INGOs were operating in Nepal, but this nearly doubled to 81 in 2008 (AIN, 2008). The number of health-related NGOs was 110 in 1995 (MoHP, 1995), but grew to over 2000 in 2008 (SWC).

Table 1: Number of public and private hospitals

Sector	1995	2008	% Change
Public hospitals	78	96	23.08
Private			
Private hospitals	69	147.0	78.0
NGOs	110	20,000	18081.82
INGOs	47	81	72.34

Source: Hospital Survey, MoHP 2008, Economic survey, MoF 2008.

The Ministry of Health and Population has engaged in public-private partnerships in a number of areas including infectious disease control and to address communicable and non-communicable diseases. The private sector, particularly NGOs, has built service provision centres for TB/HIV-AIDS in many places, particularly in urban areas. VCT centres have also attracted the private sector; in 2008 there were 100 privately-run centres, compared to 68 publicly-run centres. It should be noted, however, that the Government of Nepal has only recently started establishing VCT centres, which explains the smaller number of government facilities.

There are currently 410 public and 31 private DOTS centres in Nepal. As these numbers would suggest, the private sector has been playing mostly a supporting rather than a provider role, so many DOTS centres are getting NGOs support in establishing and operating the centres.

Private sector presence in TB treatment is limited to urban areas. In the Lalitpur Sub-Metropolitan Corporation, for example, about 50 percent of TB patients are managed by the private sector (Newell et al 2004). Patients often prefer private physicians and pharmacies because they have more convenient hours and personal services (Hurtig et al 2002).

Table 2: Public health care services, 2008

Service centre	Public	Private	Total
VCT for HIV/AIDs	68	100	168
DOTS Centres	410	31	441

Source: National Tuberculosis Centre, National Centre for AIDS and STDs 2009

The number of beds at private hospitals is nearly double that of public hospitals. A huge number of beds are located in private medical colleges, which have about 40 percent of total beds, illustrating the dominant role of the private sector in the delivery of curative health services.

Table 3: Hospitals and beds, 2008

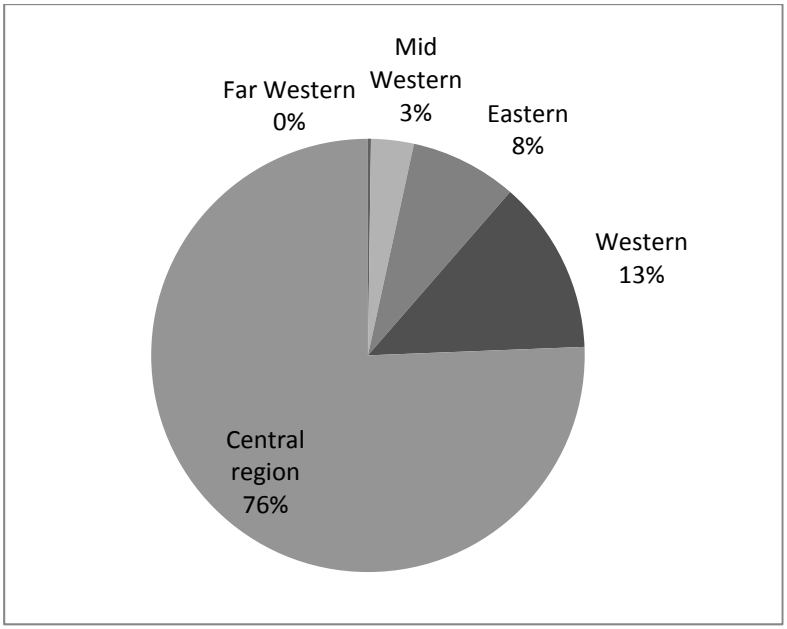
	Public	Private			
	Public hospitals	Private hospitals	Medical college hospitals	Subtotal, private	Total
Number of Hospitals	96	147	15	162	258
Beds	6,944	4,810	7,500	12,310	19,254
Share, in percent					
Hospitals %	42.11	51.32	6.58	57.89	100
Beds%	38.04	26.35	38.95	63.93	100

Source: Private hospital survey, MoHP, 2008, NMC, 2008,

Private hospital beds, however, are unevenly distributed across the development regions. Three quarters of hospital beds are located in the Central region where access is relatively

good, compared to 13 percent in the Western region, 8 percent in the Eastern region, only 3 percent in the Mid-western region, and virtually no private hospitals in the Far Western region. Private hospitals are motivated by profit, so they are mostly located in wealthy and urban areas.

Figure 1: Distribution of hospital beds



3.2 Human resources for health by public and private

Human resources are critical to delivering health care services. In the last 14 years, the number of physicians in the public sector grew by 16 percent, nurses by 7 percent, and paramedics by 1.14 percent while the population grew by 34.6 percent. As demand increased with growing incomes coupled with emerging and re-emerging diseases and disorders, the number of physicians and nurses increased dramatically in the private sector, largely due to the growing number of medical colleges and private hospitals.

There is no recent data on human resources in the private sector, making it difficult to compare to the public sector. We do know, however, there are 8,562 doctors registered with the Nepal Medical Council, including an estimated 2,000 who are currently abroad. Along with those working at public institutions, it is estimated that there are about 8,000 doctors in Nepal. Only 1,041 of them, however, are working for the Ministry of Health and Population; the rest are either self-employed or working in the organized private sector. Thus, in terms of human resources, there appear to be plenty in the market.

Table 4: Trends of HR in the public sector

Category	1995	2008	% Change
Total doctors	894	1,041	16.44
Total nursing, including ANMs	2,761	2,970	7.57
Total paramedic and allied health workers	11,382	11,512	1.14
Public health	228	225	-1.32
Traditional health workers	725	787	8.55
Total	15,990	16,535	3.41
Population	20,028,283	26,966,581	34.64

Source: Ministry of Health, Personal Administration Section

3.3 Expenditure by private and public sources

55.6 percent of all health expenditure comes from private households. About 23.7 percent of total health care expenditure comes from the government, and 20.8 percent from the rest of the world (NNHA, 2009).

Table 5: Sources of funding, 2003/04-2005/06 (in millions of NRs.)

	2003/04		2004/05		2005/06	
Health care Funding Source	Amount	Percent	Amount	Percent	Amount	Percent
General government	5,312.41	17.33	6,535.30	19.83	8,239.20	23.68
Private sector	18,857.05	61.52	19,935.84	60.48	19,332.67	55.56
Rest of the World	6,480.97	21.14	6,488.89	19.69	7,223.76	20.76
Total	30,650.43	100	32,960.03	100	34,795.63	100

Source: Shrestha, BR, Gnawali DP, Subedi GR (2006).

The private sector contributed 56 percent of total expenditure, but private sector providers' spending on health care is estimated to be 67 percent (49 percent from the private sector and 18 percent from NGOs) compared to 31 percent from public sources, meaning that public expenditure is finding its way to the private sector. Private providers, particularly pharmacies, appear to be the biggest provider of health care.

Table 6: Health expenditure by public and private providers 2003/04-2005/06 (in millions of NRs.)

	2003/04		2004/05		2005/06	
Provider	**Amount**	**Percent**	**Amount**	**Percent**	**Amount**	**Percent**
Total spending by public sector	7,534	24.58	8,181	24.82	10,553	30.33
Spending by private sector	16,750	54.65	17,565	53.29	17,124	49.21
Spending by NGOs	5,124	16.72	5,871	17.81	6,365	18.29
Total spending by private sector	21,874	71.37	23,436	71.10	23,489	67.51
Others providers	1,242	4.05	1,343	4.07	754	2.17
Total	**30,650**	**100**	**32,960**	**100**	**34,796**	**100**

Source: Shrestha, BR, Gnawali DP, Subedi GR (2006), MoHP 2009

IV. Public-Private Mix in Health Care Services

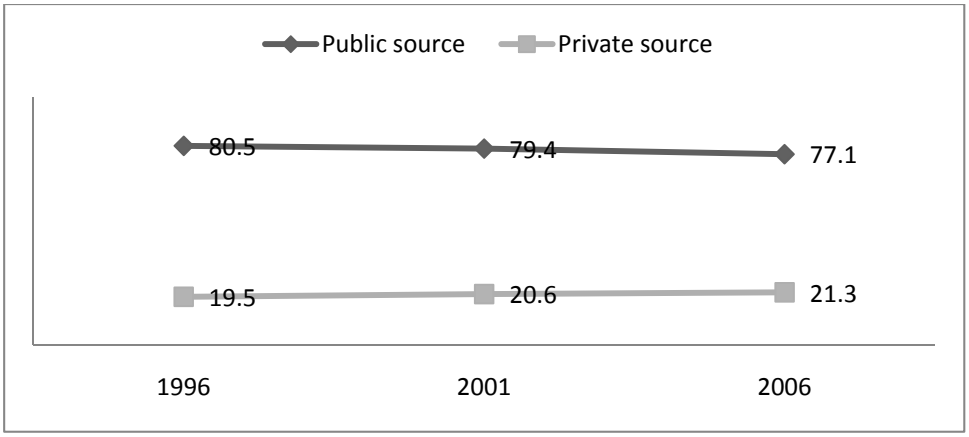
There are a few private providers who deliver public services. With the expansion of the private sector, the government adopted a policy of public service delivery through private providers. Private hospitals also offer family, maternal child health, and disease control services to attract clients.

Reproductive health services such as delivery care, safe abortion care, and gynaecological services are offered by private hospitals. Private hospitals get inputs from the government such as vaccines, contraceptives, drugs, and other medical supplies. Some of the clinics offer care free of charge while others charge a nominal fee for services. Only limited disaggregated data on public-private mix is available.

4.1 Public-private mix in family planning services

Family planning services were initiated by the Family Planning Association Nepal in 1959, and many GOs and NGOs offer family services to satisfy demand. Public-private mix in family planning services showed that the percentage of family planning clients in the public sector decreased from 80.5 percent in 1996 to 77.1 percent in 2006, indicating a gradual fall in demand. In the private sector, on the other hand, demand increased from 19.5 percent in 1996 to 21.3 percent in 2006, indicating an expansion of family planning services in the private sector.

Figure 2: Public-private mix in family planning services



Source: NDHS, 2006,

Table 7 shows that the private sector is expanding their provision of family planning services. The share of the private sector (mostly private pharmacies) in family planning was 8.8 percent in 1996, but grew to 13.8 percent in 2006. NGOs, during the same period, have continued to provide the same share of services.

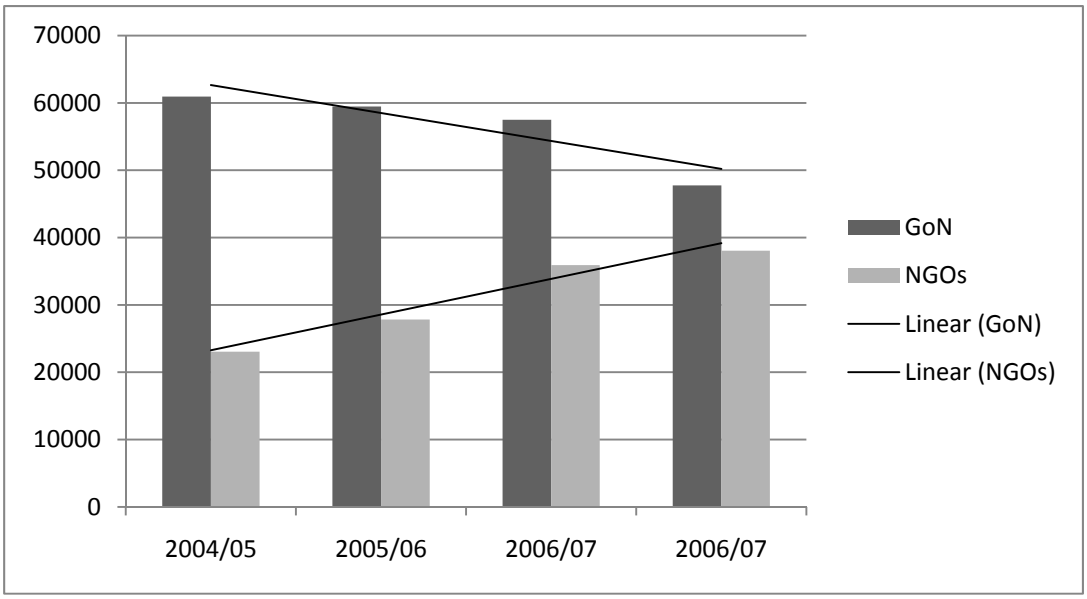
Table 7: Public-private mix in FP services.

Public private mix in FP methods	**1996**	**2001**	**2006**
Public	80.5	79.4	77.1
NGOs	5.3	7.7	6
Private medical sector	8.8	7.3	13.8
Other private friends/relatives	5.4	5.6	1.5
Total of private	19.5	20.6	21.3
Total	**100**	**100**	**98.4**

Source: NDHS, 1996, 2001, and 2006

The private sector has played a considerable role in offering voluntarily surgical contraception (VSC) services. VSC clients at public institutions have fallen to 47,760 in 2006/07 from 60,950 in 2003/04. But in the private sector, clients have increased to 38,060 in 2006/07 from 23,965 in 2003/04. In terms of share, the public sector fell from 72.5 percent in 2003/04 to 55.6 percent in 2006/07 while the private sector increased their share markedly from 27.5 percent in 2003/04 to 44.4 percent in 2006/07.

Figure 3: Public-private mix in VSC services



Source: Family Health Division, DoHS, 2007.

Table 8: Public-private mix in voluntarily surgical contraception

Fiscal year	Public	Private	Total
2003/04	60,950	23,065	84,015
2004/05	59,465	27,833	87,298
2005/06	57,499	35,914	93,413
2006/07	47,760	38,059	85,819
Total	**225,674**	**124,871**	**350,545**
	Share, in percent		
2003/04	72.55	27.45	100
2004/05	68.12	31.88	100
2005/06	61.55	38.45	100
2006/07	55.65	44.35	100

Source: Family Health Division, DoHS, 2007.

4.2 Public-private mix in maternal health care

Maternal health care services are provided by both public and private institutions. The private sector accounted for 4 percent of all deliveries compared to 13 percent in public hospitals. However, private sector performance is underreported by the HMIS, as many private hospitals do not send reports to the HMIS. Still, over 80 percent of deliveries take place in the

home without skilled birth attendants. After the introduction of the Aama programme (a demand-side financing scheme) in 2008, clients now have the option of going to either a public or a private not-for-profit institution.

Table 9: Public-private mix in deliveries

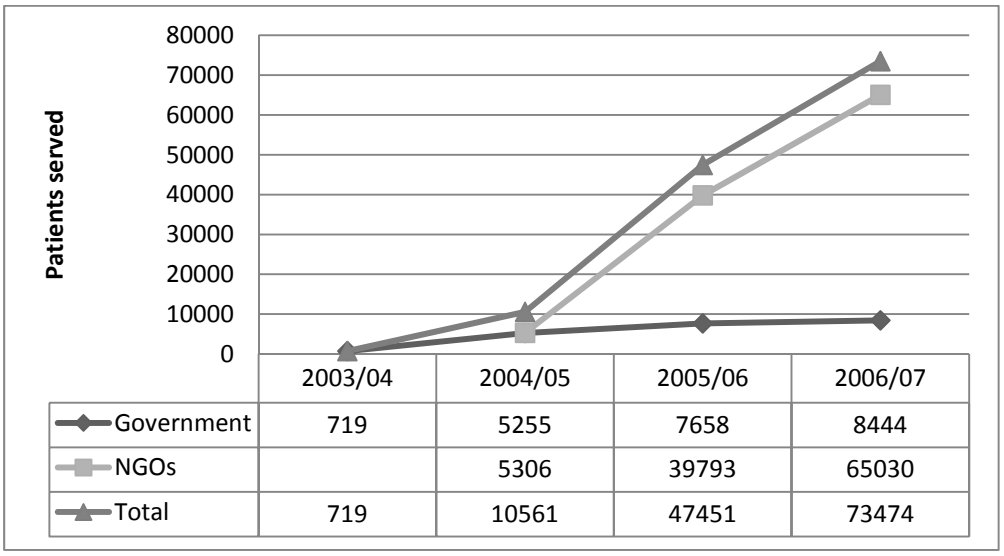
Facility	Percent
Government	13.10
Private	3.8
Home and other	82.3

Source: NDHS, 2006

4.3 Public-private mix in abortion care

Abortions were legalized in 2003, and conditional abortions are performed both in public and private hospitals and clinics. The trend of abortion care in Nepal shows a marked increase in abortion cases in the private sector. There were 89 service centres in the public sector and 78 in the private sector in 2006/07. Fifty-three percent of all service centres belong to the public sector, yet they delivered only 12 percent of the total services. The private sector has 47 percent of all centres, but delivered 88 percent of all services. As of June 2008, CAC services have been offered to 229,583 clients, but no disaggregated information on public and private deliveries is available due to the single reporting system.

Figure 4: Public-private mix in abortion care



4.4 Public-private mix in curative care

The public sector served about 83 percent of all patients while the private sector serviced 17 percent. NGOs and private hospitals served 52 percent of all hospital patients compared to 47

percent by public hospitals. The private sector's numbers are underreported because only 67 percent of NGOs and 54 percent of private hospitals submitted reports to the HMIS; thus, the number of patients served by the private sector would be much higher if adjusted for underreporting. In addition to these, there are about 8,000 private drug retailers who offer services to clients, although this too is not recorded by the HMIS.

Table 10: Public private mix in curative care

Government	Patients served	Private	Patients served	Total patients
Hospitals	2,966,640	INGOs	2,333,809	5,300,449
PHCCs	1,687,396	Private	941,319	2,628,715
HPs	3,320,451			3,320,451
SHPs	8,245,643			8,245,643
Total	16,220,130		3,275,128	19,495,258
Share	83.20		16.80	100

Source, DoHS, 2009-Annual report of 2007/08

References

Association of International NGOs in Nepal (2008). Membership report,

Department of Health services (2009). Annual Report, Department of Health Services, Teku, Kathmandu, Nepal

Hurtig, A.K., Pande, S. B., Baral, S. C., Newell, J. N., Porter J.D.H., Bam, D.S. (2002). Linking private and public sectors in tuberculosis treatment in Kathmandu Valley, Nepal. Health Policy and Planning; 17(1): 78-89. Oxford University Press

Karki D, Mirzoev T, Green A, Newell J, Baral S: Costs of a successful public-private partnership for TB control in an urban setting in Nepal. BMC Public Health 2007, 7:84.

Ministry of Finance (2008). Economic survey, Singha Darbar, Kathmandu, Nepal

Ministry of Health (1991). National Health Policy, Ministry of Health

Ministry of Health(1995). Health Information Bulletin, Ramshapatha Kathmandu Nepal

Ministry of Health(2004). Nepal Health Sector Programme Implementation Plan 2004-2009. Ministry of Health, Kathmandu, Nepal

Ministry of Health (2008). Hospital Survey, Ramshapatha Kathmandu Nepal

National Planning Commission (NPC) (2007). The Three Year-Interim Plan, National Planning Commission Secretariat, Kathmandu, Nepal

Nepal Medical Council (2008). Unpublished report – registration of doctors.

Newell, J. N., Pande, S. B., Baral, S. C., Bam, D.S., Malla, Pushpa (2004) Control of tuberculosis in an urban setting in Nepal: public-private partnership. Bull World Health Organ. 2004 February; 82(2): 92–98.

Rana, SJB and Pradhan, SM(2005), Implementation evaluation of Foreign Direct Investment. Paper prepared for Economic Policy Network His Majesty's Government of Nepal/ Ministry of Finance

Shrestha, BR, Gnawali DP, Subedi GR (2006). Nepal National Health Accounts, (Second Round) 2003/04 – 2005/06, GoN/ Ministry of Health and Population, Kathmandu.

Singha Durbar, Kathmandu, Nepal, Confederation of Nepalese Industries (CNI) 303 Bagmati Chambers, Teku, Kathmandu, Nepal

Health Sector Reform Support Programme
Ministry of Health and Population

P.O. Box: 8975 EPC 535
Kathmandu, Nepal
Phone: +977 1 4266180
Fax: +977 1 4266184
URL: www.hsrsp.org