Government of Nepal
Ministry of Health and Population

POLICY BRIEF

Hand-in-hand in healthcare

Effective management of partnerships in the health sector can be a mechanism to foster equitable, affordable and quality health service delivery

The growing private sector

The private sector has been staking out a bigger foothold in the health sector in Nepal in recent decades, notably following the promulgation of the National Health Policy in 1991. Indeed, private hospitals, diagnostic centres and pharmaceutical manufacturers have mushroomed in the country in the years since. Of the total 7,403 formal health facilities nationwide, 30 per cent (2,081) are privately-owned. Of these 2,081 facilities, approximately 75 per cent deliver basic healthcare services while 65 per cent offer diagnostic services like X-ray or ultrasound imaging.

With the influx of private healthcare providers, an increasing number of Nepalis have now come to depend on these facilities. And expectations have so risen that people's trust in public health institutions has taken a beating. As per a household survey conducted in 2011, 63 per cent of consultations for acute illnesses were made at private health facilities, in contrast to 55.7 percent in 2004 (CBS, 2011). And curative services apart, the private sector's presence in preventive care, such as immunization, is also on the rise of late.

But the distribution of these facilities is anything but even. The sheer disparity in availability of private health services between provinces is illustrated in the figure below:

Private health facilities are concentrated mainly in urban areas; around 62 per cent of these institutions are based in metropolitan and sub-metropolitan cities, with the remainder stretched thinly across the rest of the country. Further disaggregation of that figure shows that over 30 per cent is based inside the Kathmandu Valley alone.

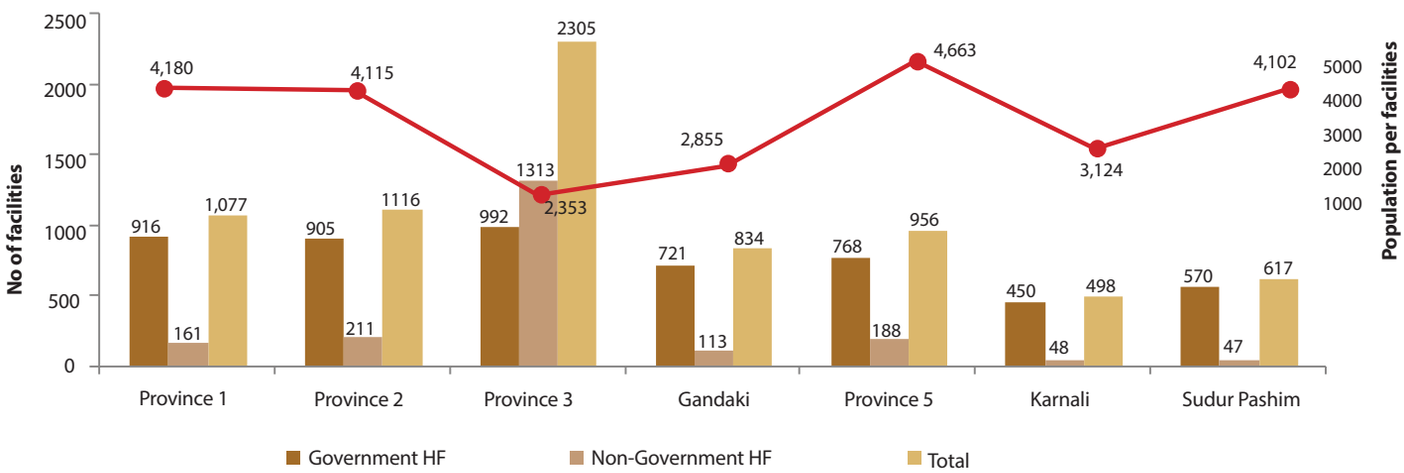
There is also a visible wealth gap when it comes to access to these facilities, frequented as they are for the most part by more affluent urbanites. For poorer sections of society, consultations and treatment at private institutions can have a major impact on out-of-pocket expenditure. Still, the burdens of the costs associated with such facilities has not stemmed the flow of patients. The most recent data shows that 12,046 ultra-poor people sought services from private health institutions. It is clear that if the government is to achieve its overarching goal of universal health care, private health service providers must be made more accessible to wider swathes of the public. There is now more than enough evidence to show that the partnerships modality might be the best option in this regard.

Existing forms of partnership

The Government of Nepal defines partnerships as "a contractual agreement between a public and private entity to the delivery of infrastructure or services in the public interest where the public partner focuses principally on the output and allows the private partner to determine the input in which a substantial transfer of appropriate risk takes place to the private party, where the private party or parties have investments at risk, although capital investment may not be required in all partnerships, where better value for money can be demonstrated than traditional public provision." (GoN, 2011)

It was the realization that government facilities by themselves would be woefully inadequate in fulfilling healthcare requirements of the country that many government policies had advocated for wider engagement with private entities. The National Health Policy 2014 and the Nepal Health Sector Strategy (2016 – 2021), for instance, both recommend more partnerships in healthcare, among other interventions. A more recent legislation – the Public Health Service Act 2018 – has also seen fit to give authority to all three levels of government to forge partnerships for healthcare with private or non-governmental institutions.

With private health facilities now being classified into commercial health service providers (for-profits) and non-commercial health service providers (not-for-profits), different forms of partner-ships have already come into play. Some partnerships are guided by a Memorandum of Under-standing (MoU) or contractual documents signed between partner institutions. In other cases, partnership arrangements are based on mutual understanding. The usual



Source: Data analysed from Health Facility Registry, MoHP, 2018.

modalities range from MoHP purchasing services (Institutional delivery and treatment package for impoverished citizens among others) and social franchising (immunisation services, DoTs provided by private facilities and distribution of FP commodities) to partnership between government entities (health camps by army hospitals and sajha pharmacy in public hospitals) and Non-government sector handing over institution to the government (Sushil Koirala Cancer Hospital) among others. Others such provisions include grants to NGOs/institutions to ensuring that 10 percent of the hospital's beds are allotted for poor people.

In majority of these partnerships, the Ministry of Health and Population (MoHP) comprises the primary governmental partner. As such, it is responsible for leasing land and buildings to the other partners, who are tasked with the day-to-day management, maintenance of physical structures and service delivery. When the contract period ends, the structure is returned to the government. As for the equipment, it depends on whether it was owned by the government or the partners to begin with. It is, however, not always clear how agreements are reached in this regard.

Financing mechanisms can vary across partnerships, and are usually either performance-based grants or tax subsidies. In some cases, the government acts as a facilitator to enable non-state partners to navigate the necessary financial procedures. And in most partnership modalities, partners are also obliged to report to the government on a quarterly basis, which is then used to evaluate the performance-based grant agreement (PBGA).

In the changed context, the management of partnerships falls under both the Policy, Planning and Monitoring Division (PPMD) and Health Coordination Division of MoHP. While the overall monitoring function lies with the PPMD, the HCD is responsible for international, inter-sectoral and inter-agency coordination as well as the Provincial and Local level coordination. Therefore, there is a need to clarify the roles of these division in order to effectively and efficiently manage the partnerships in the health sector and to provide consistence guidance to provincial and local government. What's more, the practice of formally documenting lessons learned from past contracts is also very much lacking in Nepal.

Additionally, when discussing the present state of healthcare in Nepal, one cannot omit consideration of the impact that the country's recent transition to federalism has had on the health sector, particularly at the local and provincial levels. Health facilities with upto 15 beds have been handed over to local governments, for instance, while those with 16 to 50 beds have been en-trusted to their provincial counterparts. Local governments now also have the authority to register and regulate private institutions, including clinics and polyclinics.

Amidst the growing concern about the capacity of these local and provincial governments, it is imperative that we strengthen their capacity to monitor and ensure the quality of health facilities, including that of private-sector providers.

Risk management is another area of concern, where the inherent risks or uncertainties related to financial resources and revenues can discourage the private sector from engaging with the public sector. Further exacerbating the risks are misunderstandings and lack of mutual confidence and trust between the two sides.

Partnerships re-envisioned

Bringing the private sector on board is vital in the effort to establish universal access to healthcare the country, particularly considering the resource constraints faced by the public sector. To foster and manage such partnerships more effectively:

- The government should increasingly reach out and engage with entities in the private sphere to explore possibilities of private-sector contribution in the priority areas of the health sector.
- Partnership modalities should be immediately standardized, with a basic format and approach developed to make it easy to monitor and evaluate partnerships down the line. This will also be a guide to Provincial and Local Government in managing partnerships.
- Appropriate mechanisms for the financing arraignment should also be defined for different types of partnership - such as output based payment versus salary and capitation for individual service providers and lump sum grants linked to certain performance indicators.
- More focus should be placed on introducing mechanisms to manage and minimize risks as well as building capacity among all partners to implement these.
- Proper guidelines must be established on partnership modalities, setting out key terms and conditions for partnerships, such as shared responsibility and risk, mutual accountability, exit plans and sustainability of the partnership. Similarly, rationale for partnerships should be defined, including the need to maximize resources, along with expanding services to the targeted population.

It is a positive sign that the existing policy in the health sector already focuses strongly on partnerships for service provision. It builds on Nepal's existing successful utilization of partnership models and also incorporates essential information focusing on the different spheres of government that previously have not all had the opportunity or mandate to develop partnerships. This guideline must be further strengthened going forward, by not only taking into account emerging evidence but also engaging closely with the private sector.

Managing partnerships: Opportunities and Challenges

At a time when there is a rapid growth of the private sector, partnership can be an effective approach to ensure equitable, affordable and quality health service delivery around the country. Yet, it is important to remember that these partnerships are sometime fraught with challenges – some universal, others more specific to local contexts – all of which call for immediate action.

A key challenge here is not knowing where to go for partnership. For instance, there should be identified priority areas, obviously with equity and quality being at the forefront, especially where the expertise and resources of the government is limited or lacking. Needless to say, collaboration with private sector is already happening in various areas while there remains scope for partnership in many other emerging priority areas such as specialized care, rehabilitation and palliative care, healthcare technology and healthcare waste management.

Another major challenge is the lack of consistency in MoUs. There is no standardized format or agreement model, leading to difficulties in the monitoring and evaluation of partnerships.

Similarly, there is no institution dedicated solely to managing partnerships. This has also rendered coordination and collaborations between donors and partners, and province and local-level authorities difficult and oftentimes ineffective.

Another challenge lies in incentivizing the private sector to focus on rural areas where healthcare needs are highest. Other hurdles include delays in payment, over-reliance on external funding and philanthropic donations, inability to motivate the private sector to taken an interest in government programmes, and finally, poor reporting by the private sector.