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USAID/Nepal Health Private Sector Engagement Assessment

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TABLE OF CONTENTS

Executive Summary 6

1. Introduction 11

1.1 Purpose of PSLA 11

1.2 Zeroing in on USAID Priorities 12

1.3 Methodology 12

1.4 Organization of the Report 13

1.5 Limitations 14

2. PSE Framework for the Health Sector 14

3. Key Findings 15

3.1 Nepal's Health Sector Landscape 15

3.2 Enabling Environment 16

3.2.1 Strengths in the Enabling Environment that Supports PSE 16

3.2.2 Weaknesses in the Enabling Environment 19

3.2.3 Opportunities to Strengthen the Enabling Environment 21

3.3 Private Sector Health Services 22

3.3.1 Overview of the Provision of Health Services 22

3.3.2 Strengths in Private Health Services 25

3.3.3 Weaknesses in Private Health Services 26

3.3.4 Opportunities to Leverage Private Health Services 28

3.4 Health Products 29

3.4.1 Overview of Private Pharmaceutical Products ("Pharma") 29

3.4.2 Strengths in Private Pharma 30

3.4.3 Weaknesses in Private Pharma 31

3.4.4 Opportunities to Leverage Private Pharma 31

3.5 Health Financing 32

3.5.1 Overview of Health Financing 32

3.5.2 Strengths in Health Financing 34

3.5.3 Weaknesses in Health Financing 35

3.5.4 Opportunities to Improve Health Financing 37

3.6 Other Health PSE Opportunities 38
4. Recommendations 39
4.1 Strategies and Interventions 39
Figure 11. Strategic areas to strengthen the Nepalese health system through PSE 40
4.2 Phasing of Strategies and Interventions 41
5. Conclusion 42
Table 13. Strategic Recommendations Road Map 43
Table 14. How USAID can Improve Health through PSE 45

ACRONYMS

ANC	Ante Natal Care
Aama	Aama Surakshya Karayakram
ANM	Auxiliary Nurse Midwife
BAA	Broad Agency Announcement
BCC	Behavior change communication
CIAA	Commission for the Investigation of Abuse of Authority
CMA	Community Medicine Auxiliary
CTP	USAID's Center for Transformational Partnerships
CRS	Corporate social responsibility
DDA	Department of Drug Administration
FP	Family planning
GMP	Good manufacturing practices
GoN	Government of Nepal
HA	Health Assistant
HRH	Human resources in health
HTI	Health training institute
ICT	Information communication technology
ISO	International Organization for Standardization
LMIC	Low and middle income country
MCH	Maternal and child health
MBBS	Bachelor of Medical Science degree
MOU	Memorandum of understanding
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health and Population
MDAG	Most-disadvantaged group
NHA	National Health Account
NHI	National health insurance

NHSP	National Health Strategic Plan III
NPR	Nepalese Rupee
NGO	Nongovernmental organization
ORS	Oral rehydration salts
PFP	Private for-profit
PHC	Primary healthcare
PMC	Private medical college
PNFP	Private not-for-profit
PPP	Public-private partnership
PSE	Private sector engagement
PSLA	Private sector landscape analysis
PSP	Partnership Services Program
QA	Quality assurance
RMCH	Reproductive, maternal, newborn, and child health
SHI	Social health insurance
SHOPS	USAID's Strengthening Health Outcomes Through Private Sector project
SHSDC	Social Health Security Development Committee
SOW	Scope of work
SWAP	Nepal Health Sector Programme (maintained by external development partners)
SWOT	Strengths, weaknesses, opportunities, and threats
SGDs	Sustainable Development Goals
TA	Technical assistance
THE	Total health expenditure
TPA	Third party administrator
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Purpose

At the request of USAID/Nepal, USAID's Center for Transformational Partnerships (CTP) and Partnership Services Program (PSP) conducted a Private Sector Landscape Assessment (PSLA) that examines the current and potential role of the private sector in Nepal's health sector. The PSLA explores the Mission's options to engage, partner with, and/or advocate on behalf of the private sector to achieve priority health objectives by expanding access and improving the quality of health service delivery, especially to vulnerable and traditionally disadvantaged groups.

The PSLA analyzes 1) the current role of the private sector in delivering health products, services, and financing and 2) the relationship between for-profit healthcare businesses and the policymakers and regulators responsible for overseeing the health sector. It recommends models and approaches – either through current projects or new activities – that use private sector engagement (PSE) to enhance the outcomes of USAID's health programming.[1] Given the Mission's limited engagement of the private sector to-date, the PSLA explored the potential for partnership across a wide array of organizations and industry segments.

Methodology

The assessment team ("the Team") used different methods to collect and analyze information about the private health sector and PSE activities of the Government of Nepal (GoN) and donor community. These methods include a literature review, field interviews with key private and public sector stakeholders, and focus group discussions with USAID's implementing and development partners. The Team developed interview guides, partly based on the assessment guides from the USAID SHOPS project[2]. During the two-week PSLA, the Team interviewed 49 Nepalese stakeholders (see Appendix L) across a range of functions in the health sector: policy, regulation, health services, medical education, pharma manufacturing, distribution and warehousing, retail, technology, and pharmacy. The Team constructed a framework through which it organized and interpreted the data (see Figure A) that looks at the four primary components of the sector: Enabling Environment, Health Services, Health Products, and Health Financing. Using this framework, the Team mapped the private sector's role in Nepal's health sector. It then used a modified Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis to highlight areas of interest for USAID/Nepal as it considers various PSE approaches that leverage the resources of the private sector to enhance the impact of Mission programming.

Figure A

Key Findings

Most commercial enterprises tend to concentrate in areas that do not easily correspond to USAID/Nepal's primary health objectives (i.e. high income groups who live in the Kathmandu Valley), while nonprofit and informal providers (e.g. unlicensed providers, traditional healers) traditionally work with USAID's target beneficiary populations. ***But there is strong and growing interest in the for-profit health sector to work with donors such as USAID***. The Team met with insurers, healthcare providers, and pharmaceutical companies, many of which want to collaborate with USAID because they understand its role as advocate, convener, market shaper, and funder.

[1] For the PSLA, the private health sector includes nonprofit and for-profit organizations but "private sector engagement" refers to engagement of the latter.

[2] Strengthening Health Outcomes through the Private Sector (SHOPS: http://www.shopsproject.org/about/what/assessments)

The for-profit health sector has experienced rapid growth in the last decade as Nepal becomes a more viable market for commercial health enterprises. Due to population growth, rising incomes, and higher incidence of non-communicable diseases, demand for private health services has increased and local companies are investing in new health infrastructure, medical equipment, human capacity/skills building, and technology improvements.

Enabling Environment

Despite GoN aims to achieve the Sustainable Development Goals (SDGs) by using PSE to improve public health coverage, quality, and outcomes, the Ministry of Health (MoH) acts as a service provider – as opposed to steward of public funds – in competition with the private sector. This complicates the potential for public-private collaboration, even as PSE champions from both public and private sectors build a track record of 'soft' service delivery public-private partnerships with nonprofits and faith-based organizations.

The MoH lacks sufficiently trained staff and modern, standardized systems that reflect best practices to effectively regulate the private sector. This has led to an unregulated/unevenly regulated private health sector in which companies complain of the unsophisticated, unstructured, and uneven ways in which the GoN sets the rules of engagement and holds actors accountable to provide affordable, high quality health care. The MoH has not invested enough in physical/clinical standards, accreditation, and dissemination of quality norms or protocols, nor does it have an adequate legal framework and institutional structure to supervise, monitor, or regulate private healthcare providers. While the MoH has made several attempts to ensure the quality of private health services, some accuse these efforts as politically-driven. This fuels consumer mistrust of private providers, which resort to personal relationships to navigate a poorly regulated and non-transparent system.

Little to no dialogue between public and private sectors has led to significant levels of distrust and unwillingness to collaborate, impeding attempts to modernize and reform the regulatory environment. The MoH does not consistently involve private sector stakeholders in discussions regarding policies and regulations that govern the sector; it interacts with mostly nonprofits in policy and planning conversations. Moreover, the few professional associations that represent commercial interests are seen as highly political entities that advance individual – not sector – interests.

The Team sees opportunities to improve the enabling environment for PSE, potentially through the Mission's upcoming Health Systems Strengthening project. These include: 1) build the MoH's capacity to effectively dialogue with the private sector; 2) help private health sector representative organizations participate in policy discussions; 3) support a public-private dialogue between the MoH and private health sector to address sector-wide issues; 4) strengthen the MoH's capacity to regulate the private sector; and 5) help the MoH build systems and capacity to partner with the private sector.

Health Services

Private healthcare providers deliver the best and worst of quality of care (QOC). The MoH struggles to effectively regulate the health sector, which has led to a proliferation of health enterprises that provide QOC ranging from world-class curative care facilities and medical colleges to community pharmacies suffering from poor quality and counterfeit medicines, inconsistent and inappropriate management/disposal of products and medical waste, and substandard physical environment and storage practices. Finally, many interviewees complained that private care, while always more expensive than public care, is not always better but there is no way to judge quality or assess a reasonable cost for services.

Community pharmacies, located throughout the country, extend basic healthcare services to rural and remote populations, oftentimes serving as the first point-of-contact for

mothers in rural districts seeking MCH care. The Sangini Network is an example of using community pharmacies to deliver family and reproductive health outside of Kathmandu. ***But working with community pharmacies, however successful in other countries, is a problematic option due to the political sensitivity of working with illegal health cadres who lack legal authority to dispense medicines independently***. Many 'rent' the license of registered pharmacists (who never visit the locations) or ignore the rules, leading to the proliferation of illegally-operated community pharmacies. There is strong MoH, DDA, and pharmacist opposition to resolve this issue.

Several private medical colleges (PMCs) are 'adopting' MoH district hospitals and clinics located in remote and rural areas in what many call 'win-win' partnerships. Interviewed PMCs expressed interest in expanding services to vulnerable populations in rural areas through partnerships that introduce health and quality management systems and update/refurbish MoH facilities in exchange for residency programs for students. Some nonprofits (e.g. Possible Health) also partner with PMCs such as Bir Hospital and Kathmandu University to offer rotation programs for General Medicine residents.

There are limited PSE opportunities with commercial healthcare providers without stronger incentives that attract these entities to focus on new populations in new locations. These incentives, many times provided by the host government and its Ministry of Health, include provider payments, social health insurance, subsidies, service contracts, and tax breaks. Without these incentives from the MoH, plus effective and reliable regulation, the private sector has little incentive to expand beyond what it already knows and does to regions and populations of interest to USAID.

Nonetheless, commercial providers are interested in partnering with the MoH to deliver services and the Team advocates increased public-private dialogue to discuss their role in addressing Nepal's health priorities, potentially through policies and/or programs that incentivize or mandate hospital adoption and service provision in rural areas.

Health Products

Given the high level of organization and strong public-private dialogue, the future for collaboration in pharma manufacturing is bright. The GoN has improved the regulatory environment as more transparent and standardized public procurement processes have "*leveled the playing field*" between Indian and domestic manufacturers. The GoN also committed to working with the private sector to improve the overall supply of pharmaceuticals, other health consumables, and new technologies. In response, local production facilities are up-to-date and Good Manufacturing Practice-certified, which has led public and private health providers to recognize the quality of locally-manufactured medicines and prescribe them over brand and imported medicines.

The USAID partnership with Lomus has been a success in Nepal and other developing countries. USAID incentivized and supported Lomus to carry out the R&D to develop chlorhexidine and purchase the equipment needed to manufacture and distribute it. Its funding helped Lomus market chlorhexidine domestically and internationally and the company is now one of the largest pharma manufacturers in Nepal. Lomus and other leading importers and distributors now reach all 75 districts in Nepal, which is an accomplishment given the country's topography. USAID-supported Contraceptive Retail Sales (CRS) uses these same distribution networks, which many call effective but not efficient.

Despite the industry's promising growth, domestic drug manufacturing and distribution face considerable market challenges. The Nepalese market is small, preventing individual companies from reaching economies of scale and limiting their resource base to invest in research and development, quality assurance systems, and additional training. The drug supply chain has many weaknesses, with drugs being stored in unsanitary conditions in private warehouses, shipped on public transport without proper

storage, sold after the expiration date, and improperly disposed. The porous Indian border poses challenges, with large quantities of Indian drugs entering without satisfactory guarantee of quality or authenticity. The MoH Drug Act controls drug prices but in practice they are set by manufacturers and wholesalers. Without strong regulation and enforcement of policies, it is difficult to differentiate between products and firms cut costs, compromise quality, and reduce margins to compete on price alone, leading to a "race to the bottom". Interviewees question the efficacy of the Department of Drug Administration's (DDA) efforts to regulate the industry but the agency is currently updating and modernizing its policies and regulations to reflect best practices. It also expects a substantial increase in budget to cover the cost of testing drugs, supervising manufacturers, and carrying out quality assurance and pharmacovigilance.

Pharmaceutical manufacturing and distribution are natural points of entry for PSE given the high level of private sector participation. While Nepal's pharma industry presents fewer PSE opportunities than other countries, the Team sees the value of continued support of CRS' sustainability efforts while considering other distribution models that grow the market and force CRS to improve its practices. The Mission may also use its upcoming Health System Strengthening project to help the DDA strengthen the policy and regulatory environment, particularly in the areas of pharma distribution and training.

Health Financing

While Nepal's total health expenditure (THE) has grown substantially in the last decade, the primary source of funding comes from out-of-pocket expenses, which can put financial strain on vulnerable populations. Increased consumer spending represents a significant opportunity for private health enterprises but attractive market segments are in urban areas. GoN and donor funding account for the rest of THE but Nepal spends less on health per capita than others in the region.

Subsidized social health insurance (SHI) is the most effective pooling mechanism to increase access to health services for the poor. Interviewees claim that the GoN is committed to equitable financing of health and supports the MoH in its efforts to roll out a SHI program and pass the National Health Insurance Act (which contains a subsidy program). Unfortunately, the MoH launched a SHI pilot before the Act was approved, which complicates implementation as the technical group set up to manage the project does not have strong insurance or private sector experience.

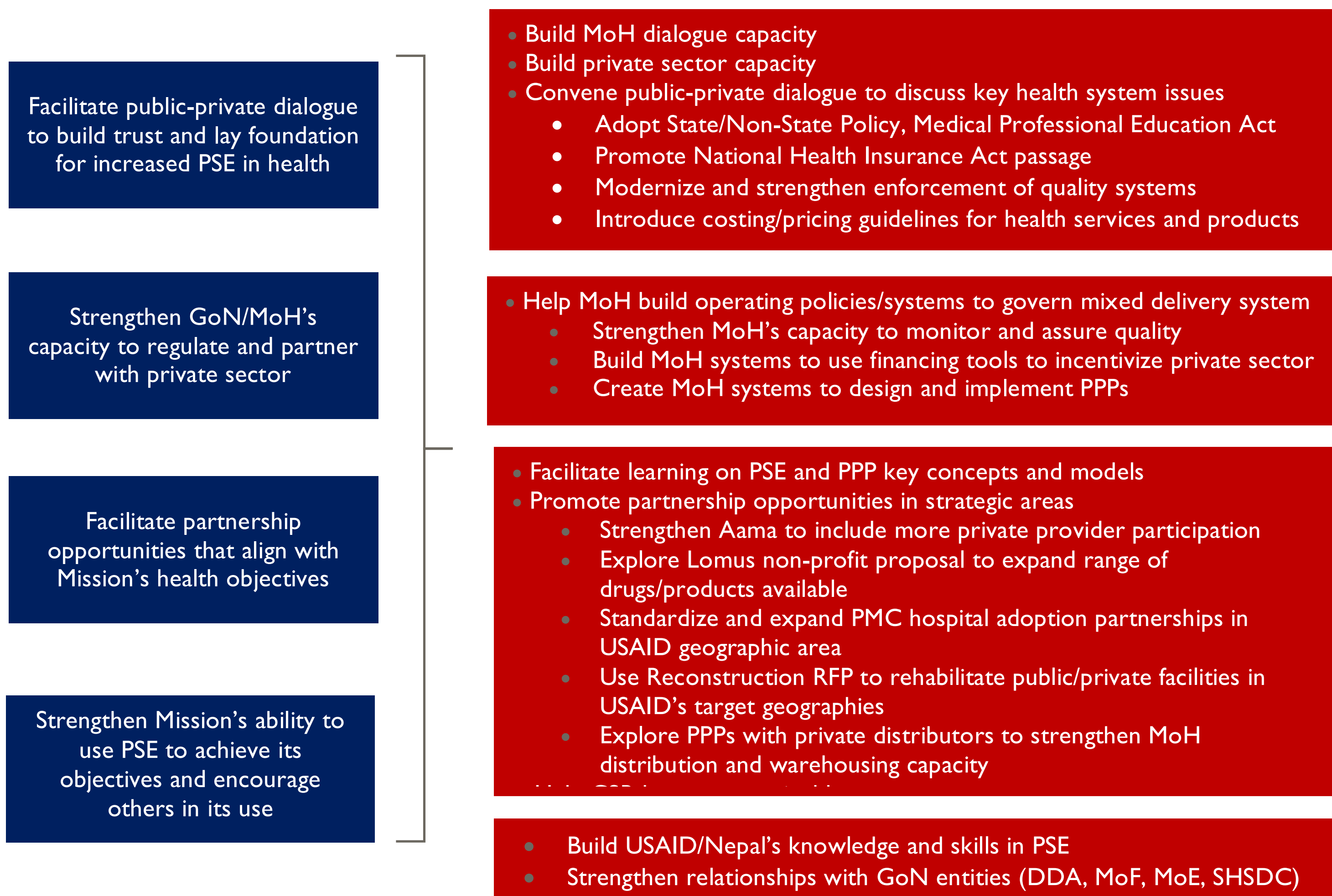
The MoH recognizes the benefits of contracting with private providers to deliver health services (e.g. improved operations and quality of care, reduced costs, enhanced capacity, increased volume) and commercial enterprises want to join their nonprofit peers in working with the MoH in the areas of specialty services and diagnostics. But most partnership arrangements (e.g. MOUs) are informal, ad hoc, and based on personal relationships; much work remains to use contracts as engagement mechanisms. MoH leadership note limited staff expertise, systems, and regulations to effectively contract with private actors and ensure quality under existing contracting mechanisms. There are policy initiatives underway that would address MoH system gaps in contracting and accelerate the use partnership to achieve priority health objectives.

A public-private dialogue can serve as the platform to promote health financing reforms (e.g. building support for the National Health Insurance Act, supporting MoH investment in its capacity to carry out strategic purchasing) to build momentum around restructuring the incentive structures to attract more commercial providers into new areas and regions.

PSE Opportunities and Recommendations

Throughout the PSLA, the Team considered the full range of roles that USAID plays when engaging, partnering with, or advocating on behalf of the private sector. Table 11 (page 45) provides an overview of how USAID engages private actors, along with illustrative examples of models used elsewhere that may work in Nepal. For instance, due to the central role that the MoH plays as a healthcare provider, the PSLA highlights

opportunities for USAID/Nepal to advocate policy adjustments and public procurement mechanisms that advance health objectives through more effective health financing. Likewise, the PSLA sees opportunities for USAID to convene public and private health stakeholders to foster improved relationships and combat distrust. After analyzing these PSE opportunities, the Team recommends four strategies and action steps that integrate PSE into how USAID/Nepal achieves its health and Mission-wide objectives. Please note that these recommendations, unless otherwise indicated, are to be carried out by a USAID implementing partner.



Conclusion

While the PSLA uncovered options for USAID to act as a convener, advocate, market shaper, and funder to advance its objectives, it found few opportunities that quickly or easily translate to reproductive, maternal, newborn and child health (RMNCH) and family planning (FP) objectives. Most companies lack the incentives to provide targeted support to vulnerable groups, especially ones in rural areas. This makes PSE an important model to complement future activities but not necessarily the principal approach to do so. Thus, USAID's continued support of public and civil society institutions remains critical. Both sectors play important roles in improving health outcomes across the country, especially as the Mission builds the bridge between Nepal's public and private sectors. Doing so will demonstrate to other donors that engagement of both private and public sectors may build the incentives, expectations, and accountability that unlock the commercial private sector's development potential. This report serves as a starting point as USAID/Nepal develops a broader approach to achieving its health objectives through PSE and the Team expects the Mission will continue to develop these ideas in order to shape recommendations into concrete action plans.

1. Introduction

Building on its 65-year history of development cooperation in Nepal, USAID/Nepal actively works with public and private institutions throughout the country to foster a more democratic, prosperous, and resilient society. As part of its efforts to support Nepal's prosperity between 2014 and 2018, the Mission aims to improve individual health outcomes by improving the quality of health services, increasing use of and access to health services, and increasing adoption of healthy behaviors, particularly among marginalized groups. Historically, much of USAID/Nepal's work in the health sector has been oriented towards improving the capacity, reach, and effectiveness of the public sector to achieve health objectives.

In recent years, however, Nepalese across the socio-economic spectrum have turned to the private sector in greater numbers for health products and services. Researchers have attributed this to a number of factors, such as growing populations of both trained healthcare professionals and patients, increased disposable income and remittance flows, increased prevalence of non-communicable diseases, growing urbanization, and changing perceptions of quality and access to healthcare.[3] Given these trends, USAID/Nepal seeks to explore new ways to improve health outcomes by leveraging the unique assets and capabilities of the private health sector to complement those of the Government of Nepal (GoN) and other development partners.

1.1 Purpose of PSLA

To identify opportunities to work with the private sector to achieve USAID's health objectives, USAID/Nepal, USAID's Center for Transformational Partnerships (CTP), USAID/Global Health, and CTP's Partnership Services Program (PSP) organized a private sector landscape assessment (PSLA) of Nepal's health sector. This PSLA involved a preliminary review of USAID's options for engaging, partnering with, and/or advocating on behalf of the private sector to improve health outcomes in Nepal. The assessment team ("the Team") worked towards this objective by following several interrelated lines of inquiry that explore the strengths, weaknesses, and interests of the private sector, as well as possible private sector engagement (PSE) models that expand access to and improve the quality of health service delivery, especially for traditionally marginalized and disadvantaged groups (MDAGs). Finally, the PSLA examined these lines of inquiry to produce a set of recommendations for USAID/Nepal as it considers a more strategic use of PSE to achieve public health objectives. The Lines of Inquiry presented in Appendix A addresses these questions directly.

Box 1. Focus on For-profit/Commercial Healthcare Businesses

Nepal's private health sector encompasses those organizations not managed by the GoN or a foreign government. The PSLA differentiates between private for-profit organizations (PFP) and private not-for-profit organizations (PNFP) to reinforce the idea that the private sector contains a wide variety of entities. But given the PSLA's objectives, the Team focused primarily on for-profit healthcare businesses to identify PSE opportunities. Unless specified (e.g. nonprofit, NGO, faith-based), 'private' refers to for-profit and/or commercial healthcare businesses. Nevertheless, the Team met with various commercial and non-commercial healthcare providers, civil society, and public sector representatives to ensure a well-rounded vision for improving the health sector.

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[3] Torres, Luis V and Gahn Shyam Guatam and Franzisak Fuerst and Chandra Mani Adhikari. Assessment of the Government Health Financing System in Nepal: Suggestions for Reform. GIZ: November, 2011. Kathmandu.

1.2 Zeroing in on USAID Priorities

The PSLA balanced the need to understand the broad state of the private health sector in Nepal against the specific geographic and technical focus areas of USAID/Nepal. Indeed, most interviewees note that private actors want to expand operations and serve unmet healthcare needs but their activities do not mirror USAID's goals, as most firms are clustered in the Kathmandu Valley. Moreover, private services are predominantly curative whereas USAID/Nepal focuses on health outreach, prevention, and primary healthcare. To design actionable recommendations, the Team thus focused on PSE opportunities through the lenses of Maternal and Child Health (MCH), Family Planning/Reproductive Health (FP/RH), Neonatal Care, and HIV/AIDS prevention and treatment. It also examined the private sector's ability and appetite to extend services to MDAGs such as women, youth, and inhabitants of rural areas.

Figure 1. Lenses for PSLA analysis

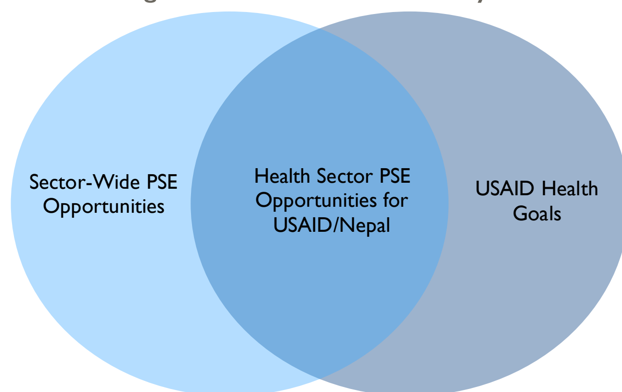


Figure 1 shows how these lenses help identify actionable PSE opportunities. The Team found that many PSE opportunities do not correspond to USAID's health objectives in MCH, family planning, neonatal care, and HIV/AIDS. Therefore, the PSLA highlights areas in which the interests of the private sector and USAID align to create 'shared value' partnerships that incentivize private sector actors to contribute to development goals and social good because they make 'business sense', thereby resulting in more sustainable outcomes.

1.3 Methodology

The PSLA consisted of various stages, such as design and planning, preliminary analysis, field-based stakeholder interviews, and final analysis and report writing, as described below.

PSLA design: In April 2016, USAID/Nepal, CTP, PSP (implemented by SSG Advisors) finalized the scope of work (SOW) and began scheduling stakeholder interviews and field visits (see Appendix L).

- **Stakeholder mapping**: USAID/Nepal's Health Team shared an initial list of interviewees with the Team in June 2016. The Team added 1) a range of service providers and facility operators (e.g. for-profit, nonprofit and faith-based hospitals and clinics, for-profit pharmacies, labs and diagnostic centers, and individual providers with private practices); 2) actors along the pharmaceutical supply chain (e.g. manufacturers, medical devise suppliers, distributors, and retail pharmacies); and, 3) health system enablers (e.g. health insurance companies, private medical colleges, and ICT firms).
- **Preliminary analysis**: In addition to resources provided by USAID/Nepal's Health Team, the Team consulted USAID's Development Exchange Clearinghouse and other databases (e.g. Nepal Demographic Health Survey, National Health Accounts, World Bank Development Indicators). The Team also conducted a literature review of articles that describe Nepal's health system, health priorities, and private health sector. Finally, the Team collected relevant health policy and planning documents from Nepal's Ministry of Health (MoH) website. A complete repository of background resources is outlined in Appendix L.
- **Private sector engagement framework**: To guide the desk research, the Team developed a framework by which to organize its preliminary findings and to shape the stakeholder interview guides. The PSE framework is discussed in greater detail in Section 2.

- **Stakeholder interviews guides**: The Team consulted and modified interview guides in the USAID SHOPs Plus Assessment to Action toolkit for use during the PSLA.[4]

Field-Based PSLA: The Team supplemented the desk review with one-on-one stakeholder interviews, round table discussions, and field visits to Accham and Dolokha. Mission staff actively participated in the stakeholder interviews and field visits.

- **Stakeholder interviews**: The Team traveled to Nepal between July 11- 21, 2016 and conducted nearly 50 interviews (see Box 2 for an overview and Appendix L for the complete list of stakeholders).
- **Round table meetings**: In addition to individual meetings, the Team organized two round table discussions. The first solicited development partners' perspectives on health system challenges, the size and scope of the private health sector, and potential areas for PSE. The second solicited similar ideas from implementing partners with extensive health sector experience in Nepal.

Box 2. Stakeholder Categories

Government of Nepal (GoN):
MoH, GoN regulatory bodies, and MoF

Development Partners:
International donors supporting health in Nepal

Implementing Partners:
Organizations implementing donor-funded projects

Service Providers:
Public, for-profit, and nonprofit hospitals; clinics; individual private practices; pharmacies, labs and clinical support services (diagnostics, laboratories, imagining centers)

Medical Colleges:
Private health teaching institutes

Health products:
Private drug manufacturers (brand and generic), distributors, retail pharmacies; consumer goods

Health Financing:
Insurance companies, banks, GoN ministries

Health System Enablers:
Transportation/logistics; lending institutions; information, communication, and technology (ICT); and life sciences companies

- **Site visits**: The Team conducted two site visits to assess PSE opportunities outside of the Kathmandu Valley (see Table 1).
- **Mission out-briefing**: On July 20, the Team debriefed Mission staff and the Mission Director (see Appendix L for links to the final presentation).

Table 1. Facilities Interviewed during Field Visit

Accham	Dolokha
- Possible Health - Balpata Hospital - CRS - MoH Social Insurance rep - Insurance Enrollment Assistants - Seti Zonal Hospital	- Possible Health - MoH - Dhulikhel Hospital

Analysis and report writing: The Team conducted nightly debriefings to share observations from the day's interviews and compare desk review findings with interview highlights. The Team also met with Mission staff on several occasions to vet preliminary findings and recommendations.

The Team used a modified strengths, weaknesses, opportunities, and threats (SWOT) analysis to synthesize key elements of Nepal's health sector and organize findings in a way that would facilitate identification of high potential recommendations. Doing so allowed the Team to identify areas of potential collaboration, as the SWOT helps articulate goals, barriers to achieving those goals, and available resources for partnership. This framework then helped the Team prioritize opportunities and prepare a list of PSE recommendations for USAID/Nepal based on alignment with Mission priorities, technical and financial feasibility, and potential impact to enhance current programming.

1.4 Organization of the Report

This report is organized into three principal sections:

[4] http://assessment-action.net/

1. **PSE Framework** presents the structure used to organize and analyze the data collected as well as a discussion on the different ways USAID engages the private health sector.
2. **Key Findings** uses a modified SWOT approach to interpret the results from the desk review, stakeholder interviews, and field visits. Findings and recommendations are organized by enabling environment, health services, health products, and health financing. This section also includes cross-cutting PSE opportunities.
3. **Recommendations** proposes strategic areas, models, and programmatic approaches that USAID/Nepal, either through current or new projects, can use to enhance the health outcomes of its programming through PSE.

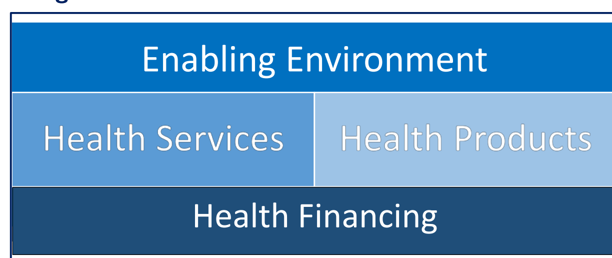
1.5 Limitations

To address the wide range of inquiries posed in the SOW, the PSLA required a broad approach to capture a variety of perspectives. Thus, the Team interviewed leaders from each stakeholder group (e.g. private hospitals, pharmaceutical companies, regulators, donors); the report represents the aggregated opinions of these health leaders. Their insights and suggestions inform PSE strategy but do not represent a comprehensive stocktaking of the sector. A deeper and more detailed understanding of the private health sector (and/or its segments) will require additional research and analysis.

2. PSE Framework for the Health Sector

To better understand the Nepal private health sector, the Team developed a framework to collect and analyze assessment data (see Figure 2). This framework shows how health systems involve the interplay between the enabling environment (i.e. the business climate and relationship between public and private sector actors), the provision of services and products, and health financing (i.e. capital and investment that helps bring services and products to consumers and patients):

Figure 2. Private Sector Assessment Framework



- **Enabling environment** includes government policies and regulations and business conditions. It determines key conditions and incentive structures that influence private sector operations and growth (e.g. market entry requirements, price controls, quality standards, regulatory oversight, subsidies).
- **Health services** includes the provision of services through hospital care, medical colleges and training institutions, clinical support (e.g. labs and diagnostics), pharmacies, and individual private practices. It also includes small- and medium-size businesses that employ several clinical and non-clinical staff.
- **Health products** involves the manufacturing, importation, warehousing, distribution, and retailing of a wide range of health products, including medicines, medical devices, and medical inputs (e.g. reagents). The supply chain of health products includes a variety of businesses, such as importers, transportation companies, warehouse companies, pharmacies, and drug stores.
- **Health financing** examines how health-related products and services are purchased and financed (e.g. government, development partners, out-of-pocket payers) as well as who tends to invest in these areas (private sector, GoN/MoH, development partners). Health financing also includes government tools to purchase health services and products to address a health system's gaps and priorities such as grants, service contracts, voucher schemes, and health insurance. Additionally, health financing includes the access to capital (e.g. debt and equity) for health-related enterprises to grow and sustain their businesses.

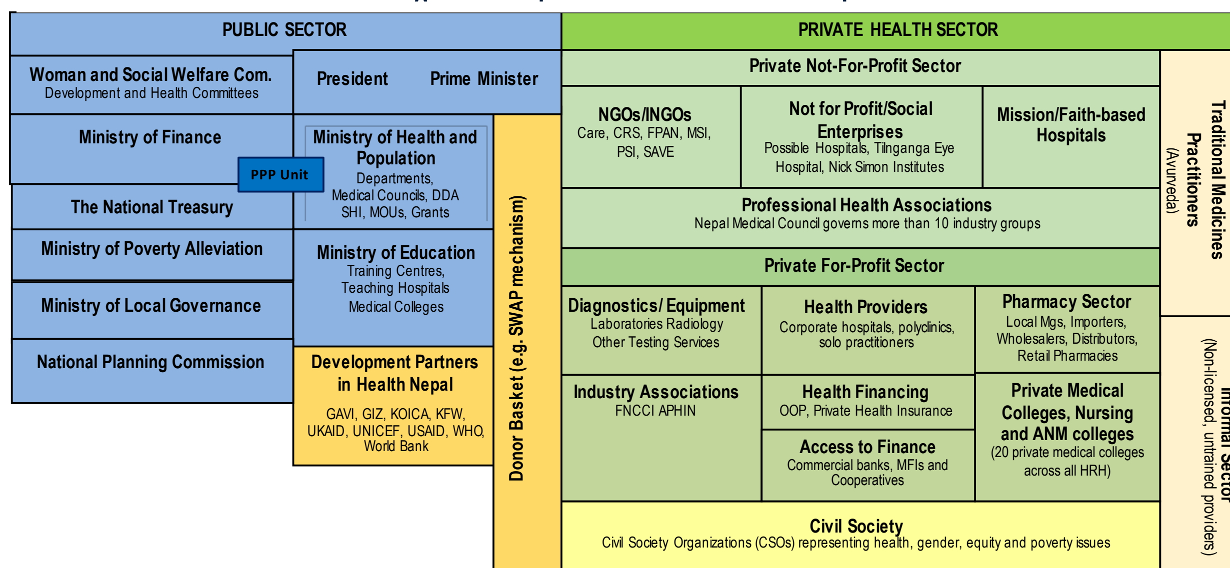
Analyzing the needs and resources of all stakeholders through this framework helped the Team understand how its recommendations would need to consider the interdependence of these four categories. Indeed, PSE interventions that improve the quality of services without recognizing the relationship between public and private sector actors or the need for financial incentives to expand coverage to MDAGs would run the risk of solving the symptom as opposed to addressing the core challenges facing Nepal's health sector.

3. Key Findings

3.1 Nepal's Health Sector Landscape

To understand where the private sector can contribute to greater health outcomes in Nepal, the Team developed a stakeholder landscape that maps out the actors involved in the provision of health-related services and products, the financing of health-related activities, and the regulation of the sector. As Figure 3[5] shows, Nepal has a 'mixed health system' that involves both public and private provision of health-related services and products.

Figure 3. Nepal Health Sector Landscape

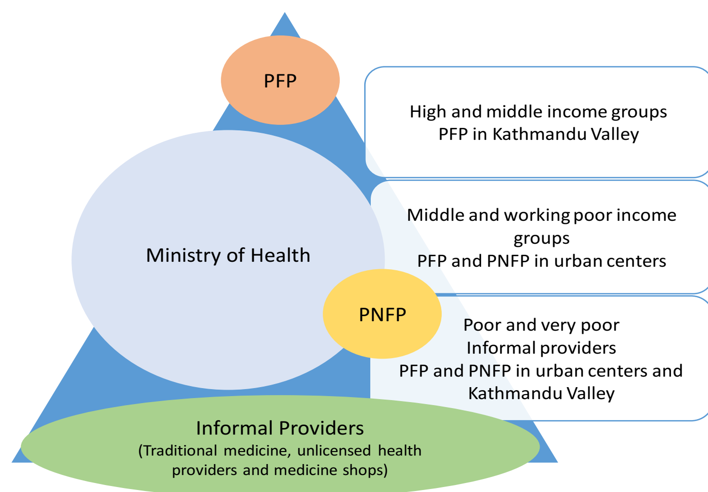


Public Sector. Although the Ministry of Health (MoH) is the steward of health for the Nepalese people and manages all health facilities, other agencies also interact with the private sector. Key among them include the Ministry of Education (MoE), which supervises private medical and training institutions; the Ministry of Finance and National Treasury (MoF), which allocates public funds to health; the Ministry of Local Governance, which funds local hospitals and clinics, and the National Planning Commission, which forms overall development plans and policies. Any PSE strategy needs to involve all relevant ministries to ensure cohesion, consistency, and effective prioritization of health within national development planning.

Development Partners. As the National Health Account (NHA) reveals, donors finance almost 25 percent of total health expenditures (THE). Most funds go through the SWAP mechanism (the external development donor-funded Nepal Health Sector Programme) to the MoH. Given their outsized role in health financing, donors can influence – both positively or negatively – the MoH's perspective on PSE.

[5] In Figure 2, 'Donor basket' refers to that which development donors do in collaboration (e.g. SWAP mechanism), as opposed to 'Development Partners in Health Nepal', which refers to bilateral activities. Health-related social enterprises are not explicitly mentioned as they fall within one (or more) of the pre-existing categories of for-profit companies or nonprofit organizations.

Figure 4. Segmentation of Nepal Health Sector



Private Sector. The private sector plays a large role in health – especially in the areas of service delivery, pharmaceuticals, human resources/education, and health financing. The Team divided the Nepalese private sector into not-for-profit (PNFP) and for-profit, commercial entities (PFP). It identified three types of not-for-profits ("nonprofits"): 1) local non-government organizations (NGOs), 2) international NGOs (INGOs), and 3) faith-based service providers. The Team found four types of for-profit companies: those whose primary business is health, system enablers, health care information/service providers, and producers of health-related products. Yet while the private sector figures prominently in the health sector, the Team uses Figure 4 to demonstrate how for-profit firms tend to serve high income groups in the Kathmandu Valley, which does not easily correspond to USAID/Nepal's primary target beneficiary populations. Those groups and geographies of interest to USAID, most notably MDAGs in rural areas, tend to concentrate at the bottom of the pyramid and receive services from the MoH, nonprofit providers, and informal providers.

3.2 Enabling Environment

This section examines the overall policy framework enabling the MoH to directly engage and interact with the private health sector; regulations governing clinical and quality of care of private healthcare provision and medicines; regulations affecting the business environment in which private healthcare businesses operate; and GoN-designed financial and other incentives that affect the private health sector.

3.2.1 Strengths in the Enabling Environment that Supports PSE

The GoN recognizes the importance of PSE to maximize coverage, improve quality of care, and utilize essential health care services in meeting the Sustainable Development Goals (SDGs).[6] According to the Draft State Non-State Policy, co-developed with DfID, the GoN sees public-private partnerships (PPPs) as a means to achieving public health goals.[7] Key drivers for partnerships include 1) augmenting private investment to address the growing gap between demand and supply of health services and health infrastructure; 2) improving equitable access to essential and tertiary care services; and 3) protecting the poor and vulnerable from further impoverishment due to health expenditures. As of this writing, there is a lack of clarity regarding the status of the policy[8] and the Team recommends USAID/Nepal confirm this status for the donor community.

The overall regulatory and policy landscape in health supports partnership with the private sector. The National Health Strategic Plan III (NHSP III) and draft State Non-State Policy (Box 3) set the stage for increased collaboration between the public and private sector. The MoH has worked with

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[6] Government of Nepal, Ministry of Health and Population. State Non-State Partnership Policy for Health Sector in Nepal: Draft for Consultation. September 2012: Kathmandu.

[7] ibid

[8] In discussions with the Health Minister's Chief Advisor, the Team discovered the "*PPP policy was issued likely in 2014*" and that it "*had already passed*". But discussions with DfID's Health Advisor hint that the policy is still with the Ministries of Finance and Industry.

Box 3. Draft State Non-State Policy

The mission statement of the MoH's Draft State Non-State Policy is to "*ensure each citizen's fundamental rights to stay healthy by utilizing available resources optimally and fostering strategic cooperation between service providers, service users and other stakeholders*".

the private sector, especially with missionary hospitals, since the 1950s[9] and it currently has 20+ active Memorandums of Understanding (MOU) – referred to as 'soft' PPPs – with mostly nonprofits (see Box 4).[10] The MoH also collaborates with private providers to provide essential health services, such as safe abortion, family planning, and basic maternal health services. Recently, NGOs like Possible Health have successfully worked with the MoH through MOUs, reinforcing the idea that well-managed partnerships can lead to improved health outcomes. Other 'soft' partnership initiatives focus on MoH training and capacity building of private health workers in tuberculosis, HIV/AIDs, and STDs. Likewise, the MoH has partnered with pharmaceutical manufacturers to produce essential drugs to manage childhood illnesses. Finally, the MoH has used transactional – or "hard" – PPPs (see Box 5) that resemble more traditional PPPs arrangements such as build, own, operate, and transfer (BOOT) and/or build, operate, and transfer (BOT).[11]

Box 4. MoH Experience in 'Soft' PPPs

- Partnerships to deliver health services (e.g. eye care, management contract of Lamjung Community Hospital, Daeldhura Hospital, and Bayalpata Hospital)
- Partnerships to deliver maternity services (e.g. Aama)
- Partnerships with local bodies (e.g. Jiri District Hospital)
- Partnerships to prevent and treat uterine prolapse

Box 5. MoH Experience in 'Hard' PPPs

- Build, Own, Operate, Transfer (BOOT): maternity hospital, Thanpathali; Phaplu Hospital; Am Pipal Hospital; Manipal Medical College, and; Bharatpur Medical College
- Build, Operate, Transfer (BOT): Lahan Eye Hospital, Trisuli Hospital, Western Regional Hospital
- Joint Venture: Nepal Eye Hospital

There are strong PSE champions in both the public sector and private sectors (see Box 6). There are strong PSE champions in the MoH and many partnerships emerge organically at the district level (e.g. private pharmacy in MoH Seti Hospital). There is strong private sector support for more collaboration and coordination with the GoN. Stakeholder interviews revealed potential areas of opportunity throughout the sector: hospitals provided 2015 post-earthquake assistance that was below cost and have committed to fulfilling the GoN's requirement to reserve 10% of all beds for low income patients; private health insurance providers commit to the GoN's proposal for social health insurance (SHI); pharmaceutical manufacturing companies commit to improving the supply chain for drugs; and for-profit medical universities work with MoH hospitals to improve hospital management and service quality.

Senior MoH officials recognize the need to assess and restructure the current organizational framework to fit the MoH's evolving role as a public steward.[12] The NHSP III focuses on strengthening the MoH's governance capacity, particularly in a decentralized system, and reforms will focus on establishing multi-sector linkages, expanding PSE, improving regulation of the private sector, and decentralizing planning and budgeting. However, select interviewees noted that the MoH may need help determining where and how to start this process.[13]

[9] Government of Nepal, Ministry of Health and Population. State Non-State Partnership Policy for Health Sector in Nepal: Draft for Consultation. September 2012: Kathmandu.

[10] Ibid.

[11] ibid

[12] Government of Nepal, Ministry of Health and Population. Nepal National Health Strategic Plan III. September 2015: Kathmandu.

[13] Government of Nepal, Ministry of Health and Population. State Non-State Partnership Policy for Health Sector in Nepal: Draft for Consultation. September 2012: Kathmandu.

Box 6. PSE Champions

The Team met public, civil society, and private sector actors who would be well-positioned to serve as champions for greater public-private partnership in health care delivery. These champions understand the importance of PSE, hold influential positions, and want to drive better collaboration between GoN and private actors. USAID should cultivate and nurture relationships with these individuals, foster improved communication between them, and build their capacity to serve as PSE champions. The team developed a list of champions interested in creating a public-civil society-private dialogue should USAID build such a platform. See Appendix F for more information.

Compared to regulation of other supply chain segments (e.g. distribution and retailing of medicine or supplies), regulation of pharmaceutical manufacturing is more advanced. MoH interviewees expressed interest in exploring how to leverage private sector entities in the private supply chain to strengthen the public one and there are many initiatives underway (e.g. expanding Department of Drug Administration's role, capacity, and budget) which will create opportunities to update, modernize, and integrate best practices into regulations.

The MoH is committed to establishing an independent quality accreditation/assurance body – key to creating a "level playing field" across public and private sectors. To ensure quality standards are developed, introduced, and applied across all health providers, the MoH (through the 2014 NHP 2071 regulation) established a semi-autonomous entity that reports directly to the GoN.[14] This body will be responsible for developing and updating standards, quality assurance and compliance, and investigating and sanctioning non-compliance. Professional associations and existing regulatory authorities will work closely with this body. As of this writing, the MoH is "*pushing forward with this independent body*" and recently received an 'agreement on principle' from the Cabinet that begins the formal process of drafting the law. According to respondents, the preliminary draft is ready and has been put forward for discussion with stakeholders/experts.

The MoH has made some progress in monitoring and evaluation (M&E) and improving health information management with the introduction of its DHIS2 program. But it has made little progress in integrating the health sector information with that of other key ministries or increasing the number of private sector providers reporting into the system. Moreover, the MoH has not leveraged modern information and communication technologies in the health sector[15] and private sector reporting is weak.

There are minimal barriers to entry in the healthcare market. Private healthcare businesses require few licenses to operate; they need only a few additional licenses (e.g. hospitals need one, pharmaceutical manufacturers need three) plus those required for all Nepalese company.[16] Time to obtain these licenses ranges from one day to one year and most interviewees did not find licensing to be costly (e.g. $0.10 USD for VAT registration, $2,000 USD for business incorporation) or cumbersome.

The GoN extends some subsidies to private hospitals and pharmaceutical manufacturers. Compared to other Low and Middle Income Countries (LMICs,) the subsidies and incentives offered are very few but they are seen as a good step forward. However, several stakeholders noted that implementation of subsidies has been weak and ineffective in attracting new entrants to the healthcare market or to encouraging investment to expand market share.

Box 7. Promotion of Private Sector Growth

The draft State Non-State Partnership Policy promotes private sector growth and development in many technologies supporting health, stating that *"the MoH will seek the support of large companies and industry associations to improve the health communication strategies (advertisement campaigns, and management skills for logistics, inventory, supply chain, and IT applications). ICT companies could propose innovative models for health informatics, telemedicine, etc. Similarly, there are possible roles for banks, insurance companies, drug manufacturers, medical equipment manufacturers, and others."*

[14] ibid

[15] Government of Nepal, Ministry of Health and Population. Nepal National Health Strategic Plan III. September 2015: Kathmandu.

[16] ibid

3.2.2 Weaknesses in the Enabling Environment

The lack of public-private dialogue impedes attempts to modernize and reform the regulatory environment. The MoH does not involve private sector stakeholders in discussions regarding policies and regulations that govern the sector. Because the private sector is not involved in regulation design, firms often ignore or even publicly reject regulations (e.g. hospital standards on bed space). Moreover, many businesses ignore reporting requirements for fear of inspection or tax liabilities and complain that the MoH reporting requirements are too cumbersome and costly (e.g. 3,200 reportable variables in the DHIS2 information management system).

Despite the growing, albeit reluctant, recognition by the MoH of the private sector's role in a functioning health sector, relations between the public, private, and civil society sectors are contentious. Without a formal or informal dialogue between the two sectors, philosophical disagreements end up feeding a high level of distrust between the MoH and private health businesses. In fact, the MoH has limited dealings with the private sector when compared other countries in a similar stage of economic development; the MoH struggles to decide *whether* to work with the private sector while other countries discuss *how* to work with the private sector.

There are few opportunities for for-profit actors to meet and discuss common interests and challenges. According to interviewees, the few professional associations that represent commercial interests are highly political and used to advance individual – not sector – interests. One respondent highlighted the need for a regular 'safe' space for leading medical practitioners and managers to learn from one another. To address this gap, a group of prominent doctors, led by Dr. Bhagwan Koirala, organized a hospital management event in 2015 and plan a second one in December 2016.

The MoH lacks experienced staff and adequate systems to effectively regulate the private sector. Key regulatory gaps identified during the PSLA include: 1) low entry requirements for pharmaceutical distributors and private medical colleges; 2) poor oversight of warehousing standards; 3) no resolution in terms of private pharmacies dispensing drugs in public hospitals[17]; 4) few consequences for pharmacists who 'rent' their license to others to open a new pharmacy; 5) current regulations that constrain profit margins and produce a "*race to the bottom on drug prices*" that negatively impacts quality; and 6) the requirement that hospitals preserve 10% of all beds for low income patients has not produced the intended results since poor patients avoid using "poor beds". As a result, the private health sector is largely unregulated, which forces companies to compete with one another based on price (contributing to a further "race to the bottom") and personal relationships (contributing to accusations of cronyism and collusion).

The MoH has limited understanding of and varying interest in the process to identify and create PSE/partnership opportunities. The National Health

Box 8. Symptoms of a poorly-regulated private health sector

Interviewees see the following issues as evidence of a system in need of leadership:

- Outdated and/or missing policies needed to regulate the private sector
- Weak institutional frameworks (e.g. medical and pharmacy councils) to monitor the private sector
- MoH policies and regulations do not reflect (regional) best practices
- Rules and regulations change frequently, oftentimes for political reasons
- The MoH lacks actionable data on private sector activities
- Lack of transparency and uneven application of policies and regulations as commercial firms complain of being held to a higher standard than their public sector counterparts
- Clinical standards and guidelines, while clear and robust, are not disseminated to private sector providers as readily as to their public sector counterparts
- MoH does not coordinate effectively with other Ministries related to health (e.g. MoF, MoE)

[17] But Health Minister Thapa's Chief Advisor told the Team that "*private pharmacies in public hospitals will likely be displaced now*".

Sector Strategy (NHSS) recommends policies for PPPs (also called state non-state partnerships) and institutional frameworks that include legal and regulatory reforms but there is uneven political support for PSE within the MoH. In addition, the 2003 Health Strategy lays out the MoH's transition from a direct service provider to steward, financier, and regulator[18] but this change is still controversial at the MoH, particularly at the district level. Many MoH staff want to remain regulator and service provider, which creates conflicts of interest as the Ministry engages private providers. Further, high turnover in MoH leadership creates instability, as staff are reluctant to take on new, potentially contentious, initiatives such as the State Non-State Policy, Professional Medical Education Act, and Social Health Insurance Act (often referred to as National Health Insurance) – all of which have significant impact on the private sector. Finally, the Commission for the Investigation of Abuse of Authority (CIAA) initiative to root out corruption has made MoH staff fearful of making mistakes, paralyzing many procurement processes.

Outdated and cumbersome regulations, administered by several agencies, govern the private sector. As Nepal's health system evolves, the MoH must manage its own network of service providers and more private entities that play an increasingly important role in the system. Yet, current MoH and subordinate authorities' regulations are 25 years old and do not reflect international best practices for mixed health system governance. Moreover, the health system is governed by multiple agencies, which complicates reform as the MoH oversees private health firms (e.g. the Department of Health Services oversees policies and guidelines establishing quality requirements for hospitals, clinics, laboratories, and diagnostic services, the Department of Drug Administration (DDA) oversees the pharmaceutical industry). See Box 9 for an illustrative example of the cumbersome nature of these current regulations.[19]

Box 9. Hospital licensing process

The draft State Non-State Policy concedes that the complicated hospital registration process contributes to the lack of data on private facilities (especially those run by for-profit firms). The GoN has multiple agencies responsible for hospital registration: 1) the Office of Company Registrar of the Ministry of Industry under the Company Registration Act; 2) District Administrative Offices and Social Welfare Councils (typically for NGOs); and 3) the Department of Co-operatives in the Ministry of Agriculture (typically for cooperative hospitals). However, new hospitals also need MoH approval as provisioned by the Operation Policy and Infrastructure Guidelines (2016). Finally, different regional entities oversee the licensing process depending on the number of beds in the hospital (the Regional Health Directorate for up to 15 beds, MoH Management Division for 15-50 beds, and MoH Curative Service Division for 50+ beds).

Lack of quality standards and poor/non-existent regulation fuel consumer mistrust of the private health sector. While the MoH has made several attempts to ensure the quality of both public and private health services, these efforts have been largely unsuccessful.[20] For example, the Policy on Quality Assurance in Health Care Services 2064 has not been fully implemented because the committees charged to set and monitor standards remain non-functional. With no oversight, quality among private providers varies from the best to the worst, creating consumer mistrust.

The impending transition to federalism adds a layer of uncertainty to most aspects of health in Nepal. If public funding flows change substantially in the next years, many of the prevailing assumptions about PSE may change. Dr. Chand, former MoH Secretary, emphasized this point, underscoring the importance of civil society engagement and governance in a healthy and effective PSE strategy.

[18] National Planning Commission. White paper on public private partnership (PPP). NPC, Editor. March 2011: Kathmandu.
[19] Government of Nepal, Ministry of Health and Population. Nepal National Health Strategic Plan III. September 2015: Kathmandu.
[20] Government of Nepal, Ministry of Health and Population. Nepal National Health Strategic Plan III. September 2015: Kathmandu.

There is a need for greater clarity and uniformity across service contracts between MoH and the private sector.[21] Most lack 1) consultation with key stakeholders, 2) supervision, and 3) adequate monitoring and reporting systems. Some of these concerns could be addressed by a broader policy framework that supports uniform guidelines and specific partnership models.

Table 2. Subsidies and Incentives Available to Private Healthcare Companies in Nepal

Subsidy or Incentive	Pharma	Hospitals
Private hospitals can claim import-duty relaxation of 1% for importing specialized vehicles (e.g. ambulances)		✓
Private healthcare companies that register for VAT do not pay 5% Health Services Tax		✓
VAT is exempted for raw materials and packaging use in local pharma manufacturing	✓	
Pharma that diversify, expand installed capacity by 25% of more, or modernize technology are entitled to 40% deduction of new additional fixed assets from taxable income	✓	
As National Priority Industries, domestic pharma manufacturing and tertiary hospitals can claim income tax relief for up to 2 years	✓	✓
National Health Policy (draft) allow for private sector hospitals to participate in scheme and be reimbursed at negotiated rates for services delivered.		✓
Aama Suraksha Policy reimburses private providers for delivery of maternity services		✓

Source: A Report on Market Data for Private Sector Investments in Nepal Healthcare Sector. 2014. Table 5

The GoN does not effectively incentivize private health sector growth in underserved geographic zones or health solutions. Aside from small private pharmacies providing consultation services and drugs, there is little access to public or private health services in rural or mountainous areas; most private health businesses (pharmaceutical manufacturing, hospitals, diagnostic centers, and PMCs) are concentrated in Kathmandu, Pokhara, and Birgunj. Without GoN assistance, it is not commercially viable for them to expand to rural areas due to high upfront capital costs associated with land acquisition, physical infrastructure, poorly maintained roads, and lack of power infrastructure. There are limited subsidy schemes available (see Table 2) but these incentives are not sufficient to achieve the GoN's goal of universal healthcare. Many interviewees claim that other industries receive "more favored treatment" that health (see Table 3) even though they share responsibility with the GoN for delivering quality health to all socio-economic groups. As one respondent noted, "*Being a service-providing institution, the government should not impose various taxes on us. The government neither removes taxes from us nor facilitates us as with other industries*."

Table 3. Taxation structure for private healthcare companies in Nepal

Type of Tax	Tax Rate	Comments
Corporate income tax	25%	Percentage of taxable profits
Employer contribution to social security	10%	Percentage of gross salaries
Vehicle tax	$260 USD	Fixed rate
Municipal tax	$100 USD	Fixed rate
Property tax	Varies	Depends on land value
Capital gains tax	20%	Percentage of capital gains
Health service tax	5%	Percentage of taxable profits

Source: A Report on Market Data for Private Sector Investments in Nepal Healthcare Sector, 2014

3.2.3 Opportunities to Strengthen the Enabling Environment

The Team found the following opportunities to improve the enabling environment for PSE: 1) build the MoH's capacity to work with the private sector; 2) help associations/representative organizations participate in policy debates; 3) support public-private dialogue to address issues of importance to both private and public sectors; 4) assist the MoH to strengthen its capacity to better regulate and monitor the private sector; and 5) support

[21] Common structural components of a contract include financing modality, procurement process (e.g. eligibility conditions or selection of private partners), scope of services, service coverage, supervision and monitoring, partner obligations, payment or reimbursement mechanisms, grievance redressal systems, exit options, and performance indicators and incentives.

the MoH build the systems and capacity to partner with the private sector. Table 4 offers more details for each of these opportunity areas.

Table 4. Opportunities for USAID to Strengthen Enabling Environment

Strategy	Interventions
Build MoH's capacity to effectively dialogue with private sector	• Convene events for public and private sector actors to discuss mutual interests • Offer technical assistance (TA) to establish a formal dialogue mechanism to: 1) develop consensus on private sector's role in health, 2) increase interactions and improve communications, and 3) take small steps towards better coordination
Help create a seat at the policy table for the private sector	• Build associations' capacity as membership organizations to unify private sector voice • Advocate private sector seat on Social Health Insurance Design Committee (SHDC) • Advocate passage of Professional Medical Education Act
Help the public and private health sectors address key policy issues and build trust	• Help MoH and private sector associations advocate passage of State/Non-State Policy • Encourage greater information flow between private healthcare businesses and MoH to strengthen implementation of current subsidies and experiment with new ones (e.g. Special Economic Zones, tax breaks, land concessions)
Help the MoH carry out key reforms that will strengthen capacity to regulate the private sector	• Mission and projects strengthen working relationships with key Ministries (MoF, MoE) • Help MoH assess policies, regulations, and institutional capacity related to quality of services as well as design a reform agenda • Help MoH share treatment/clinical protocols with private sector providers • Use Health Systems Strengthening project to 1) develop policy framework to monitor the private sector; 2) build Council(s)' tools and modernize systems to regulate private sector; 3) help MoH establish quality assurance (QA) system for all services; 4) share other country experience with 3rd party Quality Administrators; and 5) build capacity of MoH departments to implement regulations of different regulations
Build MoH systems and capacity to partner with the private sector	• Commission in-depth analysis of the private sector (i.e. market size, segmentation, scope of work, functions) to build knowledge base for later interventions • Offer the MoH TA to strengthen its existing MOUs with nonprofits • Facilitate learning opportunities for MoH and private associations in PSE/partnership • Conduct MoH training in basic PSE skills and partnership concepts • Identify 'easy' partnership opportunities (e.g. private sector reporting) and assist the GoN to pursue them through the new Health Systems Strengthening project • Help MoH create capacity and systems to design and implement partnerships

3.3 Private Sector Health Services

3.3.1 Overview of the Provision of Health Services

As noted in Section 3.1, Nepal's health system is a mixed delivery system comprising public and private healthcare providers. This section discusses the relative size and scope of each healthcare provider segment.

Box 10. Definitions

- Primary healthcare (PHC), also known as 'out-patient services', refers to 'essential' and basic health services. The MoH delivers upwards of 90% of PHC in Nepal.
- Secondary healthcare (also known as 'out-patient services' in some circles) is provided by a specialist upon referral from a PHC provider and requires more sills and specialized equipment. Both public and private providers deliver secondary healthcare but the public/private mix is unknown.
- Tertiary healthcare is highly specialized medical care over an extended period that requires advanced, complex procedures and treatment performed by a specialist in a state-of-the art facility (e.g. hospital). The private sector is the principle provider of hospital (in-patient) services in Nepal.

MoH: The MoH is the largest service provider in Nepal, delivering upwards of 90% of generalized/primary health care (PHC) to mostly the poor and underserved through its own system of hospitals.

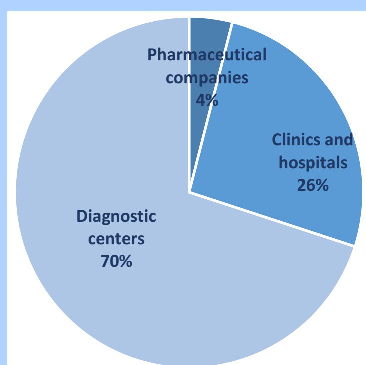
Box 11. Possible Health

Possible Health ("Possible") figured prominently in the PSLA, as both teams traveled outside of Kathmandu Valley to visit hospitals managed by the NGO. Possible has two distinct models that it uses to manage hospitals in Bayalpata and Charikot Districts, and USAID/Nepal asked the team to explore the viability of these models. In addition, the Mission wanted to understand how the 'Possible model' could represent an avenue through which the MoH engages the private sector to deliver more health-related services to under-served populations. While the Team was impressed with the quality of care provided by Possible-managed facilities in regions that traditionally lack such high levels of healthcare, it questions the efficacy of focusing USAID's resources on replicating this model exclusively. A more detailed analysis of Possible is in Appendix I.

Nonprofit healthcare providers: There are several nonprofit health centers and hospitals in Nepal, many of which deliver primary healthcare (PHC) to underserved groups. The MoH has a long history working with these nonprofits – especially faith-based – in the areas of disease control, RMNCH, HIV/AIDs, sanitation, and nutrition.[22] Senior MoH officials acknowledge and appreciate these organizations' ability to provide specialty services and introduce new and improved technology and management systems. For example, Dhulikhel Hospital and the MoH introduced management practices to help attract and retain young talent as well as expand health services to 20 adjacent communities. In the case of the Nick Simons Institute and Possible Health (see Box 11)[23], the MoH supports these hospitals mainly through grants, setting the precedent for private sector actors to provide services through contracting mechanisms.

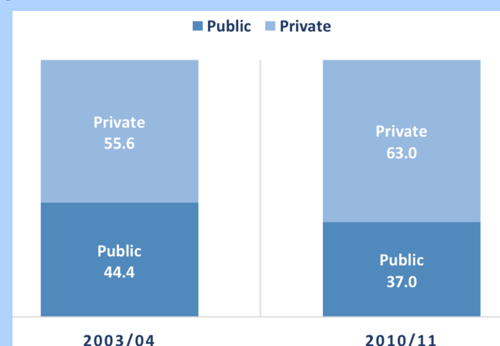
For-profit healthcare providers: Nepal has experienced strong growth in the for-profit health sector, with approximately 3,000 commercial healthcare enterprises concentrated in diagnostic and laboratory centers (70%), clinics and hospitals (26%), and pharmaceutical companies (4%) (see Figure 5). The number of private hospitals has grown from 69 in 1995 to 350 in 2013 while the MoH opened only 19 new hospitals during the same period.[24] Other areas of the sector, such as private medical colleges (PMCs), have experienced similar growth.[25] The nature of Nepal's private health sector differs from other LMICs in which the largest segments are solo practitioners, then pharmacies and hospitals. As a result, commercial clinics and hospitals have become an important source of healthcare in Nepal. As early as 2003-04, for-profit providers treated 55.6% of all acute illnesses and by 2014, privately-owned hospitals accounted for 63 percent of all

Figure 5. For-profit healthcare businesses



Source: Annual report, 2011-12, MOH

Figure 6. Source of Treatment of Acute Illness



Nepal Living Standard Survey 2010-11

[22] Ministry of Health and Population, Nepal Health Sector Programme-II and III. 2010: Kathmandu, Nepal.

[23] Most private hospitals interviewed say they comply with MoH regulations to offer 10% free beds and exempt those who cannot pay. In some cases, these hospitals offer tiered pricing (higher prices for full service and lower prices for fewer amenities).

[24] Ministry of Health and Population, Nepal Health Sector Programme-II and III. 2010: Kathmandu, Nepal. Figure 15.

[25] Planning Commission, Nepal Living Standard Survey 2010/11 Volume 1. 2011, CBS: Thapathali, Kathmandu.

inpatient care (see Figure 6).[26] Private hospitals offer care across multiple disciplines (e.g. cardiology, gynecology, nephrology, neurology orthopedics, obstetrics, trauma and emergency care) and concentrate in Kathmandu, Biratnagar, Pokhara, Chitwan, and Nepalgunj.

Retail pharmacists: Comprising private pharmacies (staffed with licensed pharmacists) and drug shops (owned and operated by auxiliary workers), these entities also offer PHC. Drug shops, also known as 'community pharmacies' (see Box 12), are often the first point of contact for Nepalese seeking healthcare in rural areas, as licensed private pharmacies tend to concentrate in Kathmandu Valley and urban centers.[27] Most community pharmacies are run by Vyabashahi[28], Health Assistants (HAs), and Community Medicine Auxiliaries (CMAs) trained in basic pharmacology practices to diagnose and treat common illnesses, refer patients for more specialized care if required, and prescribe select medicines. While Vyabashahi lack legal authority to dispense medicines independently, they help patients self-manage minor illnesses through over-the-counter medicines and basic PHC advisory services.

The Team struggled to quantify private and community pharmacies. According to a 2015 report, there are approximately 18,225 licensed pharmacies, most which are privately owned and operated.[29] The number of unlicensed pharmacies/drug shops in Nepal ranges from 5,000 to 22,000 but the most recent labor statistics from a 2010 study found only 731 licensed pharmacists and 1,496 pharmaceutical assistants and professionals.[30] These numbers are most likely low since PMCs have been overproducing pharmacists in recent years, especially in the Kathmandu Valley, but the Team did not find reliable and current data.

Box 12. Community Pharmacies in Nepal

A community pharmacy is a unique business that sells pharmaceutical products and provides information regarding the use of medicines and the prevention and treatment of diseases. It offers a wide range of services, including occasional physician consultations. Although dispensing medicine is the core business, some offer counseling, primary health care, or medical advice. Clients usually purchase medicine without a prescription but receive treatment/advice for their illness from pharmacy supervisors (proprietors who are often paramedics) or visiting physicians. Several community pharmacies have patient consultation rooms where the visiting physician, usually a MoH physician moonlighting before or after public service hours, can receive patients.

A significant percentage of community pharmacies administer injections, especially injectable contraceptives. But many are not well equipped for this procedure as they lack safety boxes, separate injection prep areas, and running water. A study showed that women from rural areas paid for injectable contraceptives at community pharmacies even though they are free at MoH-run facilities, as these pharmacies have stronger patient confidentiality and privacy reputations (important when women do not want their families to know).

Source: Gyawali et al, 2014 and Kumar et al, 2016.

Private clinics: There is a growing number of for-profit providers, usually clinics run by a clinician and 1-2 technicians, delivering health care to all socio-economic groups.[31] Only 74 report into the MoH information system but one officer called this number a "*gross underestimation*". Many stakeholders noted the recent increase of solo practitioners and said most are Kathmandu-based MoH physicians who "moonlight" after

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[26] Central Bureau of Statistics and National Planning Commission, Nepal Living Standard Survey 2010/11 Volume 1. 2011, CBS: Thapathali, Kathmandu.

[27] Gyawali, Sudesh and D. Singh Rathore, K. Adhikari, P. Ravi Shankar, V. Kumar and S. Basnet. Pharmacy practice and injection use in community pharmacies in Pokhara city, Western Nepal. BMC Health Services Research. 20141 4:190. DOI: 10.1186/1472-6963-14-190.

[28] Vyabashahi, or non-pharmacist 'professionalists', typically run community pharmacies after receiving a short training in basic health procedures and pharmacy.

[29] Mishra, Abhishek. A Study on the Pharmaceutical Industry in Nepal. December, 2015. Kathmandu

[30] World Health Organization. Nepal Pharmaceutical Country Profile. September, 2011. Kathmandu

[31] UKAID. A Report on Market Data for Private Sector Investments in Nepal Healthcare Sector. Dolma Development Fund in partnership with Intellecap. September, 2014: England.

hours. Their work tends to align with USAID's priorities, as many are in the communities where target populations live and work and offer more affordable health services to this client base. However, as the Draft State Non-State Policy observes, for-profit providers who offer PHC have grown in an unorganized manner[32] and there is little empirical information regarding composition, distribution, and quality of care of private providers.[33] Therefore, the Mission should collect more data on this segment before deciding to engage.

Private Medical Colleges: There are 20 private medical colleges (PMCs) in Nepal, of which 17 are privately owned and operated. They enjoy a good reputation; according to one estimate, nearly half of graduates find work and/or further education abroad. At current graduation rates, Nepal will double the number of doctors and increase the number of nurses by 30 percent in five years but most expect an oversupply of doctors, nurses, and pharmacists in urban areas coupled with an undersupply in rural areas.

3.3.2 Strengths in Private Health Services

Local companies are investing in capacity improvements, technology, and expertise.[34] Many private hospitals interviewed are making considerable investments in human resources, infrastructure, technology, and emergency transport. Om, Norvic, B&B, and Grande International hospitals are training their staff (doctors, nurses, technicians) in specialty care and hospital management. For the first time in Nepal's history, domestic hospitals deliver a level of care previously found in other countries, reducing the need for Nepalese patients to travel to India and Singapore for treatment.[35] Many hospitals, diagnostic clinics, and pharmaceutical manufacturers are developing private-private partnerships with foreign firms, demonstrating an improving level of quality that meets international standards.

Commercial hospitals are interested in partnering with the MoH. The Aama Program, discussed in the Health Financing section, is a successful example of the MoH paying for-profit providers (e.g. Dhangadi Hospital) to deliver four antenatal care (ANC) visits and maternity care (see Appendix D). Although the MoH has partnered primarily with nonprofit facilities, there is an opportunity to align its interests with the philanthropy of many for-profit hospitals. According to the CEOs of Om Hospital and Grande Hospital, over 60% of patients are referred from outside Kathmandu Valley, many of whom are working poor seeking

Box 13. Sangini Network

In 1994, the Contraceptive Retail Sales (CRS) company launched the Sangini Network, supported by USAID. Sangini, which means "female friend", is the brand name for CRS's Depo-Provera (DMPA) product. Currently there are approximately 2,000 participating pharmacies in 52 of Nepal's 75 districts. Sangini Network providers offer a range of counseling services and FP products (condoms, oral contraceptives, DMPA) and MNCH products (e.g. clean delivery kits, oral rehydration solution, other routine pharmaceutical products). Most providers are pharmaceutical auxiliaries or Vyabashahi (pharmacists). All providers undergo a two-day training that includes FP counseling, MCH-related illnesses, safe injections practices, and MoH reporting. Each provider must take annual refresher trainings from the Network and CRS detailers. A 2008 internal study, whose findings were corroborated in a 2014 independent study by Gyawali and Sudesh, found that:

- 70% of facilities met Sangini's minimum standards
- 80% of facilities were fully stocked with all Sangini-related products
- 50% of facilities performed satisfactorily in client-provider interaction
- 99.4% of facilities performed at/above satisfactory level in compliance with injection procedures

Source: Assessing & Improving Quality of Private FP/RH Provider Networks in Nepal. Presentation at PSP-One Social Marketing Conference, 2008.

[34] UKAID. A Report on Market Data for Private Sector Investments in Nepal Healthcare Sector. Dolma Development Fund in partnership with Intellecap. September, 2014: England.

[35] ibid

specialized care. These leaders expressed a strong interest in giving back to the community by: 1) charging fees on a sliding scale; 2) cancelling hospitals bills for the poor; 3) organizing medical camps in rural areas, often in partnership with community-run health facilities; and 4) matching and/or exceeding the MoH's requirement to maintain 10 percent of all beds for low income patients.

Community pharmacies offer an opportunity to extend basic healthcare to rural populations. Community pharmacies provide many benefits for the Nepalese health system that struggles to reach rural and remote populations. Community pharmacies are located throughout Nepal, operate on average 12 hours a day/seven days a week, and often serve as the first point of contact for mothers in rural districts seeking MCH care.[36] In a few cases, community pharmacies have a visiting physician who receives patients. According to respondents, community pharmacies have a more reliable supply of pharmaceutical products than MoH-managed facilities, including MCH-related products. Finally, the USAID-sponsored Sangini Network shows that community pharmacies can be an effective channel to deliver FP services and counseling to rural women if supported with quality products and training (Box 13).

Several PMC are 'adopting' MoH district hospitals and clinics in remote and rural areas in 'win-win' partnerships for both PMCs and the MoH. The PMCs introduce state-of-the-art health management, strengthen quality, and update and refurbish MoH facilities in exchange for residency programs for their students (see Box 14). Some nonprofits (e.g. Possible Health) partner with PMCs such as Bir Hospital and Kathmandu University to offer rotation programs for General Medicine residents. As Dr. Lok Bikram Thapa states, "*Every year there are about 1,800 PMC graduates available for field work. For a country with a serious shortage of staff and absenteeism in rural public health facilities, these graduates can be turned into an asset for Nepal*". There is a draft policy that mandates all medical colleges help manage MoH district hospitals and primary health centers but the MoH will need assistance to roll out this initiative once it is approved.

Box 14. PMC District Adoption Programs

B.P. Koirala Institute of Health Sciences (BPKIHS) has adoption programs in eight of 16 districts in the eastern region and plans to cover all 16 districts. It operates under a five-year MOU with the MoH and earns revenue through student fees and service/product sales that cover the costs incurred in the adoption program.

To house students, BPKIHS builds hostels, rents houses, and/or uses GoN lodging. Students and faculty rotate every two months to provide year-round coverage. District public health officers supervise students. "*When in the districts, students learn how to work with limited resources*," the Chief of Public Health explained. "*If one private college can take and commit to five districts, all of Nepal will be covered*."

Chitwan Medical College has agreements with 16 community clinics in adjacent districts to rotate residents and faculty members. It also pays the salary of a staff nurse for the community clinics.

3.3.3 Weaknesses in Private Health Services

Private healthcare providers deliver the best and worst of quality of care (QOC). The MoH has not invested in physical/clinical standards, accreditation, dissemination of quality norms, or protocols, nor does it have an adequate legal framework and institutional structure to supervise, monitor, or regulate private healthcare providers.[37] Thus, the private sector acts without adequate supervision and many MoH officials accuse for-profit providers of "commercializing health" at the expense of the sick and poor. Another challenge comes from often-changing, unevenly enforced, and retroactively-imposed rules/codes of conduct. As one for-profit hospital owner observed, "*Of the 366 private hospitals in Nepal, about 200 belong to former*

[36] Gyawali, Sudesh and D. Singh Rathore, K. Adhikari, P. Ravi Shankar, V. Kumar and S. Basnet. Pharmacy practice and injection use in community pharmacies in Pokhara city, Western Nepal. BMC Health Services Research, 2014 14:190. DOI: 10.1186/1472-6963-14-190.

[37] Government of Nepal, Ministry of Health and Population. State Non-State Partnership Policy for Health Sector in Nepal: Draft for Consultation. September 2012: Kathmandu.

bureaucrats, politicians, or parliamentarians who don't follow protocols. The others face unfair scrutiny and challenges from the Government."

Private providers' incentives and USAID priorities do not align. For-profit providers have limited interest in providing PHC unless there are adequate incentives (e.g. provider payment, health insurance, subsidies, donated inputs). It will be challenging for USAID to partner with this segment of the private sector without incentives that can modify private provider practices in terms of location, target populations, and quality assurance. As mentioned in 3.2.2, without significant public sector-facilitated incentives, the principal for-profit entities in rural areas will remain small community pharmacies.

Box 15. Different Pharmacy Cadres

- Pharmacist: 12 years of schooling and a 4-year Bachelor of Pharmacy program
- Assistant pharmacist: 10 years of schooling and a 3-year Diploma in Pharmacy program
- Professionalist (Vyabashahi): one 48-hour orientation training course
- Health assistant (HA): 10 years of schooling and 36 months of training
- Community medical assistant (CMA): 10 years of schooling and 18 months of training

Private pharmacies and drug shops offer variable quality of care and counseling. The MoH struggles to regulate pharmacies effectively and as one interviewee remarked, "*the DDA's inability to supervise and monitor pharmacies reinforces the pharmacists' tarnished reputation as drug dispensers trying to make a buck*". A recent study by SAGE Open Medicine confirms interviewees' claims that (community) pharmacies suffer from poor quality and counterfeit medicines, inconsistent and inappropriate management and disposal of products and medical waste, and substandard physical environment and storage practices.[38] The study also found that many pharmacists, pharmacy assistants, and 'professionalists' (Vyabashahi) demonstrate poor knowledge and dispensing practices[39], possibly due to the widely varying level of training each cadre receives (see Box 15).

Affordability and pricing consistency complicates USAID's to work with private pharmacies as service providers. Although the Consumer Protection Act and Drug Act aim to control retail prices and labelling on medicine packaging, the MoH does not actively monitor prices[40] nor publish the suggested retail price to drive the market towards consistent pricing of medicines.

The ambiguity associated with illegal private practices complicates the ability to work with community pharmacies. Since Vyabashahi lack legal authority to dispense medicines independently, many 'rent' the license of registered pharmacists (who never visit the locations) or ignore the rules, which has led to the proliferation of illegally-operated community pharmacies. The Chemists' Association has asked the MoH and DDA to grant these operators amnesty, which would create the space for the DDA, Chemists' Association, and donors to engage them. The MoH, DDA, and many pharmacists strongly oppose this proposal and the Chemists' Association doubts that the situation will be resolved soon. As such, partnering with these pharmacies is a difficult option due to the political sensitivity of their legal status.

Although the partnerships between PMC and MoH facilities are promising, joint supervision of PMCs by the MoE and MoH complicates approval and reporting processes. Indeed, some PMCs want to adopt public hospitals but are reluctant to do so due to excessive bureaucracy.

There is a shortage in skilled and qualified human resources in health (HRH) in rural and mountainous areas. Weak management of HRH plagues public and private sectors. Despite efforts to improve HRH, the MoH lacks sufficient mechanisms to attract and retain professionals to underserved areas. For-profit firms experience similar HRH challenges but offer higher salaries and benefits as compensation.

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[38] Kumar Poudel, Bhupendra and Itsuko Ishii. Assessment of physical premises of selected pharmacies of Nepal. SAGE Open Medicine Volume 4: 1–5. 2016. DOI: 10.1177/2050312116654590 smo.sagepub.com

[39] Ibid.

[40] WHO and SERO. Nepal: Situational Analysis. January, 2015. Kathmandu.

3.3.4 Opportunities to Leverage Private Health Services

Until the MoH creates mechanisms (e.g. service contracts, SHI) that engage for-profit providers at scale, there is a need for a public-private dialogue that opens a space for discussing how the private sector could help addressing Nepal's health priorities and system gaps.

PMCs offer strong partnership opportunities as their incentives align well with USAID priorities. For example, 1) PMCs want to offer their students the chance for hands-on medical training;[41] 2) PMCs with General Practice residents deliver low-cost services of interest to USAID (e.g. MCH, FP); 3) PMCs may not require USAID funds in a partnership; and 4) PMCs may help improve management practices at MoH-run hospitals/clinics in USAID's geographic areas of interest.

There is evidence across the development community that working with pharmacies is an effective strategy to offer basic health services beyond dispensing medicines. But due to the political sensitivity of working with illegal community pharmacies, interventions are best prioritized over the medium to longer term. In addition, the Social Health Security Development Committee (SHSDC) and DDA mentioned plans to open public pharmacies in MoH facilities. This will have major implications for pharmaceutical industry as it creates additional competition between the public and private sectors to deliver health services. The Team sees this as a critical area for USAID to play a role but recommends that the Mission engage as a convener and advocate (as opposed to funder), at least until the community pharmacy situation finds resolution. Once resolved, USAID may consider a workforce development program that builds private sector capacity to deliver quality services and public sector capacity to regulate the industry.

Table 5. Opportunities to Leverage Private Health Providers

Strategies	Interventions
Assist public and private health sectors to address key policy issues and build trust	• Convene for-profit and MoH hospital managers to exchange strategies to improve hospital management and service quality in coordination with Dr. Bhagwan Koirala's annual hospital management event • Support national and international hospital management experts to work with public and private medical colleges to design and implement 2-3-week hospital management course(s) that would target MoH and private sector providers/managers • Under USAID's earthquake reconstruction RFP, use funds to rebuild rural health facilities in partnership with private hospitals and/or PMCs and leverage private human resources to manage MoH facilities
Help MoH enact key reforms that strengthen its capacity to regulate private sector	• Use USAID/Nepal's Health Systems Strengthening project to partner with the MoH to develop and institutionalize financial mechanisms that incentivize private providers to expand services to rural areas • Help the MoH develop/mainstream standard guidelines and operating procedures for priority MCH services
Build MoH systems and capacity to partner with private health sector	• Help the MoH revise the Aama program to level the playing field between public and private hospitals

[41] For many PMCs, the majority of revenue comes from student tuition and any decrease in enrollment (potentially due to changes in law or regulation) may influence their willingness and ability to partner with USAID/Nepal.

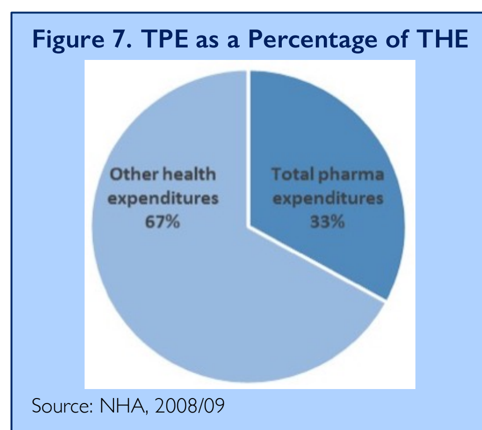
3.4 Health Products

3.4.1 Overview of Private Pharmaceutical Products ("Pharma")

During the PSLA, the Team interviewed pharmaceutical manufacturers, warehouses and distributors, industry associations, social marketing companies, and regulators. Most interviewees articulated an interest in working with donors to improve the quality, compliance, and efficiency of the pharma industry.

The pharmaceutical products market has grown 18 percent per year since 2010[42] and the 2008 National Health Account (NHA) estimated total pharmaceutical expenditures (TPE) at 13.1 billion Nepalese Rupees (NPR) ($187 million), or 1.6 percent of Nepal's GDP and 1/3 of total health expenditures (THE) (Figure 7). The DDA states that Nepal has 44 registered pharmaceutical manufacturing companies, 43 of which are for-profits and 37 are WHO good manufacturing practices-certified (GMP).[43] Seven of the 43 are small (requiring less than 30 million NPR capital investment), 32 are medium (30-100 million NPR), and five are large (100+ million NPR). Most firms are in Kathmandu Valley, Narayani Zone, Janakpur, Biratnagar, Bhairahawa, and Dharan.

Figure 7. TPE as a Percentage of THE



Source: NHA, 2008/09

The largest 10 manufacturing companies comprise 33% of the market in terms of total sales (Table 6); Indian firms figure prominently in this list due to their long-standing presence in Nepal as well as reputation for quality. But Nepalese manufacturers (including USAID-supported Lomus Pharmaceutical) increased market share from 30% in 2005 to 45% in 2016[44] and interviewees claim this growth is driven by Nepalese manufacturers' ability to compete globally.[45] Four other drug makers (NPL, Deurali, Elder and National H.C) have received the Certificate of Pharmaceutical Products, an important pre-requisite to obtain an export license from the DDA. By industry estimates, local pharmaceutical manufacturers expect to capture at least 80% of the domestic market by 2025.

Table 6. Largest Pharmaceutical Companies in Nepal

	Name	Country of Origin
1	Lomus Pharmaceutical	Nepal
2	Nepal Pharmaceutical Laboratory	Nepal
3	Deurali-Janata	Nepal
4	Aristo	India
5	Dabur	India
6	National Health Care	Nepal
7	Knoll	Multinational
8	Ranbaxy	India
9	Nicholas	India
10	Aikem	India

Source: Department of Drug Administration (DDA)

Initially, Nepali manufacturers produced only medicines, antibiotics, and tonics for illnesses such as the common cold, diarrhea, fever, and cough. Today, they produce essential drugs for cardiac, diabetic, and liver patients. According to industry leaders, newer firms introduce technologies to manufacture increasingly more complicated drugs and older firms are improving quality levels to compete.[46] The DDA claims that there are 2,350 medical importers and distributors in Nepal, which by all accounts, reach all 75 districts in Nepal.

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[42] Tripathi, Akhilesh. "The Health of Nepalese Pharma Industry." New Business Age

[43] Government of Nepal, Ministry of Health and Population. Nepal Pharmaceutical Country Profile. With WHO. September 2011.

[44] The Health of Nepali Pharma Industry. Published on: 2016-02-29 16:16:15. http://www.newbusinessage.com/MagazineArticles/view/1433.

[45] Ibid.

[46] The Health of Nepali Pharma Industry. Published on: 2016-02-29 16:16:15. http://www.newbusinessage.com/MagazineArticles/view/1433.

A 2015 WHO report examines the availability of drugs across facilities and sectors[47], finding that tertiary private hospitals with on-site pharmacies and large private pharmacies in urban areas score the highest in terms of consistent availability of essential medicines, 63-91 percent and 80-97 percent, respectively. Meanwhile, MoH-run district hospitals and polyclinics had all essential medicines in stock 50-77 percent of the time, which is better than small-to-medium private pharmacies.

3.4.2 Strengths in Private Pharma

Governance of the pharmaceutical manufacturing industry may be the most advanced area across the sector. GoN relations have improved the regulatory environment as more transparent and standardized public procurement processes level the playing field between Indian and domestic manufacturers. As one interviewee shared, "*Regulations have improved a lot in the last 12 years. The DDA has introduced new regulations that make us more competitive internationally*" (see Box 16). Increasingly, public and private healthcare providers recognize the quality of locally manufactured medicines (especially those GMP-certified) and prescribe them over brand and imported medicines.

Box 16. Successful Interaction with the GoN

Nepal's procurement policy prioritizes lowest price and gives no special concession for domestic manufacturers. During a recent procurement for Hydrocortisone, an Indian firm underbid (and won) but could not deliver the product as specified. Local firms had to step in at the last minute to avoid a gap in supply of this critical health product. As a result, the GoN modified its policy to award procurements according to price *and* quality, which represents a strong step forward. It then categorized the local pharmaceutical industry as an economic priority and now provides monetary and fiscal incentives to encourage its development.

Given the high level of organization and strong public-private dialogue, the future for collaboration in pharma manufacturing is bright. In the NHSP III, the GoN commits to "*working with the private sector on the supply side in pharmaceuticals and other consumables and new technologies. This will involve drawing up agreements on quality assurance, availability, supply chain management, and cost*." The industry is well organized as public and private sector leaders meet regularly to discuss issues. The Association of Pharmaceutical Producers of Nepal (APPON) represents manufacturers' interest with the GoN, offers continuing education for members, provides guidance in policy and regulatory matters, and serves as a platform to share industry information.

USAID's partnership with Lomus has been successful for Nepal as well as other developing countries. USAID funding successfully motivated Lomus to allocate resources to R&D to develop Chlorhexidine, invest in highly-trained staff, and purchase equipment needed to manufacture and distribute it.[48] USAID funding also helped Lomus market Chlorhexidine domestically and internationally, which led to a contract with the Nigerian MoH. Lomus executives expressed interest in establishing a nonprofit arm to manufacture and distribute a basket of essential drugs and health supplies.

According to research and interviews, pharmaceutical importers and distributors reach all 75 districts in Nepal, which is a major accomplishment given the country's topography. Two of the largest pharmaceutical manufacturers, Lomus and SR Drugs, distribute products through complex (though inefficient) networks of distributors. USAID-supported Contraceptive Retail Sales (CRS) (see Box 17) has leveraged

Box 17. Contraceptive Retail Sales (CRS)

This nonprofit was founded in 1976 with USAID support and has grown into a major social marketing enterprise that has achieved significant success in growing demand for and providing access to FP throughout Nepal. USAID invests in TA and strategic planning activities that help CRS move towards sustainability. Given these extensive efforts, the Team elected not to address CRS' sustainability directly in the PSLA.

[47] World Health Organization and SERO. Nepal: Situational Analysis. January, 2015. Kathmandu.
[48] Mishra, Abhishek. A Study on the Pharmaceutical Industry in Nepal. December, 2015. Kathmandu.

these same distributors and occasionally delivers products to remote sites not reached by private distributors such as Kailali, Accham, and other areas in the Far Western Region.

3.4.3 Weaknesses in Private Pharma

In Nepal, access to essential drugs and health products is complicated by weak infrastructure and challenging terrain, parallel supply chains for the public and private sectors, and insufficient/ineffective policy and regulations.

Despite the industry's promising growth, domestic manufacturing faces considerable market challenges. The Nepalese market is small, preventing individual companies from reaching economies of scale and limiting their resource base to invest in research and development (R&D), quality assurance systems, and training. Stakeholders expressed concern about pervasive unethical practices in public procurement processes, giving free products to wholesalers and distributors, long credit cycles, competition against low-cost Indian products, and marketing strategies that do not benefit consumers.

Interviewees expressed concern that the DDA does not effectively regulate pharmaceutical manufacturing, which affects competitiveness and overall industry quality. In response, the DDA is updating and modernizing its policies and regulations to reflect best practices and expects a substantial increase in budget to cover the cost of testing drugs, supervising manufacturers, and carrying out quality assurance and pharmacovigilance. Several respondents say relations are improving but still complain of exclusion from policy design and implementation discussions that affect the industry. The DDA Director noted improvements in its regulatory and institutional frameworks that govern manufacturing, but did admit that the agency only monitors private pharmacies in the Kathmandu Valley.

Indeed, the DDA lacks distribution governance guidelines and the manpower to monitor private distributors' distribution practices and/or warehousing and storage facilities. For instance, CRS's Kailali wholesaler puts medicines on public buses to reach remote areas, calling into question proper delivery for temperature-sensitive drugs, and a 2015 report found that the physical premises of most private wholesalers were rated *below average* or *poor*.[49] During the PSLA, the Team heard reports of drugs being stored in unsanitary conditions, shipped on public transport, sold after their expiration date, or improperly disposed. The porous Indian border poses additional regulatory challenges, with large quantities of Indian drugs entering Nepal daily without a satisfactory guarantee of quality or authenticity.

Pricing variability and access to credit pose significant challenges to affordability. The MoH Drug Act should control drug prices but in practice they are set by manufacturers and wholesalers.[50] The DDA establishes price minimums for manufacturers and distributors; manufacturers are allowed a 6-10 percent mark-up and distributors and retailers are allowed a mark-up of 16 percent. The large quantity of wholesaler distributors does not allow for economies of scale or distribution network efficiency, so firms compete on price alone. This leads to a "race to the bottom" in which wholesalers cut costs to compete – sometimes by compromising quality. Manufacturers also complained of long credit cycles with retail pharmacies, which creates cash flow problems.

3.4.4 Opportunities to Leverage Private Pharma

USAID/Nepal has heavily invested in Lomus and CRS to increase access to essential drugs. Building on these successful investments, the Mission commits to reducing CRS's dependence on donor funds and helping it become financially sustainable. The Team recommends a continued focus on CRS, potentially encouraging the organization to explore private-private partnership opportunities with other distributors. For example,

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[49] WHO and SERO. Nepal: Situational Analysis. January, 2015. Kathmandu.
[50] Ibid.

Lomus discussed plans to establish a nonprofit to distribute a basket of generic health products and consumer health goods (e.g. sanitary napkins). Even if Lomus and CRS decide against collaboration, these efforts would grow the overall market and force CRS to adopt more efficient management approaches.

The Mission, under its upcoming Health System Strengthening project, could assist DDA leadership in strengthening the policy and regulatory environment, particularly in the areas of distribution and professional training. The current head of the DDA expressed an interest in having USAID support preliminary policy analysis and capacity building as short- and long-term interventions, stating that "*private distribution of medicines is the weakest link in Nepal's supply chain*." Specifically, he expressed interest in interventions that 1) support firms' access to financial products to expand domestic and export sales and achieve economies of scale and/or 2) support dialogue to ensure private pharmaceutical manufacturers balance the needs of MDAGs by producing generics, potentially through GoN incentives.

Table 7. Opportunities to Harness the Private Pharma Sector

Strategy	Interventions
Assist public/private sectors to address key policy issues/build trust	• Support public-private dialogue through APPON to ensure private pharmaceutical manufacturing balances the needs of MDAGs by producing generics, potentially through GoN subsidies to incentivize production of less-profitable products
Assist the MoH to carry out key reforms that will strengthen its capacity to regulate the private health sector	• Support DDA to conduct a market assessment to identify comparative advantages of public and private chains and opportunities to harness private sector expertise and infrastructure to strengthen the public supply chain • Help DDA conduct a policy and regulatory review in the areas of drug pricing, mark-ups, and distribution standards, benchmarking them against international best practices
Build MoH systems and capacity to partner with private health sector	• Help DDA improve distribution regulations and develop a strategic plan for improving market efficiencies while expanding distribution and ensuring quality
Increase access to essential medicines and health supplies	• Explore Lomus' proposal to establish a nonprofit arm to manufacture and distribute a basket of affordable drugs and health products • Help CRS become financially independent distributor of drugs and health products

3.5 Health Financing

3.5.1 Overview of Health Financing

As Table 8 shows, Nepal's total health expenditure (THE) has tripled from 31 million NPR in 2004 to 112 million NPR in 2014.[51] At the same time, the size of Nepal's health market increased at an annual rate of 11.8 percent.[52] Drivers for this rapid expansion include: 1) growing incidence of illnesses (particularly non-communicable diseases), 2) mounting health care costs, 3) increasing standard of living, and 4) rising demand for private healthcare services.[53]

Table 8. Funding sources of Nepal's Total Health Expenditures[54]

Funding Sources	Percentage of Total Health Expenditure (THE)					
	2004	2005	2006	2007	2008	2009
Private (insurance < 1%)	62%	60%	56%	66%	62%	60%
Development partners	21%	20%	20%	16%	17%	19%
Gov't of Nepal	17%	20%	24%	18%	21%	21%
THE (millions of NPR)	30,650	32,960	34,796	36,019	43,613	52,526

[51] WHO NHA database

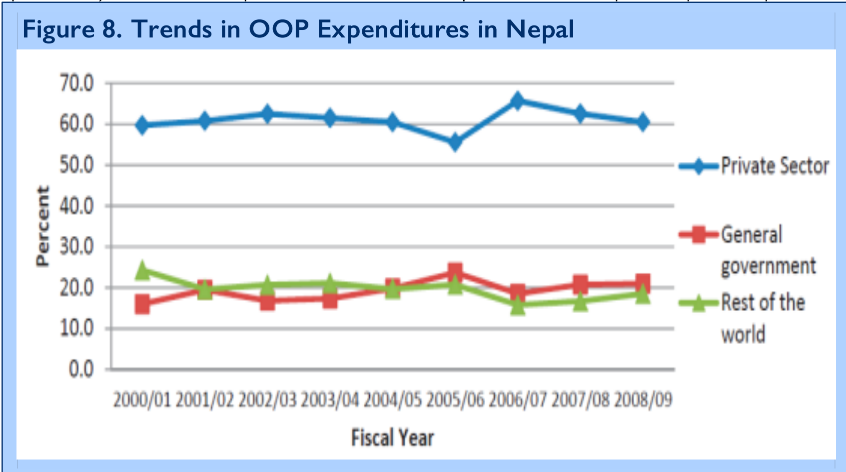
[52] Shrestah BR and Y. Gauchan, GS Gautam, P Baral. Nepal National Health Accounts 2006/07 – 2008/09. Health Economics and Financing Unit, Ministry of Health and Population, Government of Nepal. 2012, Kathmandu.

[53] Torres, Luis V and Gahn Shyam Guatam and Franzisak Fuerst and Chandra Mani Adhikari. Assessment of the Government Health Financing System in Nepal: Suggestions for Reform. GIZ: November, 2011. Kathmandu.

[54] Nepal 2004/5- 2009/9 NHA

In Nepal, there are three primary sources of health funding: GoN, development partners/rest of the world, and the private sector. Figure 8 shows the distribution of funds between these three sources. Between 2000/01 and 2008/09, private sector funding (mainly comprising out-of-pocket (OOP) expenditures) has remained relatively constant at 60 percent, as have the GoN (20 percent) and development partners (20 percent). The GoN portion is low compared to the per capita expenditure of other countries in the region.

Figure 8. Trends in OOP Expenditures in Nepal



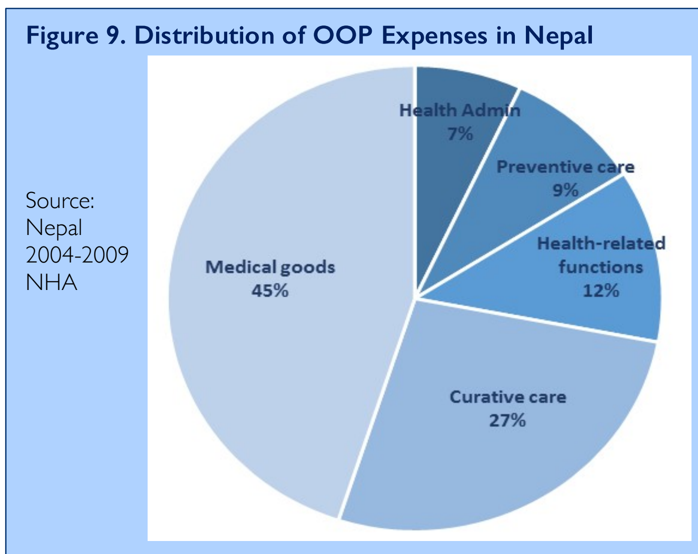
In 2011, OOP expenditures totaled $570 million USD, 45 percent and 27 percent of which was spent on drugs and hospital services (curative care), respectively (see Figure 19).[55] Increased consumer spending is usually an opportunity for PSE but individual spending is not seen as the best way to finance health for the rural poor; the NHA estimates that 14% of Nepalese suffer from financial impoverishment due to high OOP expenses. The 2014 Kathmandu Valley study found that one in seven families experienced a health-related financially catastrophic event in the last 30 days, suchs as complications from hypertension, diabetes, and asthma as well as common health issues (flu, cough, cold) that worsen when patients avoid going to the doctor.[56]

Under this backdrop, the Team examined the current financing approaches that the MoH uses to incentivize firms to provide services to underserved populations. They are organized into two categories: 1) risk pooling mechanisms and 2) strategic purchasing of health services.[57]

- **Risk pooling health funds**: The GoN pools funds through taxes, development partners pool funds through the SWAP mechanism, and private insurers pool funds through insurance schemes.
- **Strategic purchasing of health services:** Rather than acting as a health provider, the MoH uses contracts to purchase goods and services from private providers.

Figure 9. Distribution of OOP Expenses in Nepal

Source: Nepal 2004-2009 NHA



55 WHO National Health Accounts database website: http://www.who.int/nha/country/en.

56 Saito, Eiko and Stuart Gilmour, Mizanur Rhaman, Ghan Shyam Gautam, Pradeep Krishan Shrestha and Kenji Shibuya. Catastrophic Household Expenditure on Health in Nepal: A Cross Sectional Survey. Word Health Organization Bulletin 2014; 92: 760-767. Doi: http ://dx.doi.org/10.2471/BLT.13.126615.

57 While the Team examined the role of debt/equity financing in facilitating the growth of private sector companies into new regions and segments of the population, it found that MoH-supported mechanisms have stronger potential to impact USAID's target beneficiaries. In addition, most firms interviewed choose to finance their own growth through profits rather than debt or equity. However, Laxmi Bank expressed interest in supporting the growth of health-related SMEs (see section 3.6, Other PSE Opportunities).

3.5.2 Strengths in Health Financing

Social health insurance: Experience in developed and developing countries demonstrates that some form of subsidized social health insurance (SHI) is the most effective pooling mechanism to increase access to health services for the poor. However, SHI goes hand-in-hand with health financing reforms.[58] Many reforms, such as building institutional capacity to pool risk and strategically purchase health services, are outlined in the NHSS and Draft State Non-State Policy. Moreover, interviewees claim that the GoN commits to equitable financing of health and supports the MoH in its efforts to pass the National Health Insurance Act, which contains a subsidy program.

"The government is introducing social insurance and will continue to expand. If there is a reliable revenue source, private hospitals and clinics might choose to expand as well." Dr. Arjun Karki

Private health insurance: There are 17 licensed private health insurers in Nepal. Health insurance is a relatively new product in Nepal and firms have only penetrated one percent of the market. Insurers offer similar benefit packages that cover major medical (hospitalization), diagnostics, and drugs but exclude preventative care. There are 20 contracted service providers/hospitals that dominate the private insurance market and a few insurers contract with Indian and international hospitals. The industry's principal clients are global and large Nepalese companies (e.g. banks, manufacturers, telecoms) that offer health policies to their employees. MetLife and Shikhar offer individual insurance policies for upper and middle class families who can pay the premium. Interviewees see room to grow in the insurance market since the high income and corporate segments have not been fully exploited. Four of five insurers interviewed discussed "down market" opportunities and emphasized their social responsibility in working with underserved populations (see Box 18). Some expressed interest in learning about others' experiences in micro-insurance/finance and health savings plans to reach MDAGs.

Box 18. Private Insurers with A Mission

"I want to bring health insurance for the poor. I conducted a market study on the cost to bring RSBY (Indian SHI) to Nepal. I even bought the license for the RSBY software. I am confident we could deliver the same benefit package more efficiently than the pilot. Under our ag insurance all 17 companies have set up a sales force that reaches all 75 districts." Insurance leader #1

"All private insurance companies in Nepal support SHI. It is important to make health insurance available and affordable for all." Insurance leader #2

"The industry's future is in the masses…. we are prepared to assist with the SHI." Insurance leader #3

All licensed insurance carriers belong to the Health Insurance Association, which helped draft the National Health Insurance Act with the MoH, a process that ended in early 2017. As of this writing, the Act is with the Law Ministry, after which it will go to Parliament for Cabinet approval. The Association Director believes the timing is right to introduce national health insurance, stating that the current draft is "private sector-friendly" and the GoN is open to private insurers as insurance administrators and private firms as services providers. As a result, the Association is actively lobbying Parliament to approve the Act. By all accounts, this Association is more organized than the Private Hospital Association and can be an effective ally in advocating SHI.

Strategic purchasing of health services/service contracts: The GoN states that it aims to establish institutional separation between the MoH's role as financier of health/steward of public funds and provider of actual health services. Procuring/purchasing health services from the private sector is a key component to creating this separation. Creating these types of institutional arrangements, building the MoH's capacity to manage procurements effectively, and incorporating these requirements into service contracts could incentivize the private sector to deliver health services, particularly in remote areas and to underserved

[58] Saito, Eiko and Stuart Gilmour, Mizanur Rhaman, Ghan Shyam Gautam, Pradeep Krishan Shrestha and Kenji Shibuya. Catastrophic Household Expenditure on Health in Nepal: A Cross Sectional Survey. Word Health Organization Bulletin 2014; 92: 760-767. http ://dx.doi.org/10.2471/BLT.13.126615.

populations. The MOUs signed between the MoH and nonprofit providers (e.g. Nick Simons Institute, Possible Health) and successful reimbursement schemes for commercial providers through the Aama program demonstrate how the GoN has already used incentive schemes to grow the health market for MDAGs.

Interviews with providers and PMCs reveal that the MoH hires private providers to deliver health services through 30 types of contracts that include MOUs, grants that defray costs of health service delivery, and provider payments (e.g. Aama). The MoH has used MOUs and/or grants with nonprofits (e.g. Possible Health in Achham and Charikot) and commercial providers to offer health services (e.g. uterine prolapse) and manage the operations of public hospitals and maternity wards (see Lamjung Community Hospital agreement, Appendix E). According to interviewees, the MoH recognizes the benefits of contracting with private providers, which include improved management operations, reduced financial costs, enhanced capacity, increased volume, and improved quality. Meanwhile, commercial providers expressed interest in deepening their contractual relationship with the MoH in the areas of specialty services and diagnostics.

There are several new policy initiatives recently approved, including the Public Procurement Act (January 2017), NHSP III (approved) and State Non-State Policy (likely approved in 2014) that would address MoH system gaps in contracting and accelerate the use partnership to achieve priority health objectives.

Aama Program: To reduce maternal mortality rates, the GoN 1) established the Safe Delivery Incentives Program in 2005 (later renamed Aama Surakshya Karayakram, or Aama); 2) removed user fees in MoH facilities in 2009 (as a part of the Aama package); and 3) introduced the four antenatal care (ANC) incentive program to increase uptake of ANC visits during pregnancy in 2009. These initiatives aim to remove the economic barriers to access full maternity service packages. Though classified as demand-side financing, these projects include service purchasing aspects as the MoH reimburses participating public and private facilities for service delivery. The Aama program has achieved its stated goals (see Box 19) as 2/3 of nonprofit and for-profit health facilities participate in the program.[59] For more information, please see Appendix D.

Box 19. Aama Program between 2005 and 2010

Successes

- Women's awareness of cash incentives increased from 14% to 64%
- Number of participating facilities rose from 20% to 67%
- Delays in disbursement of funds for cash incentives to participating facilities decreased from 93 days to 2 days
- Percentage of institutional deliveries increased from 33% to 51%

Challenges

- Women's awareness of Aama remains low – 27%
- Uneducated, poor, Muslim, and rural women know little of Aama

Source: Powell-Jackson et all, 2010.

3.5.3 Weaknesses in Health Financing

Social health insurance: The MoH's Social Health Security Development Committee (SHSDC) launched a pilot project in three districts while waiting for approval of the Act, which has caused several implementation problems (Appendix C). The SHSDC runs the pilots but lacks technical expertise in insurance programs, so it manages them as if they were part of a public health program (in essence creating a new, parallel public agency). Because of this disjointed approach, the Kailali pilot faces many challenges that should be resolved before the SHI program is rolled out nation-wide:

- Provider payment delays even as the Claims Department processes only 35-50 claims per day;
- Weak quality assurance of participating MoH healthcare providers;
- Insufficient supply of providers that meet minimum requirements, which results in referring patients to Kathmandu Valley-based private providers for specialty care;

[59] Torres, Luis V and Gahn Shyam Guatam and Franzisak Fuerst and Chandra Mani Adhikari. Assessment of the Government Health Financing System in Nepal: Suggestions for Reform. GIZ: November, 2011. Kathmandu.

- Reluctance to empanel private hospitals in the SHI pilot despite their interest because the District Health Management Team does not trust companies and cannot control quality; and
- Poor client uptake due to poor internal GoN and MoH communication and delays in classifying exempted populations.

Private health insurance: While interviewees expressed interest in "down market opportunities" as well as a sense of social responsibility to help the underserved, the private insurance market remains nascent and focused primarily on upper class, urban customers. Without significant incentives from the GoN to reach the underserved, any movement in this area will be more based on charity than business drivers.

Strategic purchasing of health services/service contracts: Most partnership arrangements and MOUs are informal, ad hoc, and based on personal relationships rather than institutional and operational culture. Interviews with MoH leadership revealed a lack of staff expertise, systems, and regulations to effectively contract with the private sector or ensure quality under existing contracting mechanisms.

Aama Program: Challenges relating to management, implementation, and uptake of four ANC visits remain as Aama struggles to reach underserved women. A 2012 rapid assessment revealed the following:

- Quality issues in both public and private facilities due to unavailability of clinical guidelines, minimal clinical training, and lack of supervision;
- Failure to meet minimum requirements, particularly among public facilities, in the areas of staffing, equipment, and medicines;
- Financial management challenges stemming from budgeting and financial planning systems that do not follow best practices and provide low reimbursement rates; and
- Non-compliance with free delivery care as some facilities still charge patients and/or do not give the transport incentive due to cash shortages.[60]

Box 20. Opinion of MoH from Aama Providers

"The MoH recognizes it does not have sufficient capacity to monitor for-profit providers. Since they are afraid of fraud, they prefer to work with public and NGOs only." Development Partner Officer #1

"The MoH is selfish… they want all the deliveries so they can receive the extra funds. They would never refer patients to us even though we can double our capacity." Participating for-profit provider

"At higher levels of MoH leadership, there is support for for-profit firms to participate in Aama. But at lower levels, MoH management sees them as a threat." Development Partner Officer #2

For-profit facilities face additional challenges in implementing the Aama program (See Box 20). Though not difficult to become an Aama provider, few receive orientation in the program's guidelines and even fewer receive clinical training to ensure they meet minimum quality of care standards.[61] Low reimbursement levels create a disincentive for some for-profit providers since they receive a third of the cost of a delivery whether it is 'normal', 'complicated', or a C-section. Moreover, for-profit providers cannot charge patients, including those who can afford to pay, losing potential revenue from more affluent market segments. Participating for-profit providers said they can make up the cost differential through increased demand for more lucrative health services generated by added foot traffic (see Appendices D and E).[62] They also stated that they can double the number of deliveries but struggle to do so because 1) the MoH facilities, although overcrowded, will not refer excess patients to participating private providers; 2) some patients fear higher prices at private providers; and 3) there is no clear message to work with for-profit providers from MoH leadership.

[60] Ibid.

[61] Upreti, SR and SC Baral, S Tiwari, H Elsey, S Aryal, M Tandan, Y Aryal, P Lamichhane, and T Lievens. Rapid Assessment of the Demand Side Financing Schemes: Aama Programme and 4ANC. Ministry of Health and Population. Nepal Health Sector Support Programme and HERD. 2012, Kathmandu.

[62] For-profit hospitals must be strategic when planning to participate in government programs as several interviewed do not participate in the pro-lapse partnerships because the reimbursement level (12,000 rupees) is half of what they can charge (25,000 rupees).

3.5.4 Opportunities to Improve Health Financing

Potential areas for USAID to further advance health financing reforms focus on 1) building public and private sector support for the National Health Insurance (NHI) Act; 2) helping the MoH build its systems and capacity to carry out strategic purchasing; 3) strengthening the Aama program as a vehicle to grow the private provider role in maternal health; and 4) exploring debt and equity financing initiatives. See Table 9 for more details.

Build support for the NHI Act. According to interviewees, the time is right for USAID to support the GoN's proposed health reforms that will lead to more equitable financing of health in Nepal. The NHI Act is ready for passage and will provide the foundation on which to create a solidarity fund for MDAGs to pay for their health services. Some insurers want to participate in the SHI program to expand into new markets with affordable plans "*that serve the masses*". Finally, Dr. Arjun Karki urged USAID to "*take advantage of the private sector's desire to expand, potentially outside of urban centers, in response to an increasingly crowded marketplace*", demonstrating a readiness of partners once financing options expand.

Help MoH build its systems and capacity to carry out strategic purchasing. MoH leadership looks to development partners such as USAID to build the Ministry's capacity to conduct strategic purchasing, a function of all health financing initiatives that involve the private sector. Aama is a "*good first* step", as it sets the precedent of the MoH reimbursing providers for services delivered on its behalf, opening the door for commercial providers to expand in public health.

Strengthen Aama to grow the private provider's role in maternal health. Aama's current structure disincentives for-profit providers to participate, as they must offer free maternal services even though reimbursement levels do not reflect the true cost of services and some clients can pay full price. Appendix D explores Aama in more detail and includes recommendations to fortify it.

Explore debt and equity financing initiatives. If the Mission is interested in debt/equity financing solutions, it may consider financing initiatives similar to the Medical Credit Fund (MCF), a nonprofit health investment vehicle that supports clinics too large for microfinance but too small for commercial bank loans. MCF has established a partnership with commercial banks in several sub-Saharan African countries to expand health-specific lending products and services to health enterprises, such as RMNCH savings plans.

Table 9. Opportunities to Advance Health Financing Reforms

Strategy	Interventions
Build public and private sector support to pass the NHI Act	• Use USAID's convening authority, global reach, and thought leadership to bring best practices and lessons learned regarding micro-insurance/finance and health savings plans to Nepal's public and private sectors • Work with trade associations to convene a coalition of private health insurers, healthcare businesses, and civil society representatives to advocate passage of NHI Act • Include private insurers and civil society representatives in the design and implementation of a SHI program (e.g. participation in Committee, design and roll-out, possible third party administration) • Convene public-private dialogue regarding quality assurance in private hospitals to build trust as MoH considers including private providers in the SHI program
Build MoH systems and capacity to purchase private sector health services and goods	• Review MoH's current MOU/service agreement pipeline and recommend how to strengthen agreements with international best practices in contracting • Work with the German development agency (GIZ) to assess SHI pilot projects • Help MoH establish policies and regulations, operating systems, and staff capacity to purchase health services through health insurance, voucher programs, and service contracts
Strengthen Aama to grow the private sector's role in MCH	• Help MoH conduct costing analysis of MCH services in public/private facilities as an input to future service contracts • Investigate the cause of delays in provider payment processing at Claims Department to determine need for workforce development, technology, and/or governance interventions

Explore debt/equity options	• Research the Medical Credit Fund to determine whether the model would work in Nepal • Convene lending institutions (e.g. Laxmi Bank) to determine how the current Development Credit Authority (DCA) tool may be used/modified for the health sector

3.6 Other Health PSE Opportunities

The PSLA also revealed opportunities that may involve health and other industries and social groups.

Laxmi Bank. Laxmi's health portfolio (2% of its total portfolio) comprises large hospitals in urban areas, small private clinics, dental clinics, and pharmaceutical firms; the portfolio grows when traders and transporters of medical products (among other products) are considered. The portfolio produces good returns and Laxmi wants to expand into health-related SMEs that spread risk across many firms and provide better returns than more traditional large-scale health facility construction projects. Appendix G highlights potential partnership opportunity areas with the bank, which has worked with USAID in the past through the DCA.

Ncell. Nepal's largest telecom expressed strong interest in partnering with donors and NGOs that address social challenges through funding from CSR and/or business units looking to reach new consumers with additional products and services. Since the follow-through of potential partners has not lived up to initial expectations, Ncell launched its own Dial-a-Doctor and micro-insurance initiatives. As such, the Team recommends Ncell as a potential partner for USAID/Nepal at the Mission and project level and highlights insights and recommended next steps in Appendix H.

Diaspora engagement. The American Nepal Medical Foundation led by Dr. Jyoti Bhattarai is the principal body that channels diaspora resources to health care delivery in Nepal. Established in 1996, the Foundation has 500+ active members of US-trained and/or US-based doctors who raise funds and volunteer their time. It has been involved in various initiatives such as strengthening the intensive care unit (ICU) in Patan Hospital, rehabilitating 11 health posts in earthquake-affected districts, procuring an oxygen plant for the Teaching Hospital, and sponsoring certification/training in the US and Singapore. The Foundation has been largely reactive to date but would like to be more strategic and with its existing network of medical practitioners in the US and Nepal, it would be an excellent resource as USAID explores the potential role of diaspora engagement in health. There are indications of diaspora interest in health care, as evidenced by the $20 million raised among diaspora to construct Grande Hospital in Kathmandu.

Unilever Nepal Ltd. Unilever's Lifebuoy soap is the most popular soap in Nepal and Unilever has made a global commitment to improve the handwashing habits of one billion people by 2020. The Team spoke with Unilever Nepal about its School of Five program, which is a global initiative successfully implemented since 2014, especially in rural and earthquake-affected zones. Much like Unilever's other social programs, School of Five receives its funding from the Marketing Department, which demonstrates Unilever's commitment to shared value as it addresses social issues directly through its core business activities. The Team recommends contacting the Unilever Relationship Manager if the Mission wants to explore partnership opportunities with Unilever. For more information, please see Appendix J.

4. Recommendations

4.1 Strategies and Interventions

After analyzing and prioritizing opportunity areas highlighted by the PSLA, the Team presents the four strategic areas and corresponding interventions for USAID/Nepal as it considers the use of PSE to achieve greater development impact across the health sector. In addition to a general description of each strategic recommendation and its supporting sub-recommendations, the Team presents the following stand-alone analyses that articulate opportunity areas and action steps:

- Figure 10 provides a general description of each strategic area of intervention.
- Table 10 maps out strategic areas, interventions, and possible short-, medium-, and long-term activities to support the strategies. These recommendations, unless otherwise indicated, are to be carried out by a USAID implementing partner.
- Table 11 highlights potential intervention models that correspond to USAID/Nepal's PSE role as convener, advocate, thought leader, funder, co-creator of shared value, and market shaper.

4.1.1. Facilitate public-private dialogue to build trust and lay the foundation for increased private sector engagement in health

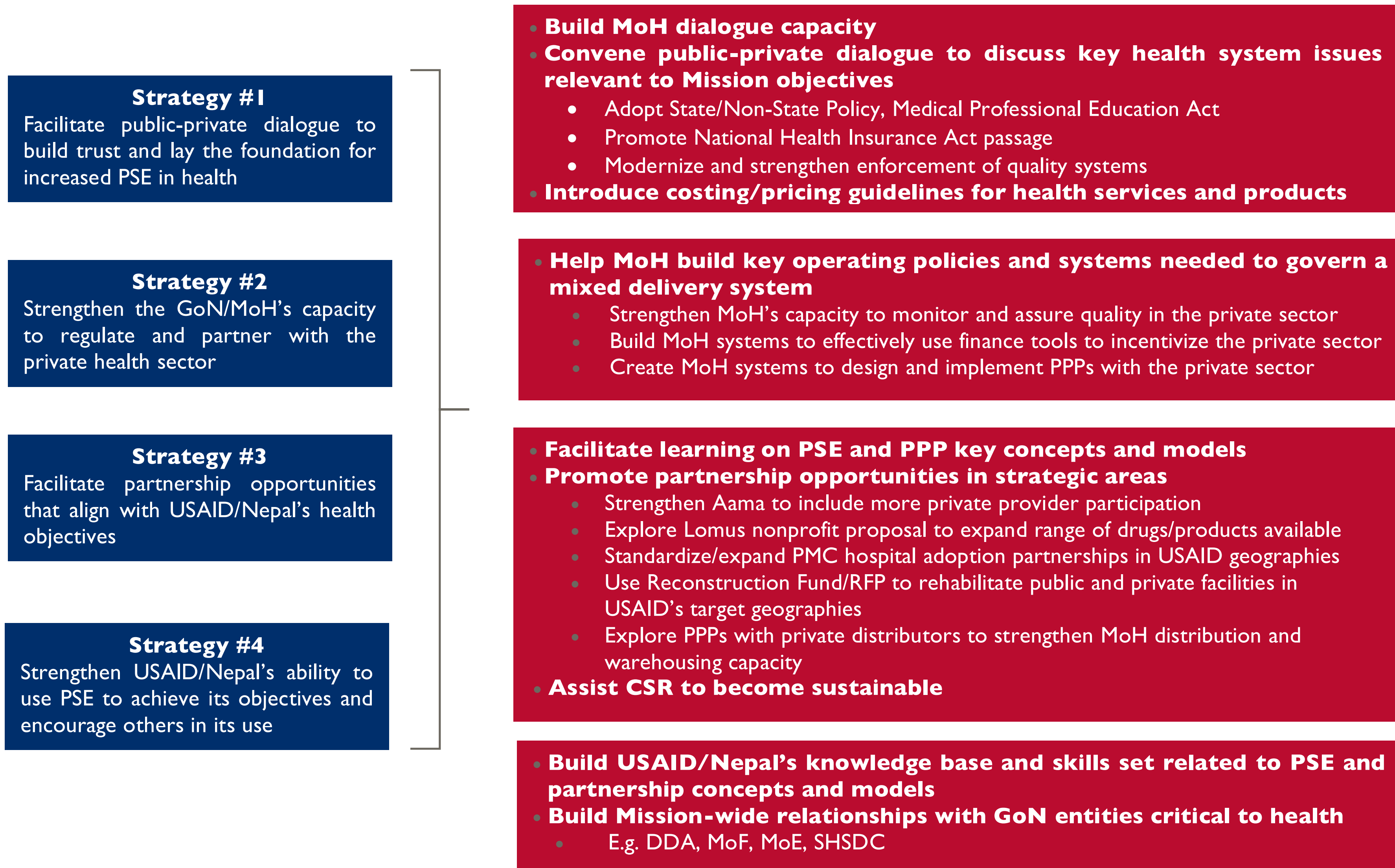
To address the mistrust between the public and private sectors, USAID should use its current Health for Life project to begin a public-private dialogue and its upcoming Health System Strengthening project to continue and strengthen that dialogue. These initiatives would aim to build public and private capacity to effectively communicate and collaborate during common policy and planning activities (e.g. strategic planning, annual planning and budgeting, policy design and Implementation). Both sectors lack organizational structure – policy frameworks, convening authority, dialogue platforms, representative bodies, and communication/information exchange mechanisms – as well as partnership skills needed for this dialogue. USAID's implementation partner for the upcoming project could serve as the 'honest broker' to promote and facilitate dialogue between the sectors. In addition, the implementing partner could provide the policy analyses to inform dialogue on key policy issues related to PSE such as the State/Non-State Policy, Professional Medical Education Act, NHI Act, regulatory reforms to strengthen quality in the private sector, and possible pricing guidelines.

4.1.2. Strengthen the GoN/MoH's capacity to regulate and partner with the private health sector

In a mixed health delivery system like Nepal's, the MoH needs to have central policy frameworks and systems in place to monitor the private health sector as well as financial mechanisms to incentivize it. As the PSLA notes, the MoH does not have these governance tools in place to effectively manage healthcare providers outside of the public health network. The Team recommends that the new Health System Strengthening project take a system-wide approach that includes strengthening the MoH stewardship capacity to effectively monitor its own services and those in the private sector through three policy initiatives:

- Create an impartial quality assurance system that puts into place a standard framework that applies equally to both public and private sectors. The PSLA highlights policy gaps in quality for both health services and health products.
- Build a tool kit of financial policy instruments that incentivize a more equitable financing of health services and private provider expansion into areas of interest to USAID. Some form of national health insurance with a subsidy program is key to achieving the first objective while service contracts, tax incentives, and supply subsidies help achieve the second.
- Create a PPP policy framework that articulates the operating systems and skills staff need to design, monitor, and evaluate partnerships. Encouraging the GoN to adopt the State/Non-State policy and facilitating learning exchanges regarding PPPs are two key steps to building this framework.

Figure 10. Strategic Areas to Strengthen the Nepalese Health System Through PSE



4.1.3. Facilitate PSE and partnership opportunities that align with USAID/Nepal's health objectives

The best strategy to promote PSE and PPPs that can achieve a public health objective is to demonstrate proof of concept. The MoH is comfortable partnering with nonprofit providers. The challenge moving forward is to identify and implement partnerships with commercial providers to show that they can complement MoH efforts to increase access to essential services for underserved population groups. There are a few 'low hanging fruits' that USAID/Nepal, with the Healthy Life Project, can pursue:

1) Help the MoH review its current pipeline of MOUs and service agreements and recommend how to strengthen them and integrate international best practices in contracting.
2) Support targeted policy analysis to recommend how to modify the Aama Project to attract more private health care providers located outside of Kathmandu Valley.
3) Continue working to make CRS a financially sustainable enterprise.

Other opportunities in the medium- and long-term include: 1) working with Lomus to create a nonprofit arm to distribute a basket of health medicines and products; 2) assisting the MoH to develop contracts with PMCs to adopt public hospitals and/or clinics in underserved geographic areas; 3) using USAID reconstruction funds to rehabilitate public or private hospitals that serve MDAGs; and 4) partnering with private distributors to strengthen MoH distribution and warehousing. The Team underscores the need for the Health Systems Strengthening project to be flexible in identifying possible partnership opportunities as the policy environment and political landscape changes over the next five years.

4.1.4. Strengthen USAID/Nepal's ability to use PSE to achieve its health objectives and encourage others in its use

USAID has a long history of working with the private health sector to achieve public health objectives as well as extensive experience in health financing and health system strengthening. Given its unique position among donor peers, the Mission should play a leadership role in integrating PSE into how it achieves its health objectives as well as supporting other donors interested in doing the same:

1. Mission staff can benefit from lessons learned from other Missions and health projects that involve PSE and health systems strengthening to inform current programs and guide the design of the upcoming Health Systems Strengthening project.
2. USAID/Nepal can convene local stakeholders, implementing partners, and donors to discuss PSE and PPP concepts and models and learn about successful PSE examples from the region.
3. USAID/Nepal can encourage its own implementing partners to examine ways to harness private sector capacity to fulfill their project mandates as well as urge other donors working in health to work with the private health sector through their programs that support the MoH.
4. The Health team can expand its working relationships with other government agencies (e.g. MoF, MoE) that play important roles in the health sector by promoting policies that impact the MoH's ability to use financial tools and PPPs to leverage the resources of the private health sector.

4.2 Phasing of Strategies and Interventions

The Team has proposed several interventions that can be implemented through many of USAID/Nepal's current projects. Key among them are the Healthy Life Project, the CRS Project, and the SHOPS project. But the upcoming Health System Strengthening project can potentially play a catalytic role in providing TA to both the public and private sectors to create the policy framework, institutional arrangements, and local expertise to engage and partner with the private health sector.

Most of these policy and systems interventions are mid- to long-term activities. However, there are some quick wins that USAID/Nepal can continue (e.g. CRS sustainability) and/or pursue in the next year with its existing implementing partners. Towards that end, the Team developed a road map that organizes the proposed interventions by strategic area and phase (see Table 10).

USAID must understand the nuances between these different entities, their core competencies, and their motivations/incentives. Partnerships succeed when they utilize USAID's and its potential partner(s)' core competencies to address a challenge, and it is important to note that successful PSE models do not always require financial resources. Throughout the PSLA, the Team maintained a broad perspective as it considered the full range of roles that USAID plays when engaging, partnering with, or advocating on behalf of the private sector. For instance, due to the central role that the GoN plays as a healthcare provider, the PSLA highlights several opportunities for USAID/Nepal to advocate policy adjustments and public procurement mechanisms that could advance health objectives through more effective health financing. Likewise, the PSLA uncovered opportunities for USAID to serve as a convener, bringing together public and private health stakeholders to foster better working relationships between the two sectors. Table 11 highlights these opportunities and the distinct roles that USAID/Nepal may play in pursuing them.

5. Conclusion

From natural barriers and infrastructure issues to weak financing schemes and regulatory inefficiencies, healthcare businesses in Nepal successfully adapt to a unique blend of challenges to succeed and grow. Again and again, the Team encountered a sense of optimism among stakeholders that could only be attributed to a sector that is not only surviving, but growing and expanding. Furthermore, these actors are eager to collaborate with USAID/Nepal under the right circumstances.

Perfect alignment of USAID's interests and those of the healthcare industry does not exist as the private sector gravitates towards curative care and other higher-margin goods and services. However, given the increasing relevance of the private sector in healthcare throughout Nepal, USAID/Nepal has an opportunity to leverage its strengths through targeted PSE. Based on the Team's analysis, this opportunity is not likely to come in the form of a single flagship partnership, but rather through broader orientation towards the private sector and use of the full range of PSE functions, from convener to advocate to market shaper.

The private health sector in Nepal continues to complement public sector solutions in health and industry leaders and service providers have demonstrated an ability to drive improvements in quality, quantity, and access. While there is a need for the GoN to act as a more effective guarantor of quality through better regulatory enforcement, the entrepreneurial energy of the private sector is not in question. If USAID can help harness that energy towards improving Nepal's quality and access to health care, the Mission will have gained a powerful ally in deepening its impact to advance health outcomes in Nepal.

Table 10. Strategic Recommendations Road Map

Strategy	Short-Term (1 yr) Existing Projects	Medium-Term (2 years) New HSS Project	Long-Term (3-5 years) New HSS Project
Strategy #1 **Facilitate dialogue to build trust and lay foundation for PSE in health**	- Build MoH capacity	- Continue public-private dialogue	- TA to establish formal public-private dialogue mechanism
	- Begin dialogue between public and private sectors	- Build private sector dialogue capacity - Advocate a private sector seat on the SHDC - Convene private and MoH hospital managers to share strategies to improve management/QOC	- Build private associations capacity as membership organizations and to unify the private sector 'voice' - Convene a coalition of private health insurers - Help private associations convene public-private technical forums similar to one re: hospital management
	- Address key policy issues relevant to USAID objectives - Advocate approval of State-Non-State Policy	- Address key policy issues relevant to Mission objectives - Advocate passage of Professional Medical Education Act and NHI Act - Include private insurance providers and civil society in design/implementation of SHI pilot	- Address key policy issues relevant to Mission objectives - Promote NHI Act and private sector role in financing and service delivery - Assist MoH to modernize and strengthen enforcement of a standardized QA for both public and private providers - Introduce costing/pricing guidelines for services and products
Strategy #2 **Strengthen public sector capacity to regulate and partner with the private health sector**	- Strengthen MoH's capacity to monitor QOC - Convene public-private dialogue regarding QA in private hospitals to build trust as MoH considers including them in SHI program	- Strengthen MoH's capacity to monitor and assure quality of services/products - Help MoH share clinical/treatment protocols, specifically re: MCH services, with private sector - Help MoH conduct assessment of policies, regulations, and institutional capacity related to health service quality - Help DDA conduct policy/regulatory review in drug pricing, mark-ups, distribution standards, and benchmark against global best practices - Share third country experience in QA systems using third party administrators to monitor QOC	- Strengthen MoH's capacity to monitor and assure quality - Assess overall QOC in select private sector organizations to determine if USAID should partner with them - TA to develop MoH regulatory policy to monitor private sector - Help build associations'/councils' tools and modernize systems to regulate private sector quality - Help MoH establish simple QA system to ensure QOC of health services in both public and private sectors - Help MoH implement different regulations mechanisms once in place - Help DDA improve distribution regulations and develop a plan to improve market efficiencies, expand distribution, and ensure quality
		- Build MoH's systems to implement financing tools - Investigate cause of delays in provider payment processing at GoN Claims Department - Work with GIZ to assess SHI Pilot	- Build MoH's systems to implement financing tools - Strengthen implementation of current subsidies and experiment with new ones (e.g. Special Economic Zones, tax breaks) - Develop/institutionalize financial mechanisms to incentivize private providers to expand to rural areas (e.g. SHI, vouchers, service contracts) - Provide TA to MoH to conduct costing analysis of MCH services in public/private facilities as an input to future service contracts
		- Build MoH capacity to design and implement PPPs - Commission private sector analysis (e.g. market size, segmentation, role) to build knowledge base - TA to strengthen existing MOUs with nonprofits	- Build MoH capacity to design and implement PPPs - Identify 'easy' partnership opportunities (e.g. private sector reporting) and assist GoN to facilitate the roll-out of these initiatives - Assist MoH to create capacity/systems to carry out PSE and implement partnerships

Table 10. Strategic Recommendations Road Map

Strategy	Short-Term (1 yr) Existing Projects	Medium-Term (2 years) New HSS Project	Long-Term (3-5 years) New HSS Project
Strategy #3 Facilitate partnership opportunities aligned with USAID health objectives	- Facilitate learning re: PSE/PPP concepts and models - Support Dr. Koirala's annual hospital management event	- Facilitate learning on PSE/PPP key concepts/models - Facilitate learning opportunities for MoH and private associations in other country experiences in PSE and partnerships - Conduct PSE training for MoH staff	- Facilitate learning on PSE/PPP key concepts/models - Facilitate learning opportunities for MoH and private associations in other country experiences in PSE and partnerships - Support 2-3-week hospital management course(s) targeting public and private hospital managers
	- Promote partnership opportunities - Explore Lomus' possible interest in a nonprofit arm through SHOPS Plus project	- Promote partnership opportunities - Support DDA to conduct a market assessment to map public and private supply chain comparative advantages - Use USAID Reconstruction Fund to rehabilitate public and private facilities in rural areas	- Promote specific partnership opportunities - Adapt Aama to expand private provider participation in program - Standardize and expand PMC hospital adoption partnerships in USAID geographies - Assist CRS to become financially sustainable - Explore opportunities to harness private sector expertise and infrastructure to strengthen public supply chain
Strategy #4 Strengthen USAID's PSE skillset	- Build Mission's PSE knowledge and skills - Facilitate USAID staff participation in on-going training re: PSE, PPPs and health systems strengthening	- Build USAID/Nepal's knowledge and skills in PSE - Continue staff capacity building in PSE/PPPs - HSS: Support USAID in collecting lessons in PSE and PPPs from other countries - Support USAID/Nepal's convening function through facilitation of specific forums and events	- Build USAID/Nepal's knowledge and skills in PSE - Continue staff capacity building in PSE/PPPs - HSS: Support USAID to collect lessons learned in PSE and PPPs from other countries - HSS: Support USAID/Nepal's convening function through facilitation of specific forums and events

Supplemental glossary of terms

DDA	Department of Drug Administration	PMC	Private medical college
GIZ	German Development Agency	PPP	Public-private partnership
HSS	Health Systems Strengthening (project)	PSE	Private sector engagement
MCH	Maternal and child health	QA	Quality assurance
MoH	Ministry of Health	QOC	Quality of care
MoU	Memorandum of understanding	SHI	Social health insurance
NHI	National health insurance	SHSDC	Social Health Security Development Committee

Table 11. How USAID can Improve Health Through PSE

Role	Activities	Example	Global Experiences	Illustrative PSE Opportunities for USAID and/or Implementing Partners
Convene and Connect	Use its networks and credibility to convene actors around a challenge	Forums	Multi-stakeholder sector-specific events (e.g. Global Education Summit)	Convene representatives from MoH, MoF, MoE, and civil society to discuss health insurance with private providers
Advocate	Advocate with the private sector to change behaviors and promote policy change	Include private sector in key health policy dialogues	In Tanzania and Kenya, USAID worked with PPP units in MoH to identify barriers to services that could not be provided by private sector providers	- Support private insurer to join Social Insurance Board - Work with donors to advocate passage of laws and policies that involve the private sector, including those in the National Health Sector Strategy
Thought Leader / Partner	Introduce new ideas that inform development approaches and push the boundaries of what is possible	Forums, pilot projects	- USAID proposed innovative distribution of behavior change communication (BCC) materials with InBev during the onset of Zika in Brazil - Triparty collaboration was formed to develop BCC materials and InBev distributed them through 2 million sales points	- Build on its global expertise in program/facility management to help public/private sector providers and managers in Nepal improve the quality of health/hospital management system - Play a leadership role among donors to include private sector in key discussions (e.g. insurance) - Support efforts to utilize new/traditional media to foster dialogue re: role of private sector in health care - Sponsor public-private hack-a-thons to encourage new collaborative ideas around quality, affordable health care
Funder	Identify development challenge and select an implementer	Annual Program Statement (APS)	Through Grand Challenge for Saving Lives at Birth, USAID and its partners curate and fund new ideas	- Strengthen use of PSE in current health programs - Integrate PSE in new health activity design - Solicit solutions to promote science, technology, innovation, and partnership (STIP)
Shared Value	Define joint vision for success and co-create PPP that utilizes respective strengths of partners	- Global Development Alliance (GDA) - Broad Agency Announcements (BAA)	- GE: test use of ultrasounds in low resources settings to improve quality of antenatal care - Vodafone/GSK: Test mVacciNation mobile app to improve coverage rates and reduce stock-outs	- Ncell: co-develop BCC and mobile health campaigns that fit into current programming - Laxmi Bank: co-develop pipeline of 'bankable' entrepreneurs and health enterprises
Market Shaper	Mitigate obstacles that prevent private sector from functioning or investing in potential market	Market incentives, market research	- USAID and Bayer are developing middle income market for oral contraceptives in 11 countries - USAID uses DCA to work with private sector to de-risk investments and increase access to capital to enable firms to provide RMNCH/FP services	Work with private sector to support advocacy of public-private partnership laws/policies designed by MoH