

The national free delivery policy in Nepal: early evidence of its effects on health facilities

Sophie Witter,^{1,2*} Sunil Khadka,³ Hom Nath³ and Suresh Tiwari³

¹Research Fellow, Immpect, University of Aberdeen, Aberdeen, UK, ²Senior Consultant, Oxford Policy Management, Oxford, UK and
³Technical officers, Supporting Safe Motherhood Programme, Kathmandu, Nepal

*Corresponding author. Institute of Applied Health Sciences, Foresterhill, Aberdeen AB25 2ZD, UK. Tel: 01224 555704.
E-mail: sophiewitter@blueyonder.co.uk

Accepted 15 July 2011

Nepal faces the challenge of high levels of poverty, difficult access to health facilities and poor, though improving, health indicators. In response, in the past 5 years it has been experimenting with a range of approaches to removing user fees. Access to health care is now enshrined as a constitutional right for all. This article examines the latest policy, which was introduced in January 2009: free delivery care across the country.

The study objective was to understand the effects of the policy on health facilities. Study methods included structured forms to retrieve financial and activity data from national, district and facility records (comparing 10 months before implementation with 10 months after). These were supplemented by semi-structured interviews with key informants at different levels of the health system.

Findings include that utilization of services (at the facilities visited) continues to rise, with caesareans proportionate to the general growth in deliveries. Funds for the free delivery policy ('Aama') are found to be adequate to cover the main costs of services, with some surplus which can be invested in staff and in improving services. The system for reimbursing facilities is operating without undue delay and there is satisfaction with the flexibility of use of resources which it allows and the additional incentives for staff. The main concerns relate to wider systemic issues—in particular, understaffing in some key posts and areas, and dwindling general revenues for the facilities, especially through loss of wider user fee revenues. This may explain the ongoing charges for patients, which both facilities and patients report. It will be challenging to build on the gains of the past few years and sustain them, at the same time as merging the separate free care funding streams.

Keywords User fee removal, financial analysis, Nepal, maternal health

KEY MESSAGES

- Nepal and its development partners have shown leadership in tackling financial barriers to care with two free care policies; one focused on curative care at district level and below, and the other on provision of free deliveries nationwide (the 'Aama' policy).
- One year after implementation of the 'Aama' policy, funds are arriving at facilities in amounts adequate to cover service costs; managers and staff appreciate the flexible resources; and utilization of facility deliveries is increasing, though there is evidence that some costs are still being passed on to patients.
- A more holistic approach to health care financing is needed, in the context of merging the two free care strands. This will likely require a mix of input- and output-based funding, and may be a meeting point for supporters of essential health care which is free at the point of use and supporters of paying providers for performance.

Introduction

A national free delivery policy was launched in Nepal in January 2009. It was influenced by a number of factors and processes: technical, financial and political. On the technical side were studies showing the high cost of deliveries for households (Borghi *et al.* 2006). On the financial side was the support of a major donor, the UK Department for International Development (DFID), which was giving priority to safe motherhood in Nepal (Ensor *et al.* 2008). Politically, the new Maoist-led government had a commitment to providing tangible benefits to the population. This was enshrined in the new Constitution of 2007, which for the first time enshrined health care as a basic human right.

From this confluence of factors has flowed a number of significant policy changes in Nepal in the past 5 years, all aimed at increasing access to health care. The first was the Maternity Incentive Scheme (later called the Safe Delivery Incentive Programme, SDIP), a cash incentive scheme, which was initiated in July 2005. This included an element of fee exemption at facilities, but only in poorer (low human development index) districts. In other areas, the main provisions were incentive payments to women and health workers. An evaluation found that the SDIP had been successful in shifting behaviour; women exposed to the policy were 24% more likely to deliver in a government institution, 5% less likely to have a home delivery and 13% more likely to have a skilled attendant at their delivery (Powell-Jackson *et al.* 2008).

The next major shift, which has been introduced incrementally since 2006, was a more general move towards free essential health care. In 2006, emergency and inpatient care was made free for various priority categories (the poor, destitute, elderly, handicapped, and Female Community Health Volunteers) at district hospital and primary health care centre (PHCC) levels. Next, in 2007, free care was offered to all at health posts and PHCCs. Finally, in 2009, district hospitals were added to the facilities offering free care to all. Facilities receive a fixed volume of essential drugs and funds to cover the costs of treating patients. Sub-district facilities receive Nepalese Rupees (NRs) 10 (around US\$0.13) and district hospitals receive NRs 25 (US\$0.33) per outpatient. This policy has not been formally evaluated, but monitoring studies suggest that the policy is functioning to a large degree, but with continuing constraints to staffing and drug availability (CARE *et al.* 2009). The right to basic health care is now enshrined in the interim Constitution of 2007.

The free delivery policy (which goes under the name of Aama, meaning 'mother') developed out of these experiences. The aim of this article is to describe the new policy and assess its implementation and impact on health facilities, after 1 year of operation. The findings are based on a monitoring study conducted by the Supporting Safe Motherhood Programme. The article discusses the lessons learned to date and the interactions between the free delivery and wider free health care policies.

Background on the policy

According to Demographic and Health Survey (DHS) data, the maternal mortality ratios in Nepal declined from 539 (per 100 000 live births) in 1996 to 281 in 2006. This has been attributed to a number of factors, including a fall in fertility, legalization of abortion (in 2002), increase in family planning acceptance, increases in antenatal care and immunization, and a three-fold increase in nurse-assisted deliveries in rural areas (Pant *et al.* 2008). However, major challenges remain. Currently, in Nepal a newborn baby dies every 20 minutes and a woman dies of childbirth-related causes every 4 hours. Despite an increase in national rates of coverage from 10% to 20% between 1996 and 2006, according to DHS data, the overall proportion of women in Nepal delivering with a skilled health professional remains low. Poverty and difficult terrain, with limited access to facilities for many households, continue to demand innovative policy measures if Nepal is to reach its Millennium Development Goal targets (a maternal mortality ratio of 134/100 000 live births and neonatal mortality target of 15 per 1000 live births).

The Aama programme aims to reduce the cost of delivery care to households and to increase facility deliveries in Nepal, and hence to improve the health outcomes for mothers and neonates. It has two parts: (1) a universal free delivery service, which was launched in 2009 and is the focus of this article; and (2) a continuation of the SDIP, providing cash payments (varied by ecological region) to women who deliver in facilities, and incentive payments for health workers who undertake home deliveries.

The Aama Guidelines, published by the Ministry of Health and Population (MOHP) in 2009, specify the services to be funded, the tariffs for reimbursement and the system for claiming and reporting on free deliveries each month. Health

facilities with 25 and more beds receive NRs 1500 (US\$20) per normal delivery, while health facilities with less than 25 beds receive NRs 1000 (US\$13). Complicated deliveries are reimbursed at NRs 3000 (US\$40), while caesarean sections are paid at NRs 7000 (US\$93). These tariffs are intended to cover the cost of all required drugs, supplies, instruments and a small incentive to health workers (US\$4).

The Department of Health Services (DoHS) allocates funds to the districts on the basis of the estimated number of institutional and home-based deliveries attended by skilled health workers. The Health Facility Management Committee (HFMC) formed at each health facility puts in monthly claims for reimbursements to their District (Public) Health Office [D(P)HO], using customized forms.

The Aama programme is currently functioning in 1000 health institutions in the public sector, ranging from central hospitals to peripheral level health facilities. In addition it has started to enrol most not-for-profit institutions [community, mission and non-governmental organisation (NGO)-run hospitals]. The programme intends to expand to the private sector eventually. This is required to fill gaps in provision and access. Currently, there are 80 MOHP facilities in 53 districts able to provide basic emergency obstetric care services, including complications not requiring surgery. In addition, there are 46 MOHP facilities in 33 districts able to provide comprehensive emergency obstetric care including caesarean sections (MOHP 2010).

DFID has funded 80% of the Aama programme's cost for its first 18 months. However, this contribution is planned to diminish over time, shifting the burden to the MOHP and other donors. For the period of 2010/11 to 2016/17 a total of £39.4 million is estimated to be required (MOHP 2010). In addition to funding, DFID has provided technical assistance for implementation and monitoring. Six regional co-ordinators have been established to supervise the programme, and a series of rapid assessments have been conducted to provide feedback to the MOHP.

Study methods

The overall aim of this monitoring exercise was to better understand the health economy at facility level in Nepal and how it was affected by and interacting with the Aama programme, taking a reference period of 10 months before and after its implementation in January 2009.

There were three main information sources:

- (1) District records were examined to track fund releases to specific facilities as part of the funding flows analysis;
- (2) Facility-recorded data (financial and for activities) were analysed, going in-depth into records for a few selected facilities of different types;
- (3) Semi-structured interviews were conducted with health managers and managers in the districts to assess how the funds have been used in practice, constraints faced by the programme, and perceptions of its effects.

The study tools took the form of a set of structured questionnaires to collect financial and activity data, and topic guides for discussion with key informants. The purpose of this exercise was not to get a nationally representative sample of

facilities, but to provide an in-depth snapshot of dynamics at facility level, which nevertheless indicates some of the differences that arise at different levels of the health system and in different areas. The facilities chosen included:

- At national level, the Maternity Hospital in the capital Kathmandu, as this deals with the majority of tertiary care cases;
- One regional hospital;
- Three zonal hospitals, selected to represent the different regions but which also have large numbers of deliveries and are Skilled Birth Attendant training centres;
- Six district hospitals, selected to provide two per ecological zone, and to include a mission hospital;
- For each of the six districts, one PHCC and one health post were selected at random for visiting. In Nawalparasi District, none of the health posts we visited had delivery services; the final number was therefore 6 PHCCs and 5 health posts.

Key informants were focused at district and facility level and included the focal person for each district; the Medical Superintendent, head nurse, HFMC chair and accountant (for each hospital); and the in-charge, the nurse and the HFMC chair (for PHCCs and health posts).

Data were collected between December 2009 and February 2010. Analysis has been done using Excel for the financial data and Word for the thematic analysis of qualitative responses. The main limitation faced was the incompleteness of financial records, which means that analysis of data is often partial.

Findings

Effects on utilization of services

Analysis of reported deliveries in the selected facilities confirms that there has been an increase in institutional deliveries in the public sector and in other facilities included in the policy since the introduction of Aama (Table 1). According to analysis of these facilities, complications and caesarean sections have grown in line with overall deliveries, which is reassuring given the concerns that the policy might encourage over-medicalization. The overall increase for normal deliveries was 19%, for complications 15.5% and for caesarean sections 18%, making an overall increase of 19% in institutional deliveries, but with particular growth in district hospitals (especially those not previously benefiting from the SDIP, such as some of the mission hospitals).

Financial effects on households

The monitoring study looked at the charges which had been levied before, and whether these are now fully waived by the health facilities. Financial information collected from facility records and semi-structured interviews revealed that while the bulk of 'core costs' (i.e. registrations, consultations, drugs and bed costs) are now officially free for deliveries, facilities do admit to continuing to charge women for some tests, supplies, food, blood and cleaning in a number of cases. This confirms the findings of a recent rapid assessment (CREHPA 2010), which found that 43% of women had paid something for their recent delivery (and that the most common charge was for

Table 1 Increase in deliveries (%), by type and level, comparing 10 months before with 10 months after Aama

	% increase in normal deliveries (mean increase in numbers per facility)	% increase in complicated deliveries (mean increase in numbers per facility)	% increase in caesarean sections (mean increase in numbers per facility)	% increase in total deliveries (mean increase in numbers per facility)	Facilities and notes
Central level	20% (2251)	2.3% (45)	19% (477)	18% (2773)	Maternity Hospital
Regional level	18% (768)	42% (130)	-11% (-158)	12% (740)	Western Regional Hospital
Zonal level	14% (422)	20% (65)	30% (231)	18% (717)	Koshi, Lumbini and Seti Zonal Hospitals
District level	35% (122)	30% (9)	271% (10)	37% (140)	Jumla, Sarlahi, Nawalparasi, Udaypur (some facilities had no caesarean sections in both periods and other facilities had to stop during the later months of the study period due to lack of human resources)
Mission hospital	125% (330)	185% (89)	132% (62)	134% (481)	Team Hospital Dadeldhura
Primary health care centre (PHCC)	11% (17)	61% (4)	n.a.	12% (20)	6 primary health care centres
Health post	18% (16)	Initiated by some facilities	n.a.	24% (21)	5 different health posts; 2 health posts have started handling complications after SBAs joined the facility

Source: health facility registers.

n.a. = not applicable.

SBA = Skilled Birth Attendant.

cleaning, but also sometimes for drugs and informal payments to staff). A household survey carried out early in 2010 (Powell-Jackson *et al.* 2010) also found that while households' payments in facilities for deliveries had fallen since the start of Aama, payments outside had not been affected. This suggests that facilities are continuing to pass on to households costs which should be covered by their reimbursement (either for financial reasons or because of poor supply systems).

Financial effect on facilities

The study looked at the comparison between the official user fees raised before by facilities and the current reimbursement. Prior to the Aama programme, facilities levied charges according to the number of nights' stay and also a fixed charge for deliveries of different types. These covered the cost of tests, but supplies and drugs were paid separately by patients. Since the introduction of Aama, facilities receive a lump sum which also has to cover the cost of drugs and supplies. We found that for most levels of facility and for most delivery types, facilities have gained financially from the shift (Table 2); allowing for the need to fund drugs and incentivize their staff, they are still paid more than they charged patients before. The only exception to this was for the Maternity Hospital in respect of normal deliveries. However, the 'surplus' it gains on complicated deliveries and caesarean sections should compensate for this. Moreover, being a higher level tertiary hospital, the Maternity

Hospital should not be focusing on normal deliveries (though in practice they form 70% of its reported workload at present).

The results of the very small-scale costing analysis which was undertaken (focusing on the costs which facilities have to cover out of their own revenues, i.e. supplies, drugs, staff incentives and some overhead costs such as cleaning) reinforce the conclusion that the reimbursement tariff does cover the direct costs and some overheads. For normal deliveries at one facility, direct costs were estimated at NRs 775–1225, while complicated deliveries were costed at NRs 1645 and NRs 4857–5207. Given the tariff of NRs 1000–1500 for normal deliveries, NRs 3000 for complications and NRs 7000 for caesarean sections, there is some margin for contributing to overhead and investment costs. This is supported by the key informant interviews; the majority were satisfied with payments, although those facilities who received lower public subsidies or were in remote areas (with higher input costs) argued for differential payments.

Claims by facilities for deliveries provided were reimbursed by the district quickly—usually within the month—and in full, although delays can occur early in the financial year due to national-level delay in approving the budget (and occasionally at the local level due to the absence of a key member of staff).

According to key informants, the Aama funds are managed as part of general revenues and expenditures. As such, they are not seen as administratively too burdensome and informants appreciated the flexibility of use. However, this means that it is hard to track Aama revenues and expenditure. For the facilities

Table 2 Comparing Aama reimbursement per delivery with previous fees for deliveries (NRs)

	Normal deliveries	Complications	Caesareans
National			
User payments per delivery	780	1825	2430
Cost of total drugs and supplies	557	660	2288
Incentive payment to staff	300	300	300
Payments from Aama	1500	3000	7000
Surplus	137	215	1982
Regional hospital			
User payments per delivery	445	1460	1995
Cost of total drugs and supplies	570	660	2144
Incentive payment to staff	300	300	300
Payments from Aama	1500	3000	7000
Surplus	185	580	2561
Zonal			
User payments per delivery	545	1803	2703
Cost of total drugs and supplies	488	660	1985
Incentive payment to staff	300	300	300
Payments from Aama	1500	3000	7000
Surplus	167	237	2012
District			
User payments per delivery	460	1308	1112
Cost of total drugs and supplies	413	660	1944
Incentive payment to staff	300	300	300
Payments from Aama	1500	3000	7000
Surplus	327	732	3644
Primary health care centre (PHCC)			
User payments per delivery	261		
Cost of total drugs and supplies	317		
Incentive payment to staff	300		
Payments from Aama	1000		
Surplus	122		
Health post			
User payments per delivery	255		
Cost of total drugs and supplies	220		
Incentive payment to staff	300		
Payments from Aama	1000		
Surplus	225		

where Aama expenditure was recorded separately (just under one-quarter of them), 80% was used to buy drugs and 20% to pay incentives or salaries to staff. These costs amounted to 42% of the funds which should have been received (estimated from delivery numbers and the Aama tariffs). This again suggests that facilities should have surplus funds to pay for investments in care. Anecdotally, the funds have supported a range of minor recurrent costs and investments.

The overall financial balance sheet of the facilities for the periods before and after Aama gives some indication of how the policy is affecting them (clearly the policy is only one factor, but an important one, as deliveries are core business for most

facilities). All facilities saw an increase in income and expenditure. At lower levels, PHCCs and health posts had positive balances which in most cases increased over the period. The district hospitals had positive balances too. However, the Maternity Hospital moved into deficit over this period. Facilities were asked about savings and debts at financial year end. Most did not report either, but for those which did, 10 reported savings and only one (Lumbini Zonal Hospital) a debt.

The study also shed light on the income and revenue structure of this selection of facilities. It is striking that there is considerable variation, even in the public sector, with some

PHCCs and health posts, for example, receiving government annual grants, and others not. For facilities that do not receive other forms of public support (e.g. Team Hospital, which is a community hospital), more funds are needed to cover salaries and maintenance costs. Support from the government for public facilities mainly takes the form of the Aama programme, payments for free care and payment of salaries. Other local sources of income include, in some cases, rent from medical stores and canteens, and small charges to clients for lab tests, some small procedures and for use of ambulances. If drugs run out or are not covered under the free care programme, then clients pay for those or bring them. Some Village Development Committees provide support for Assistant Nurse Midwife salaries, or one-off grants.

Interaction with wider free care policy

The other main change of this period was the extension of the general free care policy (which has also removed revenues, in parallel with Aama, but with a different system of replacing them). While most user fees have been abolished, some facilities continue to levy charges for tests and (less commonly) registration. The majority report no income from user fees now.

Disentangling the effects of these two policies on facilities is not easy. Most of the facilities at district level and below were in receipt of free drugs from the general free care programme, which to some extent cover some of the delivery drug and supply needs (e.g. gentamycin, oxytocin, magnesium sulphate, minor antibiotics, gloves and cotton). However, these were reported to be generally inadequate in quantity. The subsidy is therefore limited. Meanwhile, the Aama policy is bringing in very important revenue which supports other services at the facilities. Key informants say that their facilities are struggling financially but that Aama is a help. For one facility, Aama was its only reported source of income.

“We could not be able to meet overall costs of the health post without Aama programme.”

(Navdurga health post, Dadeldhura)

Effect on staff

In relation to staff, key informants reported an increased workload (technical and administrative), but also appreciated the flexibility to hire and reward staff, and reported a range of changes to services to meet the increased demand.

“We are using Aama fund to hire support staff which are being very useful to support our nursing staffs at night.”

(Dullu PHCC, Dailekh)

Staff numbers (for staff working on delivery care) have either remained stable or have increased over the period. Facilities of the same kind reported considerable variation in staffing numbers. Comparing reported numbers with those present when the field team visited, there was an attendance of 70% (higher at lower level facilities, on average, which presumably reflects the low overall staffing).

Staff are said to have improved morale, particularly as the Aama policy has made it easier to fund drugs and supplies and to treat people quickly and equally, without worrying about

their ability to pay. In most cases, members of staff were appreciative of the incentive payments, though in some facilities there were concerns about how they had been distributed, and there were also concerns in remote areas about overall staffing numbers remaining low.

Most facilities were spending NRs 300 per delivery on incentives, but one (the mission hospital) was not paying any, while others were paying over the recommended amount (NRs 500 in Jumla district hospital and 700–800 in Sasapur health post). These monies are being distributed in various ways: sometimes just to the nurses, sometimes to a range of staff including support staff and administrators (and the HFMC), and in other cases again are not paid as incentives at all but are used to fund additional support staff positions. In most cases, staff have benefited financially, though some (just a few) facilities reported paying staff incentives from user fees prior to the policy, in which case the benefits to their staff may be limited.

At the national referral Maternity Hospital, it was reported that the attendance of staff has improved after Aama since they introduced a rule that any staff member who is on leave for more than 2 weeks does not get a share of the incentive. The Aama programme is also reported to have contributed to more active HFMCs in some cases.

Overall feedback

A summary of perceived positive and negative impacts of the Aama programme is given in Box 1. It is clear that the positives outweigh the negatives. The recommendations of key informants, while covering a wide range of issues, are all framed within a desire for the policy to continue. None of the key informants recommended that it should be stopped or even redesigned in any major way. The majority of recommendations covered enhancements (improved management and other investments to increase quality of care, such as increasing nursing staff), as well as requests to increase the incentives for staff. However, some informants suggested that a guideline with maximum limits for incentives (and suggestions on how to share them) should be clearly communicated to all managers and staff, to remove managerial discretion and hence the pressure on them to increase staff incentives.

Discussion

Some important study limitations need to be highlighted, particularly the difficulty of getting full financial data for most of the facilities, which means that analysis has had to be partial. The structured forms were not fully filled for any of the facilities, and in one facility (Dailekh), no financial data of any kind was obtained. As Aama finances are integrated at most facilities, getting separate accounts was rarely possible, and it was also challenging to separate the cash incentive component from the free delivery component when interviewing staff. It was observed that the system of accounting and record-keeping varied, and in the lower level facilities it was weaker in general. Despite this, the research provides useful evidence and case studies on how the Aama policy has affected the economy of selected health facilities in Nepal.

Box 1 Summary of key informant comments on positive and negative effects of the Aama programme in Nepal**Reported positive effects**

- Able to serve more clients.
- Reduced delays in accessing services.
- Not having to worry about whether patients can pay.
- Better trust between the community and staff.
- Increased efficiency as staff do not have to wait for patients to secure funds and drugs.
- Increased facility revenues.
- Strengthened 24-hour service.
- Increased employment for local women in support roles.
- Improved infrastructure.
- Enhancing the skill of staff through increased practice.
- Increased equity.
- Contributed to strengthening the financial, reporting and management system.
- Increased awareness in communities.
- Improved women's rights.

Reported negative effects

- May encourage people to have more children.
- Increased workload with limited staff may lead to demotivation.
- Lack of physical space and equipment to deal with increased workload (may lead to lower quality of care).
- Have to send women home more quickly.
- Some rich people who used to pay for cabins now move to the general wards.

Constraints

- Lack of administrative staff.
- Delay in funds.
- Need for more awareness-raising in communities.

Nepal presents a very interesting example in relation to the wider literature on user fee removal as the government is now operating two national user fee removal policies in tandem; one focused on general curative care at district hospitals and below, and another focused on deliveries. There are historical reasons why these are separate programmes, with separate funding sources and payment systems. The Aama programme has received more financial and technical support, and maintains tighter financial and reporting systems. The conditional cash transfers to households necessitate close monitoring and control, given the additional fiduciary risks. However, at the facility level, all of the funds merge, and understanding the combined impact of the two free care policies is important.

According to a health facility efficiency survey conducted in 2004 (Nepal Health Economics Association 2004), user fees contributed more than 50% of total revenues at regional hospital level, but very much less at lower levels (8% at district hospitals and health posts, 5% at PHCC and 3% at sub-health posts). In that context, it should be relatively easy to remove fees for lower level facilities. The policy of general free care is currently operationalized by boosting funding for essential drugs and providing small payments to health facilities per visit (funding inputs and outputs, then, at least to some extent). There is as yet no formal assessment of the impact of the policy. However, early evidence suggested that outpatient visits have doubled and inpatient visits increased six- to ten-fold (CARE *et al.* 2009). Although most facilities reported receiving reimbursements, they also reported drug stock-outs (but there was no evidence of how that compared with the period before free care). It seems likely that the increased utilization has placed a burden on the facilities' overall finances. Unless reimbursements for general free care fully cover costs, facilities can be expected to pass on costs for general or delivery services to patients (under- or over-the-counter).

The Nepal findings are consonant with documented user fee removal processes in other regions (Witter 2009).

They demonstrate the importance of political leadership and strong technical support, both of which have been present in Nepal. They also illustrate the problems of communicating policies (the lack of clarity on the package of care to be offered free is typical, for example). In addition, they illustrate the tendency to under-fund 'free care', particularly in the case of the general free care policy, where resources do not appear to have matched growing demand for services. The difficulty of establishing clear operating procedures is also shared.

The Nepal case study also illustrates the difficult balance between funding facilities and incentivizing staff. The HFMCs faced considerable pressure to divert resources from Aama to staff, resources which are therefore not available for investment in the facility.

Given Nepal's terrain, and the variable costs faced by facilities in different areas, there is a case for offering higher payments to facilities which are based in remote areas, and therefore face higher input costs as well as lower overall utilization (and therefore reduced revenue). Just as women in the mountains receive higher transport subsidies, so too the facility payments could be varied by ecological zone.

In terms of overall incentives for the facilities, the Aama programme replaces a fee-for-service payment system with a fixed payment per case. It therefore creates incentives to reduce length of stay and interventions, something which is also reported in the qualitative interviews (though here it is presented as a response to increased workloads and limited increases in resources such as staff). The policy does increase the risk of cost-cutting or cutting corners in care of patients, a risk which should be controlled by building in more quality of care indicators into the monitoring system. Most monitoring of free care focuses on volume of services provided, rather than any quality or outcome measures.

As free health care strands are merged, more general thinking will be needed about the best mechanisms for financing essential public health care, in Nepal as well as in other

comparable health systems. It is likely that this will blend input-based funding (for semi-fixed costs, such as maintenance and salaries) with output-based funding (for variable costs, such as drugs, tests and supplies) (see also Meessen *et al.* 2011, this issue). In this way, the stream of writing about free health care and the stream of writing about pay for performance approaches may be joined.

Over 10 years from 1996 to 2006, the percentage of deliveries in a health facility in Nepal increased from 7.6% to 14%, and by 2009 this had further increased to 22.5%. The Aama programme has contributed to this increase, alongside many other policies including the earlier SDIP, training of SBAs and community factors, such as increased female education. However, the overall coverage remains low, compared with other countries. The Skilled Birth Attendance Policy of 2006 set a target of 60% of births to be attended by a trained health worker by 2015. To reinforce this, in 2010, a Safe Motherhood Bill was drafted, which defines the rights of women to quality reproductive health care and maternal and newborn health care, and provides a legal framework, with accountability mechanisms, to enable them to exercise these rights.

Conclusion

The Aama policy appears to be operating with reasonable effectiveness, as seen from the facility perspective. Funds are arriving without large delays and in predictable amounts. The funds which are received are appropriate to the costs which facilities incur and to the income which they have lost. They allow for some overhead costs and improvements, if managed well. Managers appreciate the flexibility which they offer and see the policy as supportive of their work, on the whole. Most staff have benefited from some additional small incentives and an improved working relationship with their clients, although there remain concerns about staffing levels in some areas. Utilization continues to increase, and there is no evidence that caesarean sections are growing disproportionately.

The main concern relates to on-going charges to patients in some facilities. These undermine the policy and should not be necessary—all of these costs are covered by the reimbursement tariffs. It is possible that these reflect opportunism by staff, or that they are a safety valve for a wider problem that many of the financing sources for the facilities have recently been eroded (and inadequately replaced, possibly, in the case of general free care). The deficits at national and zonal hospital level also raise concerns about overall financial sustainability (or wider financial management issues). Close monitoring of the new policy, and further incremental reform to strengthen it will be needed over the next few years.

The approach that Nepal has taken to user fee removal is similar to a number of other countries, focusing on maternal

and primary care and blending input- and output-based funding. Sustaining and merging these two free care policies will be the next challenge.

Funding

This study was funded by UK Department for International Development (DFID) as part of its support to the Supporting Safe Motherhood Programme in Nepal.

Conflict of interest

None declared.

References

- Borghi J, Ensor T, Neupane B, Tiwari S. 2006. Financial implications of skilled attendance at delivery in Nepal. *Tropical Medicine and International Health* **11**: 228–37.
- CARE, RTI International, MOHP. 2009. *Examining the Impact of Nepal's Free Health Care Policy: First Facility Survey Report*. Research Triangle Park, NC: RTI International.
- CREHPA. 2010. Rapid assessment of Aama programme: round V. Centre for Research on Environment Health and Population Activities (CREHPA) for Support to the Safe Motherhood Programme (SSMP), Kathmandu.
- Ensor T, Clapham S, Prasai D. 2008. What drives health policy formulation: insights from the Nepal maternity incentives scheme? *Health Policy* **90**: 247–53.
- MOHP. 2010. The Aama programme: an initiative towards reducing maternal and newborn deaths in Nepal. Kathmandu: Ministry of Health & Population; Support to the Safe Motherhood Programme (SSMP).
- Nepal Health Economics Association. 2004. Public health facility efficiency survey. Kathmandu: British Council (District Health Strengthening Project).
- Pant P, Suvedi B, Pradhan A *et al.* 2008. *Improvements in Maternal Health in Nepal: Further analysis of the 2006 Nepal Demographic and Health Survey*. Calverton, MD: Macro International Inc.
- Powell-Jackson T, Neupane B, Tiwari S, Morrison J, Costello A. 2008. *Final Report of the Evaluation of the Safe Delivery Incentive Programme*. London: Department for International Development.
- Powell-Jackson T, Tiwari S, Neupane B, Singh M. 2010. *An Early Evaluation of the Aama Free Delivery Care Programme*. Kathmandu: Support to the Safe Motherhood Programme (SSMP).
- Witter S. 2009. Service- and population-based exemptions: are these the way forward for equity and efficiency in health financing in low income countries? *Advances in Health Economics and Health Services Research* **21**: 249–86.