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Study Report of Free Health Care Services and Subsidy Provisions in Koshi, Bheri and Bharatpur Hospitals

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Strengthening Health Systems-Improving Services

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LIST OF ACRONYMS

BPL	Below the Poverty Line
BS	Bikram Sambat (Nepali Official Era)
DDC	District Development Committee
DoHS	Department of Health Services
EAP	Equity and Access Programme
FCHV	Female Community Health Volunteer
FY	Fiscal Year
GESI	Gender Equality and Social Inclusion
HDC	Hospital Development Committee
HR	Human Resource
ID	Identity Card
MLD	Ministry of Local Development
MoHP	Ministry of Health and Population
MS	Medical Superintendent
NHSSP	Nepal Health Sector Support Programme
NPR	Nepali Rupee (Currency)
OPD	Outpatient Department
PA	Personal Assistant
PHCC	Primary Health Care Centre
SSD	Social Service Department
SSU	Social Service Unit
ToR	Terms of Reference
VDC	Village Development Committee

1. INTRODUCTION

1.1 BACKGROUND AND CONTEXT

The Interim Constitution of Nepal 2006 assures health as a fundamental right, stating, "every citizen will have the right to free basic healthcare services as provisioned by the State." As a result, the Ministry of Health and Population (MoHP) has recently launched several initiatives, the largest of which is free essential health care services to all citizens at the Primary Health Care Centre (PHCC) level and below.

At district hospitals, certain target groups including the ultra-poor/vulnerable, poor, senior citizens, people living with physical and psychological disabilities, women and children affected by conflict, and Female Community Health Volunteers (FCHVs) are treated either free of charge, or at partially subsidised rates depending on their particular needs and circumstances.

In addition, and with a view to promoting access by underserved groups to services at secondary and tertiary level facilities, MoHP proposes to pilot Social Service Units (SSUs) in five zonal or regional hospitals following promulgation of the Social Service Unit Implementation Guidelines, which were developed in 2010. However, consultations with management teams in some of these hospitals by the Nepal Health Sector Support Programme (NHSSP) have indicated that treatment costs for certain target groups are already being subsidised. These practices may not have been considered during development of the SSU Guidelines.

In this context, NHSSP decided to carry out a rapid assessment of current subsidy practices at three broadly representative hospitals prior to establishing the SSUs in selected facilities. The overall purpose of the rapid assessment was to *conduct close observation and documentation of existing subsidy practices, processes and provisions for poor and marginalised target groups in the Koshi and Bheri Zonal hospitals and at Bharatpur hospital.*

NHSSP contracted Kumar Upadhyaya, a development management consultant with significant experience in organisation development and gender and social inclusion analysis, with the rapid assessment. The consultant carried out the assessment during February and March 2012. See annex 3 for the terms of reference. This is the end-of-assignment report by the consultant and contains the following:

- Methodologies and process followed
- Current subsidy processes and practices
- Issues of access to subsidy
- Conclusions and recommendations

Other related information is annexed with this report. The annexes include:

- Hospital-wise summary reports of the rapid assessment
- Key features of the legal basis for hospital operations and subsidy practices

1.2 METHODOLOGY AND PROCESS FOLLOWED

The consultant worked in close coordination with NHSSP's Gender Equality and Social Inclusion/Equity and Access Programme (GESI/EAP) Advisor at MoHP/DoHS and Regional GESI specialists during the assessment, and specifically carried out the following tasks:

- Desk study of relevant documents, particularly the government guidelines and directives concerning provision of free health services, Formation Orders of the three hospitals and the SSU Implementation Guideline-2010. See annex 2 for the key features of these Formation Orders (Hospital Acts) and the MoHP Directive on free health services of the year 2059 Bikram Sambat

(BS, equivalent to 2003 AD).

- Consultations with relevant officials in MoHP and NHSSP.
- Field visits to Koshi Zonal Hospital, Bheri Zonal Hospital and Bharatpur Hospital and semi-structured interviews with hospital staff, patients, representatives of local civil society organisations involved in facilitating the free or subsidised services, and members of Hospital Development Committees. Following an oral request from NHSSP, brief meetings were also held with key officials in Patan and Bir Hospitals, although these two facilities were not part of the ToR. (See annex 1 for detailed hospital-wise notes.)
- Observation, documentation and assessment of the hospitals' service delivery chain focusing on existing staff, systems and structures involved at different stages: patients' entry and registration through subsidy decisions to treatment and exit. This includes follow-up of some helpless and vulnerable patients along the service chain in the hospitals.
- Debriefing of the preliminary findings and observations to hospital management.
- Presentation of findings to a core NHSSP/MoHP team and incorporation of their feedback.
- Presentation of the findings to a wider NHSSP/MoHP audience and preparation of the final report.

2. CURRENT SUBSIDY PROCESSES AND PRACTICES

Provision of free health services began following an MoHP directive to this effect dated 059/08/25 BS (2003). The directive mandates the hospital to set aside five percent of its income (from government grants and hospital services) to provide free health services. The directive-specified target groups for the free health services are the following: disabled persons, vulnerable persons, ultra-poor persons, persons without homes and income, abandoned women and street children.

2.1 SUBSIDY PROVISION PROCESS

The process typically involves the following steps. Based on the government directives, each hospital designed its own process:

- A patient pays a nominal fee to receive a "registration card" at the registration counter. The card records the patient's name, age, sex, address and health problem. The registration process is computerised in Koshi Zonal Hospital and Bharatpur Hospital, and is manual in Bheri Zonal Hospital. Koshi Zonal Hospital uses two types of registration cards: blue cards for certain groups that are exempted from the registration fee (prisoners, senior citizens and so on), and red cards for the others. There is no central directive to regulate the registration fee and each hospital has its own rules on this.
- The patient is examined at an Outpatient Department (OPD), as specified on the registration card, or at the Emergency Department, if it is an emergency case. The patient or her/his companion requests free or subsidised service from the doctor on duty.
- If the doctor agrees, the patient is either provided "free or subsidised service forms" (in Bheri Zonal Hospital, where all the departments keep copies of these forms) or sent to a specific room to collect the forms (in Koshi Zonal Hospital and Bharatpur Hospital).
- The patient or his/her companion obtains the "free or subsidised service forms" from the specified room, fills in his/her personal details and signs that form. One of these forms, meant to identify the socio-economic condition of the patient, is either not used at all or is left blank, so therefore any statistics related to the patients' socio-economic condition cannot be traced when required.

When signing the form, the doctor sometimes recommends a percentage of subsidy to be provided to the patient. However, this practice is not common these days and the final subsidy decision is often left to the Medical Superintendent (MS).

- The patient or his/her companion returns to the same department to have the forms signed by the same doctor. In a few cases, patients acquire the “free service forms” from someone in the hospital and directly request the doctor to sign them. In all the hospitals, the doctor or nurse on duty at the department or ward can also initiate free or subsidised service for a patient if s/he feels that the patient is very poor or cannot afford to pay for the services. Many patients receive free or subsidised services in Bharatpur Hospital through the initiative of the staff on duty in the wards. Compared to other two hospitals, the number of inpatients receiving free service in Bharatpur Hospital is very high. On the forms, the doctor on duty specifies (i) the examinations that the patient needs to have, (ii) the medicines that s/he needs to take, and (iii) in some serious cases, admission into a ward.
- After having the forms signed by the authorised doctor in the department or ward, the patient or his/her companion goes to find the MS for final approval of the free or subsidised service. Locating the MS is not always an easy task, as he might not be present in his office. It is not uncommon to find patients catching him at odd places and requesting him to sign the forms.
- Once the MS signs the forms and indicates the percentage of subsidy to be provided, the patient or his/her companion goes to cash counter to obtain either one “free” receipt or two receipts in case of partial exemption of charges: one for the free service and the other for what must be paid. In Koshi Zonal Hospital, the Personal Secretary of the MS has the duty of stamping the subsidy percentage on the subsidy recommendation form after subsidy approval by the Superintendent. In recent times, the use of partial subsidy is very rare, and 100 percent subsidy is provided in almost all cases, since use of partial subsidy for some patients invites unnecessary arguements with them, which the MS or concerned doctors would rather avoid.
- The patient or his/her companion next goes to (i) an examination rooms for tests, (ii) the medical store for medicines, and/or (iii) a ward if s/he needs to be admitted. In Koshi Zonal Hospital, the patient must undergo the whole process twice if s/he requires medical tests as well as medicines: once for medical tests and then again for medicines. This is a glaring example of inefficient use of patient and provider time.
- In case the needed medicine is not in stock, the medical store sends the patient to a medical shop (private or sajha) to purchase the medicines. The hospital periodically pays the medical shop on an actual supply basis. In Bharatpur Hospital, all outpatients receive their medicines from shops, while those admitted to wards obtain the medicines from the wards, and the hospital pays for the medicines. When the same patient visits the hospital again, the whole process must be repeated, as there is no system of providing the patient any sort of identity card.

2.2 MOHP DIRECTIVES AND CURRENT PRACTICE

Current practice in all the hospitals has deviated from the MoHP directive in some respects. See "Key features of the MoHP circular concerning free health services to selected target groups" in annex 2 for details of the directives.

The following major deviations were noticed:

- The form prescribed by MoHP for assessing whether a patient belongs to the specified target group (the downtrodden, the disabled, abandoned women and children, street children and orphans, and homeless and helpless) can be found only at Koshi Zonal Hospital, and is not used, as the information relating to the patient’s socio-economic condition is left blank. Other hospitals do

not even produce the form.

- The hospitals use different forms for free or subsidised service. Koshi Zonal Hospital uses two forms in addition to the one originally prescribed; Bheri Zonal Hospital and Bharatpur Hospital use two forms each, different from each other. Bharatpur Hospital has attempted to develop and adapt the originally prescribed form, whereas Bheri Zonal Hospital has simplified the process by allowing the doctor to mark the right target group.
- Based on the free or subsidised service form developed and used by Bharatpur Hospital, the target groups are the poor, very poor, senior citizens, FCHVs or disabled persons. This definition of the target group is more in line with the National Health Programme than the directive of the MoHP dated BS 2059. In the case of Bheri Zonal Hospital, the target groups specified in the form are helpless, disabled, abandoned, beggar, ultra-poor and others. Other details in the forms also differ from hospital to hospital.
- The guideline regarding the total subsidy per patient being limited to NPR 5000.00 at one time is not followed. The per-patient subsidy cost is not calculated, recorded or reported. In one case in Bharatpur Hospital, as much as NPR 300,000 was used to subsidise a Chepang patient in a very critical condition, though a note in one of the free or subsidised service forms emphasises that the hospital cannot exempt more than NPR 3000 (per patient at one time).
- The initially prescribed reporting format is not used at all. Recording and reporting on the free or subsidised service is a problem even in Koshi Zonal and Bharatpur hospitals where some parts of the transactions are computerised.
- The practice of setting aside five percent of hospital income for the free treatment fund was discontinued several years ago since the income (from rents and surplus from government grants) could barely cover staff salaries and allowances. However, none of the hospitals could tell exactly when the practice was discontinued and no records could be obtained on this issue. In addition, the government began providing funds for free treatment under a direct heading and the directive to set aside five percent of the government fund for free treatment became defunct two years ago.

2.3 ASSESSING THE PATIENT'S SOCIO-ECONOMIC CONDITION

In practice, this assessment is rarely done, and the form meant for this assessment is not completed. The doctors or medical staff on duty do not have the time, competence or willingness to carry out the assessment. In reality, they even lack the time to assess the patients medically. Some doctors may attempt to discourage relatively well-off patients from accessing free or subsidised service when they have doubts regarding the patient's economic condition. However, their attempts usually fail because of political pressure or because the patients are close relatives or friends of hospital staff members.

In the case of patients admitted into wards, the staff on-duty tend to observe their economic condition closely and recommend free or subsidised service for the poor, though the patients might initially have been admitted as non-poor. Some relatively well-off patients also receive free or subsidised services in these government hospitals after they exhaust their financial capacity by spending most of their savings in private clinics or hospitals.

2.4 ASSESSING THE AMOUNT OF SUBSIDY

Earlier in Koshi Zonal Hospital, the following subsidy rates were used: 10, 25, 50, 75 and 100 percent. The current forms used by Bheri Zonal Hospital recommend 25, 50 and 100 percent. The forms in Bharatpur hospital recommend two rates: 50 and 100 percent. Nowadays, however, only 100 percent is used and the

other percentages are hardly used in any of the hospitals. No evidence-based criteria are provided for deciding how much subsidy should be provided.

2.5 APPROVING AND PROVIDING THE SUBSIDY

The final authority for approving the subsidy lies with the MS of the hospital. Very few cases of rejection by the MS are found once a doctor has recommended the subsidy. Approval is almost always automatic.

2.6 RECORDING AND REPORTING

As mentioned under section 2.2 above, recording and reporting systems and practices are very weak. Even to investigate how many persons have accessed free or subsidised service, individual forms first must be located in different sections and counted. Despite computerisation, the Record Section in Koshi Zonal Hospital could not provide the number disaggregated by sex. Other details about the patients (caste/ethnic group, place of origin, age and referral status) are all the more difficult to obtain. Information related to the patients' socio-economic status cannot be found, as the form meant to record this information is never completed.

Doubts also arise regarding the total number of "free or subsidised" patients reported. The data on the number of such patients and the total budget reveal a huge difference in the cost per patient:

Hospital	Koshi Zonal Hospital	Bheri Zonal Hospital	Bharatpur Hospital
Number of patients	17,376	15,534	3,170
Budget under 3.05 heading + added by the hospital)	NPR 12,000,000	NPR 6,000,000	NPR 8,000,000 + NPR 13,500,000
Average Subsidy	NPR 690.60	NPR 386.25	NPR 6,782.30

One explanation for the discrepancy could be the proportion of inpatients among the total number of "free or subsidised" patients. Field observations in Bharatpur Hospital confirmed that most of these patients are inpatients. The Chepang man who received free service worth around NPR 300,000 was also reported. The cost per outpatient is usually very small compared to the cost per inpatient. However, this aspect alone cannot explain the entire discrepancy. Without improving the current recording and reporting system and practice, discrepancies like this are likely to remain.

The problem of recording spans every step of the process: registration, assessment of patients' socio-economic conditions, and the final decision on the proportion of subsidy.

3. ISSUES IN MANAGING THE FREE HEALTH SERVICES

Most people interviewed in all the hospitals agreed that many well-off people with appropriate connections access the free or subsidised service, whereas many poor people do not. Many poor people end up paying for the services that they should have received free and many non-poor people who can afford to use even expensive private hospitals end up receiving free service. Some people go to expensive private clinics, spend huge amounts of money, and later come to the hospital for free service and get it. Some local politicians help their supporters access the free service to maintain their patronage without bothering about issues of eligibility.

However, poor and excluded people are also found among the patients accessing the free or subsidised services in all the hospitals. Some are brought to the hospital from the streets by the police or social workers. Others are identified by the doctors or nurses on duty as extremely poor based on close observations of their look, clothes, food and other factors. Many poor patients are recognised as such by

the staff on duty after they have been admitted to the wards. Many of the poor patients receiving free or subsidised treatment in Bharatpur Hospital are inpatients. The lion's share of the budget meant for free treatment is spent on inpatients.

Attempts were made to estimate the proportion of the poor and non-poor among those receiving the free or subsidised services. Without any evidence, this cannot be done. Many stakeholders in all the hospitals informally stated that it is roughly 50-50, but no evidence can be found to either accept or reject the claim.

Ensuring smooth access of the targeted groups to the free or subsidised service requires addressing major issues such as the following:

- The wider public, particularly the intended target groups, does not know about the availability of free or subsidised health care. Only limited groups of people (hospital staff, local political groups, ex-patients and some social workers) are aware of this service. The service meant for the poor and excluded is thus mostly accessed by patients close to these groups. In addition to lack of access by the genuinely poor and excluded, questions concerning good governance also arise: should the staff, their families and acquaintances be provided the free health services meant for the poor and excluded? Should a doctor refer her/his private patients for this free service?
- Hospital management fears disseminating the information to the wider public, as this could lead to an unmanageable demand for the free or subsidised service. No signboard (citizens' charter) on the hospital premises provides information on the free services. Some of the "lucky" poor and excluded patients accessing the free service learn about it too late, after they have already spent their hard-earned savings (or loans). The important question here is whether it is fair and just for the poor and excluded not to learn about the free or subsidised service before they decide to go to the hospital.
- No objective criteria or evidence-based process is used to assess apatient's socio-economic condition. Doctors can hardly reject a patient's request for free service when the patient is accompanied by staff members or local politicians. Doctors have no competence on poverty, gender and social inclusion issues. Nor do they wish to become involved in assessing whether a patient belongs to a particular social-economic target group. They are even hard-pressed for time to examine the patients medically.
- Doctors also generally hesitate to generate enmity by refusing free service to a patient who dares to ask for it.
- Record-keeping and reporting on the free or subsidised service is very weak and inadequate, despite computerisation initiatives taken by two of the hospitals. In Koshi Zonal Hospital the computer programme completely ignores the free medicine distribution from the store and medical shop. In Bharatpur Hospital, free service is not entered into the computer programme at all and is handled manually. The scope of the computerisation is extremely limited from the point of view of obtaining disaggregated information on the patients. Without strong monitoring and supervision from the MoHP, expecting locally-led improvements in the existing record-keeping and reporting system and practice will be difficult.
- The directive of BS 2059 is neither followed by the hospitals nor is it adequate to meet the current requirements. Many hospital staff involved in the subsidy provision were completely unaware of the directive. A major weakness of the directive is the assumption that existing medical professionals are competent and ready to undertake the politically charged task of assessing a patient's socio-economic condition.
- In most cases, the layouts of the hospitals for service delivery are not patient-friendly. In Koshi

Zonal Hospital and Bharatpur Hospital, unnecessary backtracking is quite common. Disparities are also found between the time required per person at the registration and cash counters: the time required at the cash counter is approximately twice that required for registration. As a result, the patients lose significant time waiting at the cash counter. The manual counters at Bheri Zonal Hospital are as good as the "computerised" counters at the other two hospitals when it comes to efficiency. Relatively speaking, the service layouts in Bheri Zonal Hospital are friendlier than in other hospitals: locating the different service units and departments does not require much effort.

- Patients who were not accompanied by hospital staff or other knowledgeable persons mentioned certain typical problems, which were confirmed by repeated observation and follow-up of some poor and helpless patients through the service delivery chain in all hospitals:
  - ✓ Not knowing where to approach first for the service
  - ✓ Not knowing about the need to complete the forms for free service
  - ✓ Not knowing where to obtain the forms
  - ✓ Not being able to complete the forms
  - ✓ Not knowing where to go after completing the forms
  - ✓ Not knowing how and where to find the Medical Superintendent to sign the forms
  - ✓ Not knowing where to find the right department or room for the service
  - ✓ Not knowing about the hospital's service time, the time when doctors examine patients
  - ✓ Not knowing how and when one will be called for examination by the doctor
  - ✓ Not knowing where to find the medicine store or the examination rooms
  - ✓ Repeating the same processes of filling and signing the forms, when for example, free medicines and examinations are required, or when more medicines are required (in the case of Koshi Zonal Hospital)
  - ✓ Coordinating the signing of the free treatment forms with the working time of the laboratories, doctors and medical store. Patients from other districts or relatively remote parts of the district face this issue more often
  - ✓ Repeating the same process of certification on every hospital visit, despite an earlier record of accessing free services.

- The Hospital Development Committee (HDC) is not effective, and as long as the committee remains weak in its responsibilities and leadership, moving ahead will be very difficult. The practice of appointing a party member (in the name of a reputed social worker) weakens the governance and integrity of the hospital. Similarly, when the MS does not perform well, the Chairperson of the HDC is powerless to hold him accountable and control his "undue" activity or inactivity.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

The programme of free or subsidised service for selected target groups started by MoHP's 2003 directive and added to more recently by MoHP's lumpsum grants for free service has grown significantly in terms of budget and patient coverage. Many of the guidelines are no longer practiced, however. Significant variations are found in how the directive is implemented in different hospitals. Contrary to the directive's original intention, those taking advantage of the free service are not always members of the intended target groups.

Most patients from poor and excluded groups are not even aware of the programme. The only way to access information about the programme is from relatives, friends and acquaintances among the hospital staff and medical personnel. In a few cases, people learn about the services from informed social or

political workers, or to an even lesser extent, from someone who has already utilised the service. This lack of information or late information often prevents people from accessing services meant for them.

The poor and excluded, who are frequently illiterate, find it impossible to complete all the hospital formalities and procedures required for the services without the assistance of someone well-informed. Plan Nepal has been using the assistance of Sanjivani Sewa Sangh, a volunteer organisation in Koshi Zonal Hospital, to facilitate the services for its poorest beneficiaries. Sanjivani Sewa Sangh also assists poor and helpless patients to access free services at Bir Hospital.

The service providers find identifying the poor to be extremely difficult since no evidence-based foolproof systems or tools are available. None of the hospitals uses the MoHP guidelines and tools. The doctors have neither the time nor the aptitude, and are generally not willing, to involve themselves in assessing whether a patient is poor or not. Nor do they bother to interview the patients on this issue and complete the prescribed forms. In addition, they face undue pressure from hospital staff and political workers regarding the provision of free services. Leaving the programme entirely to the hospital management, as has been the case so far, will not achieve its objectives and the programme will instead continue deviating from the intended target groups. Many poor patients will continue to be left out of the system and many non-poor patients will continue taking advantage of it.

Given this situation, new systems, staff and structures are required for effective implementation. In this context, the experience of Patan Hospital is very important. Among the hospitals visited, Patan is the only hospital where a system for free or subsidised service is working effectively. Only Patan has a separate unit named the Social Service Department and an operational recording and reporting system. The purpose of this Department is the same as that of the proposed SSU, though Patan Hospital does not call it "SSU". Good practices from other hospitals (see section 4.2 below) can also be considered in drafting the future course of action.

Overall, institutionalising the Social Service Unit Implementation Guidelines (2010) with appropriate modifications can address most of the issues and problems. However, ample evidence reveals that institutionalising the Guidelines cannot be left entirely to the hospitals; MoHP's role in facilitating, monitoring and supervising the process is very crucial.

4.2 GOOD PRACTICES

Several good practices have been initiated and are practiced in different hospitals. These should become an aspect of future guidelines for handling the free treatments.

- In the absence of the Medical Superintendent (during leave or travel), another senior doctor automatically acts as the MS and continues signing the form authorising free treatment. No written delegation is required. All three hospitals practice this.
- Plan Nepal's arrangement offers a model for ensuring free services to the poor and excluded. The model incorporates several aspects. First of all, it correctly identifies the poor and excluded and provides them with identify cards, and secondly it assists them through all the steps and processes in the hospital. A volunteer from Sanjivani Sewa Sangh receives Plan's beneficiary patients from Morang and Sunsari districts at the Sangh's counter at the Koshi Zonal Hospital. The patient comes with her/his identify card and a recommendation letter from the Plan office. The volunteer assists the patient through all the steps from registration to the final provision of service. Plan periodically reimburses the hospital for the costs of their patients' care via the Sangh's account and provides a volunteer fee for each patient and some support to the Sangh. As another example of on-going good practice, the Sangh has been providing volunteer assistance to poor and helpless patients in Bir Hospital for about three decades.

- The Bharatpur Hospital Committee has decided to provide free services to the following set of ethnic groups that are extremely marginalised and are considered to be endangered: Chepang/Praja, Bote, Majhi and Mushahar.
- Bharatpur Hospital also developed a system for staff members and their dependents to receive subsidised services. This system provides staff members with a 90 percent subsidy and a 50 percent subsidy for to up to five specified family members. Currently, however, they all receive a 100 percent subsidy. Bir Hospital provides free service to all of its staff members (over 1100) and their dependents, including father, son, mother, daughter, grandfather and grandmother. All the dependents have identity cards with photos.
- In all the wards in Bharatpur Hospital, the names and details of persons who have received free service are recorded and updated on a white board. Making the names public is expected to prevent well-off persons from taking advantage of the system. However, this study did not survey the public's or the patients' opinion as to its effectiveness. The hospital management believes that it is a good tool.
- Patan Hospital has a separate Social Service Department with a chief and an assistant (currently vacant) and a five-member committee to handle matters concerning free or subsidised services. Depending on the amount involved in the treatment, the system of delegating authority is very clear:

Chief of Social Service Department	Coordinator
Nursing Supervisor	Member
Concerned Department or Ward In-Charge and a doctor	Members
Business Manager (Finance/Accounts)	Member

The chief of the Social Service Department can approve up to a cost of NPR 10,000 per patient; for costs above this amount, the committee sits and decides. In the absence of the Chief, nursing supervisors are delegated this authority.

Patan Hospital also has a functional system for recording free service.

- In Bir Hospital, free treatments to staff members and dependents, the disabled, senior citizens, children under 15, people affected by the conflict, and people wounded during the People's Movement and People's War are directly approved by any of the two under-secretaries (a one tier system). Staff members and their dependents are well-defined, and provided with ID cards.

4.3 RECOMMENDATIONS

The following recommendations should be implemented in the near future:

1. Direct selected hospitals to institutionalise SSUs (according to the SSU Implementation Guidelines 2010) to better manage free or subsidised health services, and to undertake a series of hospital-wise orientation programmes on their implementation. Instead of implementing the SSUs in all the hospitals at one time, it would be better to pilot implementation and institutionalisation of SSUs in selected hospitals.
2. Promote incorporation and utilisation of all the good practices outlined under section 4.2 above during the hospital-wise SSU implementation orientation programmes.
3. Delegate the necessary authority to the concerned Hospital Development Committees[1] and Social

[1] Though the HDCs are not very effective, involving them in the process of institutionalising the SSUs is still preferable, albeit with some facilitation support from NHSSP.

Service Sub-Committee (as envisaged in the SSU Guidelines-2010) to design clear rules and revisions (as an integral part of the Guidelines) concerning the following:

- ✓ Delegation of authority as done in Patan Hospital, where the Chief of Social Service Department has the authority to approve subsidies of up to NPR 10,000 per patient. In his absence, Nursing Supervisors on duty are authorised to act on his behalf. As outpatient costs are considerably less than this amount, almost all outpatient cases are approved by the Chief of Social Service Department or the Nursing Supervisors in his absence. Cases above NPR 10,000 are handled by a five-member committee coordinated by the Chief of the SSD, with the concerned ward or department head playing a key role in the final decision.
- ✓ Delegation of authority as in Bir Hospital where a designated under-secretary directly handled some categories of people such as senior citizens or disabled persons.
- ✓ Utilisation of the services of social organisations like Sanjivani, as Plan Nepal currently does, with appropriate modalities. Facilitating the poor and excluded patients through the service chain (tackling issues outlined in the last paragraph of section 3) is a difficult task requiring tremendous effort and patience. Two modalities are found for this: recruiting members as volunteers for the SSU and/or outsourcing the job of patient facilitation along the service chain, as Plan Nepal does in Koshi Zonal Hospital.
- ✓ Decisions regarding educational and experience related qualifications, and the remuneration proposed for SSU staff and volunteers. The decision on required qualifications should depend on the size of the hospital. For example, Bir Hospital has more than 1100 staff members and the Director acts as the final approving authority for free service. Therefore, to function effectively the SSU chief should have a rank equivalent to that of the level of under-secretary.
- ✓ Upgrading doctors, Department Chiefs and Chief Accountants to be an integral part of the Social Service Sub-Committee/SSU. They should not be mere invitees, since in all hospitals a large proportion of the total expenses for free service is incurred by inpatients.
- ✓ Use of the Information Display Board to provide all necessary details about the free or subsidised services, in line with the practice of Citizen's Charters. Currently, some hospitals fear that this sort of transparency might lead to demands for free services that are beyond their capacity to manage and subsidise.
- ✓ Target groups for the free service should include widows and other groups who receive monthly allowances from the wards or Village Development Committees (VDCs) as per government programmes, and some endangered ethnic groups as identified by Bharatpur Hospital.
- ✓ A separate subsidy provision should be made for hospital staff and their eligible dependents (identified in advance with photographs) in line with the practice in Bir Hospital and Bharatpur Hospital. In fact, in all the hospitals, staff members and their dependents are receiving free services, but not all hospitals have made this practice transparent.

4. Regularly monitor the performance of the newly installed SSUs, undertake social audits of their performance, and encourage publishing the names of those individuals who receive free or subsidised service in local newspapers and provide necessary support.

In addition to the above, the following recommendations should be implemented in the longer term for effective functioning of the free health services.

5. Coordinate and advocate with the Ministry of Local Development (MLD) and the National Planning Commission to provide identity cards for the poor, as it is not within the competence and mandate of MoHP or its hospitals to determine who is poor and who is not. In the longer run, providing ID cards to people "below the poverty line" is necessary to better target and manage the provision of free health

services. The recent initiative by the Government of Nepal in this direction is very timely.

6. Ensure that poor and excluded patients receive proper information regarding the free or subsidised services (including their rights and responsibilities) at their places of residence through the MoHP's networks, MLD and its local bodies, or other appropriate agencies and suitable media. Ideally, the poor and excluded should have the information before they decide to visit a hospital.
7. Promote computerisation of all hospital transactions to improve recording, reporting and operational transparency. Koshi Zonal Hospital and Bharatpur Hospital are using locally developed software programmes, but they are inadequate. Two options are suggested: (i) to use the same software for all the hospitals with central control, and (ii) to use different software for each hospital without any central control. If handled properly, the centrally controlled software programme could be more cost-effective and provide more benefits in terms of better monitoring, reporting and supervision.
8. Update and enrich the SSU Guidelines 2010 by incorporating the lessons and good practices (outlined under recommendation 2) and based on the experience of piloting in selected hospitals.

ANNEX-1: HOSPITAL-WISE NOTES

KOSHI ZONAL HOSPITAL

General information on the free health services

Background of the free service

Provision of free health services started following the MoHP's circular to this effect dated 059/08/25 BS. The circular directs the hospital to set aside five percent of its total income (from government grants and hospital services) for free health services. The target groups defined for the free health services were disabled persons, vulnerable persons, ultra-poor persons, persons without home and income, abandoned women and street children.

Budget and expenses

Government grants to hospitals are provided under different budget headings. Major grants (headings 3.03, 3.05 and 8.05) for FY 2067/68 BS came to NPR 71,507,592, which was fully spent. Additionally, a grant of NPR 39,470,000 was provided for the Mother Protection Programme (budget heading 3.04). A grant is also provided under heading 4.04 (for uterus prolapse), but that budget is not included here. The total income from registration fees and services in the same year was NPR 27,686,000 of which NPR 3,768,000 (after income tax deduction) comes from rented premises (shutters).

The practice of setting aside five percent of hospital income for free treatment fund was discontinued several years ago since the income could barely pay staff salaries and allowances. In addition, the government began providing funds for free treatment under a direct heading and the directive to set aside five percent of the government fund for free treatment became defunct two years ago. Therefore, the total fund for free treatment (heading 3.05) consists of the government grant, which was NPR 12,000,000 for the last year.

Sajha Medical Store received NPR 5,399,000 for medicine, including NPR 900,000 arrears from the previous year. NPR 2,531,000 was paid for free examination services, NPR 1,517,000 for oxygen, which is supplied free to all patients, and the rest was spent on medicine supplied by the hospital.

Earlier, subsidy rates had been standardised at 10, 25, 50, 75 and 100 percent, with five separate stamp pads for the purpose. However, fractional subsidies are no longer used, and only 100 percent subsidies are provided.

Total staff in the hospital

Currently there are 153 government staff and 248 committee staff (187 permanent, 42 on contract and 19 on a daily wage basis). Therefore, the total number of hospital staff is about 400.

Number of patients served by the hospital in FY 2067/68 BS

Departments	Total number
OPD patients	172,972
Emergency patients	32,989
Inpatients	22,973
Total patients served	228,934
Number receiving free service	17,376

The record keeping section of the hospital has the following estimates regarding which districts the patients come from:

- 60 percent of the patients are from Morang district
- 25 percent are from Sunsari district

- 15 percent are from other districts: Jhapa, Siraha, Saptari, Khotang and Bhojpur

The section also estimates that around 40 percent are women.

Analysis of 129 cases of patients who received free treatment in the emergency department between 20/01/068 and 12/11/068, indicates the following:

Category	Number	Percentage
Women	51	40
Senior citizens	26	20
Age 15 and below	22	17

Schedule for Help Desk duty by volunteers

Unlike in a typical hospital where regular staff run an "enquiry" counter, no staff members attend such counters here. However, volunteers from three social organisations take this duty in rotation as part of their social service. The duty schedules are as follows:

- SanjeevaniSeva Sangh - Sunday and Friday
- Om Shanti - Monday and Wednesday
- Sai Ram - Tuesday and Thursday

The normal duty time is from 09:30 AM to 12:30 PM, with adjustments depending on the flow of the patients.

Interviews with volunteers of the three organisations revealed that though they know about the free service provision in the hospital, they do not generally inform the poor and helpless about the service. They feel that simply informing them is not sufficient and they would have to facilitate the patients through all the steps every time. This would in many cases become a full time job.

Current structure and system of social service provision

Information about the free service provision

Communities in general, regardless of their socio-economic status, are not aware of the free health services available in the hospital, and the hospital does nothing to inform the targeted groups about the provision. Some patients learn of the possibility of free care through ward mates only after admission. Some very poor patients are assisted to secure the free services by medical attendants on a ward or by the emergency department. Only a few select groups of people know about the hospital's free health services:

- Hospital staff, their relatives and friends;
- Local political groups;
- Some local social organisations;
- Individuals who used the free service in the past.

Thirty-five patients (in wards and in the OPD) were interviewed at random based on their availability during the consultant's time in the hospital. The interviewees included 23 males and 12 females; 26 were at least 60 years old and two were 15 or under. When asked how they learned about the free service, they answered as follows:

Source of knowledge	No. of Persons	Percentage
Knew it already***	15 persons	43
Hospital staff	10 persons	29
Social organisations	08 persons	23
Political parties	02 persons	06

***Respondents who "knew about the free service already" did not reveal who first told them about the service. Their hesitation to disclose the source hints that the source was either hospital staff or some local political group or individual.

Eight people came through local social organisations and did not hesitate to name the organisation. Five were from AMDA Jhapa; two from Birateshor Old Age Home and one from the local Organisation of the Disabled. Two were brought by local political parties, one each by the Maoists and the Madhesi Janadhikar Forum. These days only the Maoist party representative regularly assists the patients to receive free service. The Forum volunteer is sometimes noticed, however.

Patients' entry and registration

The patient enters the hospital and comes to (i) Outpatient Department or (ii) Emergency Department based on her/his condition. Some OPD patients might be admitted to a ward as inpatients, after being sent to the Emergency Department for preparation. Patients brought directly to the Emergency Department in critical condition are either sent back home after treatment or admitted to the relevant ward. (Some prior patients come to the hospital simply to access free medicines, but they usually go through the OPD process for this.)

In most cases, a patient looking for free health services either knows about the service and process or is accompanied by someone who knows about it. In a few cases, the medical staff in wards, emergency or outpatient departments identify very poor and helpless patients and initiate a process for free treatment. Generally, all patients requesting free health services must register by paying NPR 10 at the registration counter, where they receive a "registration card" (red card) with their name, age, sex, health complaints, and the particular OPD room they should go to next. The registration fee of NPR 10 is waived for certain specified groups of people and they receive blue cards:

- Persons over 75 years (even if they do not carry the proof, such as a citizenship certificate);
- Disabled persons who can show certificates or identity card from their respective organisations;
- Prisoners who show identity cards provided by the prison.While prisoners receive the blue cards without paying (as they are exempted from the registration fee), the Prison Authority bears their other expenses.

The standard registration time is from 08:30 to 11:30 AM on working days. Two people are on duty for registration, with separate lines for men and women. The registration process was computerised last year. On the average, one staff member handles 85 (80-90) registrations per hour.

Patient's general examination

The patient then goes to the particular OPD as directed at the registration counter. The OPD doctor on duty examines him or her and recommends further examinations, tests, medicines and/or admission into a ward, as necessary.

At this stage, the patient requests free health services from the doctor. If the doctor agrees, the patient must go to Room Number 5 to obtain the free treatment forms. This is the OPD management room, where rabies injections are given and dressing is also done.

Filling in forms for free health services

Patients requesting free service must obtain three forms from room 5 and have them completed. Many patients cannot fill in the forms. Sometimes the staff members in room 5 help the patients complete the form; otherwise, the patients must get help from others. The staff members in room 5 are usually busy providing injections and vaccines, as well as dressing wounds. They thus consider the task of assisting with the forms for free care as an additional burden.

In the existing system, doctors have the responsibility to assess the patients'socio-economic condition by using a form the MoHP prescribed in its 2059 BS directive. The present Medical Superintendent added two

additional forms, based on the practice in his previous office tenure in Jhapa, though the evidence (a MoHP circular to the effect) was not found. Since doctors have neither time, competence nor willingness to conduct socio-economic assessments of the patients, the forms are not completed.

The three forms for free service are kept in room 5, (which is in the OPD), in the wards, the emergency department, the medical store and with the Medical Superintendent's Personal Assistant (PA). Depending on his/her contacts, a patient can pick up the forms from any of these places.

Recommendation and approval of free health services

Once the free forms are filled in, the patients take them to the same OPD doctor they approached earlier for her/his signature (recommendation). After obtaining a signature, patients take the forms to the MS for final approval and signature. After the MS has signed, his PA stamps the forms, indicating the percentage of subsidy. In the case of a patient in the Emergency Room or in a ward, the warden recommends the subsidy, which the MS then approves. When the MS is absent, an Acting Superintendent with authority to approve the free service is always available.

On the average, 15 to 25 minutes were required to get through the medical OPD (general check-up and signing of the form).

At the MS level, not a single case of rejection has occurred so far. Earlier practice was to give subsidies in fractions of the total cost: 10, 25, 50, 75 and 100 percent, but the present MS has discontinued this for the last two years, and the subsidy is now always 100 percent.

Completing cash counter formalities

The patient shows the registration card (red card) and the approved "free service" forms, and, if necessary, (in cases of partly subsidised cost) pays the rest of the cost and completes the accounting formalities before receiving services.

The OPD has two cash payment counters: one for women and one for men. On average, one staff member handles 30-40 payments in an hour. Therefore, the two staff members handle a total of 60-80 payments per hour. This counter clearly requires two additional persons to cope with the registration load: the time required for one patient at this counter is nearly double the time required for registration.

Provision of free service

Depending on the case, the patient is sent either to a ward (inpatient) or to the medical store for medicines, or to examination/lab rooms where s/he receives the free/subsidised service. When there are not enough medicines in the store, the patient is sent to the nearby Sajha Medical Shop, which the hospital compensates on a monthly basis.

If a patient requires more than one type of service (admission to a ward, obtaining medicine, or following up with an examination), s/he must fill in forms for each of these services and have them signed by the doctor and the MS.

Recording and reporting

A computerised system using specially developed software was installed last year. However, the system has a few gaps. The three forms are not completely filled in. In particular, information relating to the patient's socio-economic conditions is left blank. In addition, the forms at the medical store are not part of the regular recording system, and are therefore not helpful for making a meaningful analysis. Additionally, in some cases, no forms at all are completed in the Emergency Department. A total of 129 cases were recorded in the register where the three forms had not been filled in.

The free treatment forms from the wards and the emergency sectionare brought to the outdoor recording centre once a month and their entry takes some time. As a result, up-to-date information cannot be obtained.

Key issues and concerns raised by different stakeholders

- A patient generally learns of the free or subsidised service through hospital staff, social workers or local politicians. The wider public remains unaware of the availability of free or subsidised service. No information or signboard displays a citizens' charter where the poor could obtain information on the free services. However, the hospital staff, their families and acquaintances have easy access to free services. A total of 17,376 patients received free service in FY 2067/68 BS. Hospital management fears that if the information about the free service were widely disseminated, the flow of patients might become unmanageable.
- The most important issue is using practical criteria and developing a system to define the poor or very poor. No objective criteria orevidence-based process has been established to assess the patients'socio-economic condition.
- Many poor people pay for services they should have received for free, and many non-poor people who can afford to use expensive nursing home services obtain free services. Some local politicians use the free service for their political advantage, often without bothering about the poverty criteria; nor do they help people outside their political fold. The doctors can hardly reject a patient's request for free service when the patient is accompanied by staff members or local politicians. Attempts to refuse by some doctors meet with political pressure. Why would a doctor generate enmity by refusing free service? When the demand for services exceeds the budget, the situation will be more difficult to manage. Eventually, the total number of patients seeking free services is bound to reach unmanageable limits as more and more people come to ask for this service.
- The form meant for assessing the patients' socio-economic condition is never completed. Doctors do not usually have competence on poverty, gender and social inclusion issues. Nor is it a good idea to have them become involved in assessing whether a patient belongs to a certain social-economic target group.
- Although signing the form does not take much time, the key issue is the availability of the doctor and MS when required, and the signing must be coordinated with the opening time of the laboratories for examinations. This problem is a key issue for patients who come from other districts or from relatively remote regions of the district.
- The HDC is not effective and as long as the committee remains weak in its responsibilities and leadership, moving ahead is very difficult. The practice of appointing a party member (in the name of being a reputed social worker) has weakened the governance and integrity of the hospital. Similarly, when the MS does not perform well, the HDC Chairperson is powerless to hold him accountable and control his "undue" activity or inactivity.
- Some good governance issues have also been raised. How can utilisation of the services by staff, their families and acquaintances be prevented? How can the conflict of interest between the private clinics belonging to hospital doctors and the use of free service by the patients be resolved, since many of these patients might need to utilise hospital services, particularly for those services (eg, operations and some tests) that are not available at private clinics?
- Patients who had no help from hospital staff or other knowledgeable persons mention the following typical problems that they faced, which were confirmed by observation and follow up of some poor and helpless patients through the service delivery chain:
  - ✓ Not knowing where to make the first approach for the service
  - ✓ Not knowing about the need to fill in the free service forms

- ✓ Not knowing where to get the forms
- ✓ Not being able to fill in the forms
- ✓ Not knowing where to go after filling in the forms
- ✓ Not knowing how and where to find the MS to sign the form
- ✓ Not knowing where to find the right department or room for the service
- ✓ Not knowing about the hospital's service time (time when a doctor examines)
- ✓ Not knowing how and when one will be called for examination by the doctor
- ✓ Not knowing where to find the medicine store or the investigation rooms
- ✓ Repeating the same process of form filling and signing, when for example, free medicines and investigations are required or when more medicines are required
- ✓ Coordinating the signing of the free treatment forms with the working time of the laboratories, doctors and medical store (Patients from other districts or relatively remote parts of the district face this issue more often)

Some good practices initiated

- In the absence of the MS (during leave or travel), another senior doctor automatically acts as the MS and the signing of forms for free treatment can continue. No written delegations are required for this. Earlier, the departmental heads were also authorised to approve the free service (on behalf of the Superintendent) but this practice has been discontinued for fear of misuse.
- The arrangement that Plan Nepal has offers a model for ensuring free services for the poor and excluded. The important aspects in the model are (i) correctly identifying the poor and excluded and providing them with identify cards, and (ii) assisting them through all the steps and processes in the hospital. A volunteer from Sanjivani Sewa Sangh, asocial organisation, receives Plan's poor beneficiaries (patients) from Morang and Sunsari districts at the Sangh's counter at the Koshi Zonal Hospital. The patient comes with her/his identify card and a recommendation letter from the Plan office. The volunteer assists the patient through all the steps, from registration to the final provision of service. Plan periodically reimburses the hospital for the costs of their patients via the Sangh's account, and also provides a volunteer fee for one person as well as some support to the Sangh.

Some recommendations

- Provide below the poverty line (BPL) Identity Cards to people for the provision of free health services (Identifying the disabled, senior citizens, and FCHVs is not a problem.) Limit the free service to people with BPL cards and members of other specified groups only.
- Provide identity cards for government staff members, and their eligible dependents (with photographs), and decide on subsidy rates and criteria.
- Include in the target group widows and others who receive monthly allowances from the wards or VDCs as per programmes of the Government of Nepal.
- Since most services in gynaecology are already free, make all the services free.
- Photocopies of the signed forms should be enough for record keeping purposes, instead of asking patients to obtain and complete separate signed forms for medicines and examinations (However, the Superintendent believes that simplifying the process will enhance the flow of the people for free service beyond the hospital's management capacity, and thinks that keeping the process complicated to control the flow of patients is better.)
- Design a system of delegating authority (from the Superintendent to the Department Heads) to better manage the free services, with special arrangements made for emergency and serious cases. (The Superintendent, however, is apprehensive that authority delegation might lead to misuse of the funds, based on his experience.)

BHERI ZONAL HOSPITAL

General information on the free health services

Background of the free service

Provision of free health services started following the MoHP circular dated 059/08/25 BS. The circular directs the hospital to set aside five percent of its total income from government grants and hospital servicesto provide free health services. The target groups defined for the free health services: disabled persons, vulnerable persons, ultra-poor persons, persons without home and income, abandoned women and street children.

Budget and expenses

The government grants to the hospital (under headings 3.03, 3.04, 3.05 and 4.04) for the fiscal year 2067/68 BS were NPR 35,600,000, 15,125,000, 12,000,000 and 588,000. More or less all of the budget was spent. Budget under the headings 3.04 and 4.04 (Mother Protection Programme and Uterus Prolapse Programme) was transferred to the account of the Hospital Committee and accounted for accordingly. Income from services and rental was NPR 22,567,000. The District Development Committee (DDC) Banke also provided NPR 1,500,000, which was spent on the Emergency Department's medicines and supplies, and the accounts were audited by the DDC. NPR 4,000,000 is in fixed deposit and bears interest of around NPR 600,000 per year. The rest of the accumulated surplus is kept as the running capital. The income from rentals alone before income tax is over NPR 5,300,000 per annum.

The practice of setting aside five percent of hospital income for the free treatment fund was discontinued two years ago as the government began providing separate funds under heading 3.05 for that purpose. The total fund for free treatment in FYs 2066/67 was NPR 5,000,000, with the actual expense at over NPR 4,943,000. The grant for FY 2067/68 was NPR 6,000,000 and was fully spent. Starting this FY (2068/69), all hospital beds (except cabins) are provided free of charge to everyone admitted to the hospital. Earlier, the cost of the beds was also met from the free treatment budget. The subsidy rates are standardised at 25 percent, 50 percent and 100 percent. However, fractional subsidies are no longer used, and all patients are provided 100 percent. Earlier, a 50 percent subsidy was often used for staff members.

Two meals are provided free of cost to about 150 patients enrolled in the wards. The number depends on whether a patient wants to eat the free meal and on the number of inpatients. During the high season (July-August) the total number might exceed 150. The costs are borne from the heading 3.03 (new code being 26411, unconditional recurrent grant). Some patients (in the Burn Ward and the Helpless Ward) receive one egg and a glass of milk every morning, in addition to the two meals. During the last Nepali month (Magh), 946 patients received free meals and about NPR 74,000 was spent on food. The meal supplier is compensated monthly based on actual expenses and some costing standards.

The total amount spent on salary and allowances in the last fiscal year was as follows:

Type of staff	Salary expenses	Allowances	Total expenses
Government staff	19,003,000	2,237,000	21,240,000
Committee staff	12,535,000	5,326,000	17,861,000
Total	31,538,000	7,563,000	39,101,000

Total staff in the hospital

Of the total 116 government staff positions, 28 are vacant currently, and there area total of 94 Committee staff.

Number of patients served by the hospital in the fiscal year 2067/68 BS:

Departments	Total number
OPD patients	80,745

Emergency patients	6,333
Inpatients	12,819
Total patients served	99,897
Number receiving free service	**15,534** (of which 5,694 are women)

On peak days (Sundays) the daily flow of new patients is as high as 400-450, and previous patients as high as 80-90. On other days, new patients are 250-275. On 4 March 2012 there were 290 new patients and 77 old ones: the number being less than usual because a political group had called for a general strike. On 5 March, there were 163 new patients and 34 old ones due to the effect of the strike.

The data related to the districts the patients came from were not tabulated by the hospital. The data for this fiscal year have not yet been entered. The relevant staff raised the issue that the data concerning free treatment was not part of the HMIS report.

Current structure and system of social service provision

Information about the free service provision

Communities in general (regardless of their socio-economic status) are not aware of the free health services available in the hospital. Nor does the hospital engage in any activities to inform the targeted groups about the services. The lack of a visible and friendly "enquiry" counter adds to the problem. Some patients learn about the free service from other ward mates and attempt to access free service themselves. Only the following select groups of people know about the free health services in the hospital:

- Hospital staff, their relatives and friends;
- Local political groups;
- Individuals who once used the service.

Twenty patients in the OPD were asked if they knew about the hospital's free health services. None was aware of the provision. Fifteen patients who received free health services were also interviewed. They were asked how they learned about the free service in the hospital and the answers were:

Source of knowledge	Persons	Percentage
Do not know, have no idea who brought me here from the road	4 persons	27
Learned through Plan Nepal, INF, Karnali Zonal Hospital	3 persons	20
Hospital staff (nurses, ambulance driver and others)	5 persons	33
Political party/chairperson of Hospital Committee	3 persons	20
Total	15 persons	100

Patient's entry and registration

The patient enters the hospital and comes to (i) Outpatient Department or (ii) Emergency Department based on her/his condition. Some OPD patients might be admitted to a ward as an inpatient. Patients are also referred to the Emergency Department by private clinics in order to be admitted to wards. Patients who are brought directly to the Emergency Department in critical condition are either sent back home after treatment or are admitted to the relevant ward.

In most cases, the patient seeking free health services either knows about the service and process or is accompanied by a person who knows. Two separate free service forms (one for free medicine and another for free examination) have been developed and are kept at all the OPDs, wards, emergency and outpatient departments. Generally, all patients seeking free health services must register with a payment of NPR 5 (for new patients) and NPR 2 (for old patients) at the registration counter.

At the registration counter, they receive a "registration card" with their name, age, sex, health complaints, and the particular OPD room where they should go next.

The standard registration time is from 08:30 to 11:30 AM on working days. Two persons are on duty for the registration process, with separate registration lines for men and women. The registration process is fully manual. One staff member can handle 100-120 registrations per hour and therefore the two staff members handle around 200-240 registrations in one hour.

Patient's general examination

The patient next goes to the particular OPD as directed at the registration counter. The doctor on duty examines him/her and recommends further examinations, medicines and/or admission into a ward, as necessary. At this stage, the patient requests free health services or the doctor, considering his/her economic condition, might recommend free or subsidised service.

Filling in forms for free health services

The doctor must complete two forms. Both have space to check the target group the patient belongs to: poor, ultra-poor, senior citizen, FCHV or disabled. The yellow form assists in identifying the free medicine and the red form the type of examination. The red form has spaces for determining the portion of subsidy recommended: 25, 50 or 100 percent. The doctors mark the appropriate box to indicate the patient's socio-economic condition or target group. Although the form prescribed by the MoHP in its 2059 BS directive was used for some time, it has been replaced with the two newly developed forms. The two forms are kept at all the OPDs, wards, and the store. The patient must request the forms at these places.

Recommendation and approval of free health services

Once the free forms are completed and the concerned doctor signs and recommends free service, the patient must take the form to the MS for final approval and signature. The MS decides the percentage of subsidy and approves the free service. Rejections by the Superintendent are very rarely heard of.

Though signing the form does not take much time, the key issue is the availability of the doctor and MS when required, and the signing has to be coordinated with the opening time of the laboratories for investigations. Patients who come from other districts face this problem more often.

Cash counter formalities

The patient must go to the cash counter for accounting formalities, even though s/he might have been recommended for full free services. Patients who are exempted from only a portion of the total cost must pay the remainder.

The OPD has two counters for cash payment: one for women and one for men. One staff member handles roughly 30-40 payments in an hour, for a total of 60-80 payments per hour by the two staff members. This counter clearly requires two additional persons to cope with the registration load: the time required for one patient at this counter is nearly double the time required during registration.

Provision of free service

After completing the formalities at the cash counter, the patient goes to the ward (inpatient), to the medical store for medicines, or to the examination/lab rooms where s/he receives the free or subsidised service. When the store does not have enough medicines, very poor patients are sent to a nearby Sajha Medical Shop, which the hospital compensates on a monthly basis. For patients who have already been admitted, the free services are taken care of by the ward staff and warden.

Recording and reporting

The basic recording is manual. The recording section inputs the records on a computer. Thus, all the previous year's data have been computerised but the data of this current fiscal year have not been entered. After the input of the data on the computer, the number of male and female service receivers can be determined, but the category of the target group and the districts of the patients cannot be extracted.

Key issues and concerns raised by different stakeholders

- A patient generally learns about the free or subsidised service through hospital staff, local politicians, or persons who have already utilised the service. Some people were informed about the service by International Nepal Fellowship, Plan Nepal and district hospitals. The wider public is unaware of the free or subsidised service. No signboard displays a citizens' charter providing information on the free services. A total of 15,534 patients received free service in the fiscal year 2067/68 BS.
- The most important issue is defining the poor or very poor by using practical criteria and developing a system. Currently, no objective criteria or evidence-based processes are used to assess patients' socio-economic status.
- Many poor people pay for services they should receive free and many non-poor people who can afford to use expensive nursing home services access the free service.
- Some local politicians use free service for political gain, and they often do not bother about the poverty criteria, nor do they help people outside their political fold. The doctors can hardly reject a patient's request for free service when staff members or local politicians accompany the patient. Attempts by some doctors to refuse meet with political pressure. Why would a doctor generate enmity by refusing free service? When the demand for services exceeds the budget, it will be more difficult to manage. Eventually, the total number of patients seeking free services is bound to reach unmanageable limits as more and more people come to ask for this service.
- Many people go to expensive medical services in India or private clinics in the area and spend significant amounts of money on their health care. When these same people come to the hospital, they want free service; refusing them is often difficult.

A local schoolteacher over the phone requested the Chairperson of the Hospital Management Committee to grant an exemption of hospital charges worth a few thousand Nepali Rupees. The chairperson had a difficult time convincing the teacher that since the patient had used a cabin and not a general bed, waiving the charges was not possible.

A political worker approached the Chairperson for free medical service, and was directed to get the forms for free service. He went to the OPD to collect the forms, and had the attending doctor sign them, which he did only hesitantly. Then the political worker asked about the next step, and was told to have the Superintendent sign the form. Learning that the MS was at his residence, he went there and had the form signed. He was definitely not poor.

- Doctors are not competent regarding questions of poverty, gender and social inclusion. Nor do they wish to become involved in assessing whether a patient belongs to a particular social-economic target group. Why should a doctor generate enmity by refusing free service? Since the doctors can now recommend free services to all who approach, there are no problems. However, if the demand for services exceeds the budget, the issue will become different and difficult.
- In addition, some issues of good governance have been raised. How to prevent utilisation of the services by staff, their families and acquaintances? How to resolve the conflict of interest between the private clinics belonging to hospital doctors and the patients' use of free service, since many of these patients might need to utilise hospital services, particularly those treatments such as operations and certaintests that are not available at private clinics?
- The Hospital Development Committee is not effective and as long as the committee remains weak in its responsibilities and leadership, moving ahead is very difficult. The practice of appointing a party person (in the name of reputed social worker) has weakened the governance and integrity of the hospital. Similarly, when the MS does not perform well, the Chairperson of the HDC is legally powerless to hold him accountable or to control his "undue" activity or inactivity.

- Hospital property has been used by others (Red Cross, Doctors' Association, and a private NGO) without adequate compensation; as a result, the hospital's income is much lower than it should be with good management of the property.

During the study at Bheri Zonal Hospital, the researcher came upon the following patients and recorded their stories, in interviews with the patients, their attendants and nurses.

In Surkhet district, Mrs Dhansara Pokharel, age 18, delivered a child. On the third day after the birth (in Magh) she was warming herself and the child in front of a fire when she caught fire and her lower body (below her waist) was burnt. She received initial treatment in Lekforsa and was brought to a nursing home in Kohalpur, Banke. After spending most of her money without success, she was sent to Bheri Zonal Hospital though a Maoist connection and was treated for free.

Puja Gudia, age 16 from Phultekra, Nepalgunj, burnt the entire front of her body, except her face. She was initially admitted on a paying basis but later the doctors in the ward realised her family's inability to pay the bills and decided to provide free medical services.

Tulasa Khatri, aged 70-80, was bitten by a snake at night and came alone to the hospital around 9 am, as she had no one to accompany her. First, she registered and was sent to room 4. From there she was sent to the medicine store for medicine. The storekeeper asked for a signed form to provide the medicine. A woman spotted the patient and voluntarily took her to room 4 and asked the doctor on duty about the signed form. The doctor suggested taking her to the Emergency Department, and the woman did so. The woman briefed the doctor about the snakebite and was about to return when the doctor insisted that she could not leave the old patient there alone. The woman tried to explain that the old woman was not her relative but simply someone she helped locate the Emergency Department. The doctor did not try to understand the situation and continued to stress that the volunteer must stay. Nevertheless, the volunteer left the old woman. This case amply shows the need of a facilitator/volunteer for helpless patients as well as the insensitivity of the attending doctor in insisting that the woman stay with the patient.

Some good practices initiated

- In the absence of the MS (during leave or travel), the other senior doctor automatically acts as the MS and can signthe form for free treatment. No written delegation is required. Earlier, the departmental heads were also authorised to approve the free service on behalf of the Superintendent, but this practice has been discontinued for fear of misuse.

Some recommendations

- Provide BPL Identity Cards to people for the provision of free health services. No problems occur in identifying the disabled, senior citizens and FCHVs. Limit the free service to people with BPL cards only.
- Provide identity cards for government staff members, and their eligible dependents (with photographs), and decide on subsidy rates and criteria.
- Develop a system for delegation of authority, from the MS to the Department Heads, to better manage the free services, with special arrangements for emergency and serious cases. The Superintendent fears that the delegation of authority might lead to the misuse of the funds. The previous Superintendent had delegated authority to the Department Heads.

BHARATPUR HOSPITAL

General information on the free health services

Background of the free service

Provision of free health services started following the MoHP circulardated 059/08/25 BS. The circular directs the hospital to set aside five percent of its total income from government grants and hospital services for free health services. The following target groups were defined for the free health services: disabled persons, vulnerable persons, ultra-poor persons, persons without home and income, abandoned women and street children. However, in actual practice, the free service form mentions five types of target groups: helpless, disabled, abandoned women and children, beggars, the ultra-poor and others.

The Hospital Committee (by a decision dated 065 Phagun 18) has also identified some endangered ethnic groups as the target: Bote, Mushahar, Majhi and Chepang. Though not officially mentioned, Darai are also provided free service irrespective of their poverty status.

Budget and expenses

The government (and donor) grants (based on actual expenses) to the hospital (under headings 3.03, 3.04, 3.05 and 4.04) for the fiscal year 2067/68 BS were NPR 31,500,000, 36,471,000, 8,000,000 and 516,000 respectively. Budgets under the headings 3.04 and 4.04 (Mother Protection Programme and Uterus Prolapse Programme respectively) are transferred to the account of the Hospital Committee and accounted for accordingly. Income from providing health services and rentals was NPR 22,567,000. Nearly NPR 25,300,000 is in fixed deposits and bears interest of nearly NPR 1,100,000 per year. The hospital's total income from services, rents, internship arrangements with local medical college, and some programme budgets was over NPR 91,900,000, of which about 88,067,000 was actually spent. The sources of income of the hospital are as follows:

- On-the-job training arrangements for staff nurses, health assistants, laboratory technicians and others, and arrangement for MBBS examinations with medical colleges;
- Rents from the medical college, other nursing training institutes, medical stores (including Sajha), a restaurant and a bank for the use of hospital land and premises;
- Paying wards, cabins, extended hospital services (operations) and intensive care services.

Instead of setting aside five percent of hospital income for free treatment, a lump sum budget is set aside under that heading every year. For example, the hospital put in NPR 13,500,000 for free services, in addition to the government grant of NPR 8,000,000. However, for the current fiscal year, only NPR 2,000,000 was set aside for the purpose, as the hospital is already incurring a huge cost for a new building. Starting this fiscal year (2068/69) all hospital beds (except cabins) are provided free of charge to everyone admitted to the hospital. However, this amount underestimates the actual funds used by the hospital since the budget does not reflect the costs of free operations and laboratory chemicals. The subsidy rates are standardised at 50 percent and 100 percent. The 50 percent subsidies are used for operations, and in all other cases patients are provided a 100 percent subsidy.

Two meals per day are provided free of cost to all patients admitted to the hospital. The total beds are over 250. The costs are borne from the heading 3.03 (new code being 26411, unconditional recurrent grant). The supplier of the meals is compensated monthly based on the actual expenses and some costing standards.

The total amount spent on salaries and allowances of the committee staff in the last fiscal year was as follows:

Salary expenses	Allowances	Total expenses
10,579,000	13,550,000	24,129,000

Total staff in the hospital

There are 163 government staff positions and 175 Committee staff positions in total.

Number of inpatients receiving free services in the fiscal year 2067/68 BS

Departments	Total number
OPD patients	99,892
Emergency patients	32,681
Inpatients	25,672
Total patients served	158,245
Number receiving free service	**3,170** (of which 2,028 are women)

On peak days the daily flow of new patients is as high as 700; in winter, the number is as low as 250-300. On average, there are about 500 patients per day. The hospital management estimates that about 30 patients receive free service daily. Since the software used by the hospital does not track the free service, assessing the exact number of patients receiving free serviceis difficult; nor is it possible to analyse their places of origin or their socio-economic status.

A check of the records of free services from the cash counter for the five-month period between the Nepalese months of Shrawan and Mansir shows that 1200 patients received free services.The number of patients receiving free medicines from Sajha or the private medicine store (on recommendation of the hospital) was 1,327 during the same period. Assuming no overlap between these two figures, over 2,300 persons received free service over the five months.

This yields an average of 460 persons per month; therefore, the annual number of free service receivers for this year could be estimated as roughly 5500. However, because of the problems with record keeping, one cannot be exact on the number, not to mention the non-availability of segregated data.

Current structure and system of providing social services

Information about the provision of free service

Communities in general (regardless of their socio-economic status) are not aware of the free health services available in the hospital. Nor does the hospital do anything to inform the targeted groups about the services. Some patients learn about the service through ward mates only after hospital admission.

Some very poor patients are directly assisted by medical attendants on the ward or in the emergency department to secure the free services. Only a few select groups of people, as follows, have any information concerning free health services in the hospital:

- Hospital staff, their relatives and friends;
- Local (private) clinics/hospitals/health posts;
- Local political groups;
- Individuals who previously used the free service.

All hospital staff know that members of the Chepang community are provided free treatment. However, three Chepang patients who were interviewed were unaware of their rights. All three were brought to the hospital by other people (schoolteacher, local health post staff), and they had learned about the free service for the first time. This indicates that the information about the free service is not widely disseminated among the Chepangs.

A Chepang patient admitted to the ICU in critical condition was kept in the hospital for 18 days, and about NPR 300,000 was spent on his treatment, despite a rule restricting the cost per patient to NPR 3,000. The rule is printed at the bottom of the form for free service.

Thirty-five patients who received free health services were interviewed and asked how they learned about the free service.Their responses were the following:

Source of knowledge	Persons	Percentage
Brought from the road by the police, social organisations or social	8	23

workers		
Learned of free service after admissionto the hospital through the staff, who assisted them in accessing the free service	21	60
Learned from others: private hospitals/clinics, hospital staff, health posts, teachers, political persons	6	17

Patient's entry and registration

The patient enters the hospital and comes to (i) Outpatient Department or (ii) Emergency Department based on his or her condition. Some OPD patients might be admitted to a ward as inpatients. Patients are also referred to the Emergency Department by private clinics in order to admit them to the wards. Patients who are brought directly to the Emergency Department in critical condition are either sent back home after treatment or are admitted to the relevant ward.

In most cases, a patient seeking free health services either already knows about the service and process or is accompanied by someone who does. A free service form and application has been developed and is kept in room 10 (the medicine distribution room), the wards, and the Emergency Department.

Generally, all patients seeking health services must register at the OPD registration counter for a fee of NPR 20 or at the Emergency Department for a fee of NPR 30. At the registration counter, they receive a "registration card" with their name, age, sex, health complaints, and the particular OPD room where they should go next.

The standard registration time is from 08:30 to 11:30 AM on working days. Two persons are on duty for the registration process and separate registration lines handle men and women. The registration process is computerised. One staff member handles 80-90 registrations per hour. This rate is lower than in other hospitals, mainly due to a bad working layout: both staff members sit on the same side of the window but handle only one of the two lines of patients. In the process they unintentionally disturb each other.

Patient's general examination

The patient goes to the particular OPD as directed at the registration counter. The doctor on duty examines the patient and recommends further tests, medicines and/or admission into the wards, as necessary. At this stage, the patient requests the doctor for free health services, or considering the patient's economic condition, the doctor might recommend free or subsidised service. Orthopaedic and medical departments tend to have the highest number of patients.

Filling in forms for free health services

One form must be completed by the patient and signed by the doctor. The form determines the patient's socio-economic statusas ultra-poor, vulnerable, beggar or disabled. The form includes spaces to mark to determine the recommended amount of subsidy: 50 percent or 100 percent. In case a patient requires medicines not available at the hospital, the doctor completes another form authorising the provision of medicines through the medical stores in the hospital premises and has the MS sign it. The medical stores are compensated on a monthly basis based on actual bills, against the recommended forms and bills.

The hospital has developed its own form for the free service, which has been used for about the last four years. Dr Sainendra Upreti developed the form when he was the hospital's MS.

Recommendation and approval of free health services

Once the forms for free service are completed and the concerned doctor signs, recommending free service, the patient must take the form to the Department Head or the MS for final approval and signature. The MS decides the percentage of subsidy and approves the free service. Rejections by the

Superintendent are very rare. In the absence of the MS, any senior doctor acting as the MS can sign on his or her behalf.

Though signing the form does not take much time, the key issue is the availability of the doctor and MS when required. In addition, the signing must be coordinated with the laboratory opening time. This is a key issue for patients comingfrom other districts, many of whom are unaware of the hospital hours.

Cash counter formalities

Patients must go to the cash counter for the accounting formalities, even though full free services might have been recommended. Patients who are exempted from only a portion of the total cost must pay the remaining costs. In cases of partial subsidy, the patient receives two receipts: one for the subsidised costs and the other for the rest. The receipt for the free service is still manual, not computerised.

Two counters take cash payment: 15Ka for ward admission, emergency tickets, deposits, operations, delivery and discharge slips; and 15Kha for X-rays, laboratory tests, ultrasound tests and dental tests. Counter 15Ka has two lines: a women's and a men's. Counter 15Kha has only one line for both men and women, the area being too narrow for two lines. Patients requiring free services use counter 15Ka and not 15Kha.

One staff member can handle roughly 40-45 payments per hour, so that a total of 80-90 payments are handled every hour by the two staff members. Clearly, this counter requires two additional persons to cope with the registration load: the time required for one patient at this counter is nearly double the time required during registration.

Provision of free service

After completing the formalities at the cash counter, inpatients go to the ward or to the medical store for medicines, or to lab rooms where they receive the free or subsidised service.

When the hospital store does not have enough medicine, very poor patients are also sent to the medical stores on the hospital premises, either the Sajha Medical Shop or a private one. The patient chooses the medical store. The hospital compensates the medical stores on a monthly basis. The free services for patients who are already admitted are taken care of by the ward staff and warden.

Recording and reporting

The free service is not part of the recording system, even though the rest of the registrations are computerised. The reason cited for not including free service data on the newly installed software is the apprehension that some misuse of the free service might occur at the cash counter: some non-free service might be entered as free service and the money pocketed privately. The recording section does not input the records on a computer but periodically receives the data from accounts and from cash counter 15Ka.

The hospital management had difficulty believing the data covering the number of patients receiving free service during the last fiscal year. They think the actual number must be much larger than 3,170. However, they failed to produce any evidence.

Key issues and concerns raised by different stakeholders

- A patient generally learns about the free or subsidised service through hospital staff, local politicians, persons who have already utilised the service or other health service providers, including private clinics and hospitals. A significant number learn about the service after their admission to the hospital when ward nurses notice their inability to pay for medicines or other tests, and take the initiative to provide them free service. In some cases Emergency Department medical staff inform them of the service and help them in practical ways. Some people from other districts learned about the service from people who already knew about it. The wider public is unaware of the availability of free or

subsidised service. No signboard or citizen charter provides information on the free services.

- The most important issue concerns how to define the very poor by the use of practical criteria, and how to develop a system to identify people below the poverty line and provide them with ID Cards, based on which they could access free services without much difficulty. Realistically, free services can be provided only to people below the poverty line and not to all the "poor."
- Most poor people pay for services they should have received free and many others who are not poor and can even afford to use nursing homes end up accessing free service. Some local politicians use the free service for political gains, and often do not bother about the poverty criteria. Their help is more or less limited to people within their political fold.

A patient was operated on and after the operation decided to stay in the paying ward (which was much better than the free general ward). Upon release, the patient was asked to pay the general ward fee (a total of NPR 800 @200 per night). A journalist (the patient's relative) kept insisting to the MS that the patient be exempted from the charge, despite refusal by the Superintendent. Finally, and with much difficulty, the journalist agreed that the patient would be paid NPR 500 as transport cost and would pay the remaining NPR 300.

- Many people go to expensive private clinics in the area for medical services and spend significant amounts of money. When these same people come to the hospital, they want free service and refusing them is often difficult.

An orthopaedic patient spent NPR 400,000 in a private hospital in Hetauda but his condition did not improve and he was referred to this hospital. He is receiving medicines, meals and a bed for free, and looking at his financial condition, he might receive a significant subsidy on other treatment costs as he has already exhausted his financial capacity.

- No objective criteria or evidence-based process has been developed to assess the socio-economic conditions of the patients. The doctors can hardly reject a patient's request for free service when the patient is accompanied by staff members or local politicians.
- Doctors do not have competence on poverty, gender and social inclusion issues. Nor do they wish to become involved in assessing whether a patient belongs to a certain social-economic target group. Why should a doctor generate enmity by refusing free service? Since the doctors can now recommend free services to all who approach, there are no problems. If the demand for services exceeds the budget, however, then the situation will be different and difficult.
- Questions of good governance also arise. How can utilisation of the services by staff, their families and acquaintances be prevented? How can conflicts of interest between private clinics belonging to hospital doctors and the patients' use of free service be resolved, since many of these patients might need to utilise hospital services, particularly for operations and tests that are not available at private clinics?

The following case illustrates the struggle of a patient from Gorkha:

Shiva BahadurKhadka, a 68-year-old male, took a loan of NPR 400 from some people in his village to have a medical check-up for a chest problem and fever. During a six-year tenure in the Nepalese Army, he had served as a nurse in the army hospital in Kathmandu and was very familiar with the technicalities of the health service. Based on his knowledge, he suspected he might have TB and wanted to test for this. Earlier, he had visited Gorkha Zonal Hospital but could not trust the hospital because the necessary facilities were not available. He proceeded to Bharatpur Hospital, about which he had previously heard favourable things.

He walked from Gorkha to Bharatpur, not taking a bus because his funds were quite limited. He had a few tablets for fever control that a friend had given him. He arrived at Bharatpur Hospital in the morning of the fourth day after leaving Gorkha. As is common, he had considerable difficulty before he finally reached the medical ward, where he was given a bed on the floor while the hospital staff prepared for his tests and formal admission. By the time he reached the hospital he had almost finished his money. He knew that beds and meals in the hospital would be free but did not want to stay long. He wanted to leave as soon as his test for TB was done. He was finally admitted into the hospital for free services. This case is an exception where a poor person without connections and power succeeded in accessing the hospital's free service provision.

The following issues were also discovered during the stakeholder interviews:

- Nepal Netra Jyoti Sangh (NNJS) was provided four bigha of land (out of the nearly 32 bigha belonging to the hospital). However, NNJS is using only one bigha, and has rented three bigha to others and is taking the rental income for itself.
- The lack of elected representatives in the local bodies (DDC and Municipality) has reduced the effectiveness of the Hospital Development Committee.
- Five positions for Nursing Supervisors are vacant (one hundred such positions are vacant across Nepal, with five being from this hospital). The government has taken no initiative to fill these positions. This has affected the overall hospital management, particularly with regard to quality assurance.

Some good practices initiated

- The HDC decided to provide free services to several ethnic groups that are extremely marginalised and are considered endangered: Chepang/Praja, Bote, Majhi and Mushahar. However, most staff members could not name any group other than the Chepang.
- A system for staff members and their dependents to receive subsidised service was developed and used, though it has now become practically defunct. According to the system, staff members receive a 90 percent subsidy and up to five specified family members receive a 50 percent subsidy.
- A white board is kept in all the wards for updating the names and details of individuals who have received free service. Publishing the names on the white board is expected to deter wealthy persons from taking advantage of the free service. Some wards use the board regularly and some do not.
- In the absence of the MS (during leave or travel), another senior doctor automatically acts as MS and the signing of formsfor free treatment can continue. No written delegations are required for this.

Some recommendations

- Provide BPL Identity Cards to people for the provision of free health services. Limit the free service to people with BPL cards only. The disabled, senior citizens, and FCHVs are easily identified, as they already have identity cards, and free service to them should be continued.
- Provide identity cards for government staff members and their eligible dependents (with photographs), and decide on subsidy rates and criteria.
- Work out a delegation of authority system, from Superintendent to Department Heads, to better manage the free services, with special arrangements for emergency and serious cases.

(Note that the Superintendent fears that the delegation of authority might lead to the misuse of funds. The previous Superintendent had delegated authority to the Department Heads.)

PATAN HOSPITAL

Patan Hospital has a separate charity section, the Social Service Department (SSD). Earlier, the department chief had anassistant, but the assistant position is currently vacant. A five-member committee handles all matters related to free or subsidised service:

- Chief of SSD — Coordinator
- Nursing Supervisor — Member
- Concerned Department or Ward In-Charge and a doctor — Members
- Business Manager (Finance/Accounts) — Member

Depending on the patient's economic condition and ability to pay, the subsidy provided can be 25, 50, 75 or 100 percent. The annual expense for free or subsidised treatment is between NPR 10,000,000 and 11,500,000, and the amount is increasing every year. The sources of the fund are the hospital's own income from paying services, and donations from national and international donors. Most of the expense goes for inpatients, and the expenditure for inpatients is generally larger than for outpatients.

For expenses up to NPR 10,000 per patient, the Coordinator (or the Chief of the SSD) can make the decision regarding a subsidy or waiver of the expenses, but he or she should inform other members of the committee in due time. Generally, all outpatient related subsidies (for medical examinations and medicines) are handled by the Coordinator, as the amount involved is much smaller than NPR 10,000. In cases of subsidy above NPR 10,000, the committee decides. For a committee decision, a minimum of three members must be present.

In the absence of the Department Chief, Nursing Supervisors are delegated authority regarding the subsidy provision. Of the three Directors—Nursing, Medical and Administration—the SSD is under the Administrative Director.

The process for free or subsidised service is as follows:

- The doctors or nurses on duty in the OPDs or Emergency Department observe and assess the patient's financial condition.
- The patient is referred to the SSD if the doctors or nurses on duty find that the patient is poor and cannot fully pay for the services.
- The SSD takes the appropriate decision based on the patient's condition. The decision of the Department applies until the patient receives the final treatment and is discharged.
- Sometimes the cash counter observes that patients are having difficulty in paying their bills. When this happens, the cash counter refers the patients to the SSD, which takes the necessary decision regarding providing a partial subsidy to the patient.
- Subsidies are provided for check-up, examinations, medicines, beds, and free meals. Closer control over the subsidy is maintained in cases requiring a CT scan, delivery cases and police cases. Close control, however, will not hamper provision of free tests when the situation is life-threatening.
- The patient is generally asked to present recommendations from local bodies and social organisations. When this is not possible, the patient or his/hercompanionis asked to write a request letter for free or subsidised service elaborating his/her financial condition.
- Occasionally different political groups and trade unions apply pressure for free or subsidised service. Sometimes this is difficult to resist. However, in police cases and cases of delivery, pressures are hardly entertained.

Some 25 percent of the patients receiving the free or subsidised service already know about it from previous experience, from the previous experience of someone they know, or from ward mates in the hospital. The rest learn about the service for the first time. Since most of the subsidy is spent on

inpatients, the nurses in wards monitor the patients' ability to pay closely. The largest amount ever paid to a single patient was around NPR 250,000.

BIR HOSPITAL

Sanjivani Sewa Sangh was initiated on 2037.05.03 by Princess Princep Shah and has been providing services to the helpless and poor in the hospital since then. Its services include giving the following:

- Free blood to patientsincritical condition;
- Travel expenses for the journey home;
- Cremation expenses;
- Expenses for medicine, food and clothes;
- Shelter (accommodation and food);
- Free pathology tests (on the Sangh's recommendation);
- Guidance to patients seeking the wards, OPD, etc, and
- Collecting and delivering test reports to wards.

The organisation's capacity to provide the above services on a voluntary basis has been exhausted over the years. The hospital gives the Sangh NPR 5,000 monthly, but this amount is something of a joke considering the total volume of service the Sangh provides to poor and helpless patients. Occasionally, the MoPH has provided some funding to the Sangh. The key issue for most volunteers is the cost of transport from home to the hospital and back. These volunteers would be happy to receive the equivalent of a peon's salary—NPR 10,000 per month—as transport/travel cost. The funds come from membership fees (very nominal and negligible) and donations.

The Sangh provides volunteers for the Help Desk on a rotational basis six days a week. Normally, five volunteers are on duty at the Help Desk: one team of volunteers attends the Desk two days a week. One staff paid by the Sangh is working in the hospital. The chairperson of the Sangh receives NPR 350 per day as compensation for his transportation.

The Sangh has requested the MoHP to provide it about NPR 2,800,000 and has presented a detailed justification for the demand. The Sangh is not aware of what happens to the segment of the hospital budget that is meant for free service.

The daily patient flow in the hospital is between 700 and 1,000.

Up to three years ago, the Sangh used to recommend poor and helpless patients for free treatment and the hospital provided free services to such patients. Beginning with the tenure of Dr CP Maskey as Director, this very old practice was discontinued. Sangh volunteers are not aware why this long-established practice was abruptly stopped.

At present, though the Sangh still has an office on the hospital premises and continue assisting the poor and helpless, the members are not involved in the mainstream decision making on free or subsidised treatment. Reportedly, a newspaper recently wrote that the hospital was paying 47 "volunteers" on a monthly basis; this news has disturbed Sangh volunteers. They feel that the hospital management does not value their decades of devotion and self-less work.

Of the 460 beds in Bir Hospital, 331 are free beds and patients admitted to these beds get not only free meals twice a day (with meat), but all examinations and operations free. They also receive some inexpensive common medicines available at the hospital free.

Hospital staff and their dependents (1,168 staff in total), people wounded during the People's Movement, people affected by the conflict and people wounded during the People's War, disabled people, senior citizens above 75 and children below 15 get completely free treatment. For this, they have to produce

various evidence (letters from concerned agencies or citizenship certificates). Helpless people, beggars, homeless and poor people also receive free treatment based on an assessment of their socio-economic conditions by the doctors on duty.

The hospital has a three-tier decision-making process for providing free or subsidised services to the poor and helpless. The doctors on duty at the OPD or Emergency Department or on a Ward recommend a subsidy (indicating also the percentage to be provided free). The head of the concerned department then agrees and signs the request, which is finally approved by the Director. Subsidy rates still practiced are 25, 50, 75 and 100. In the case of the other target groups, two under-secretaries have been delegated the authority to directly approve free treatment (a one-tier system). Staff dependents need to have ID cards with photos; dependents include father-mother, husband-wife, son-daughter and grandfather-grandmother. The staff and dependent cases should be computerised to eliminate the need to go to the under-secretary for approval.

Although the transactions have been computerised, the programme does not capture the number of patients receiving free services, but only gives the amount of money spent per month. Roughly, NPR 20 lakh is spent on free treatment per month. The annual expense is around six crore (including the costs of indoor tests and examinations).

The government grant last year was 36 crore unconditional and 10 crore conditional, including the expenses of the hospital, academy and Nursing College. Roughly 360,000 OPD cases (daily 1000-1200) and 69,000 emergency cases (daily 150-200) were seen.

ANNEX-2: SUMMARY NOTES ON HOSPITAL ACTS AND MOHP DIRECTIVES

KOSHI ZONAL HOSPITAL DEVELOPMENT COMMITTEE (FORMATION) ORDER

(2043 BS, amended in BS 2051)

Committee Members

- A retired senior doctor nominated by the government – chairperson***
- President, DDC Morang – member
- CDO, DAO, Morang – member
- Mayor, Biratnagar Sub-metropolis – member
- Two renowned social workers nominated by the government – members
- Two specialist doctors nominated by the government on recommendation of the committee– members
- Medical officer nominated by the government on recommendation of the committee– member
- One paramedic or nurse (on a yearly rotation basis) nominated by the government on recommendation of the committee – member
- Medical Superintendent of Koshi Zonal Hospital- member (secretary)

***This provision was possibly proposed in the draft version of the Act but the version published in the Government Gazette, the legally binding version, mentions that the chairperson will be nominated by the government from among reputed social workers. That is why the last chairperson whose tenure just expired was from outside the medical community.

The Committee's provisions related to personnel management in the hospital

- Create medical or administrative positions as necessary and fill them with (i) personnel deputed from the MoHP and/or the Teaching Hospital, or (ii) contracted personnel paid by the committee from its own sources of funds.
- The government's Human Resource (HR) policies and practices concerning pay and benefits, transfer, promotion and disciplinary actions will apply to all the government staff working in the hospital. The committee can, however, pay special allowances to its staff for special services. Transfer or deputation of the government staff can be done after the committee is informed. The committee can, with adequate justification, also recommend transfer and disciplinary actions for the staff. The committee can sanction all staff leaves, as provided by the government, except unpaid leave and study leave.

Other provisions

- The committee should meet at least three times a year.
- The committee can delegate all or some of its authority to the secretary general, a sub-committee of members, or to an officer if necessary.
- The committee can formulate rules for its operation with the approval of the government.

BHERI ZONAL HOSPITAL DEVELOPMENT COMMITTEE (FORMATION) ORDER

(BS2041amended in BS2051)

Committee Members

- A retired senior doctor nominated by the government – chairperson***
- President, DDC Morang – member
- CDO, DAO, Morang – member
- Mayor, Nepalgunj municipality – member
- Two renowned social workers nominated by the government – members
- Two specialist doctors nominated by the government on recommendation of the committee – members
- Medical officer nominated by the government on recommendation of the committee – member
- One paramedic or nurse (on a yearly rotation basis) nominated by the government on recommendation of the committee – member
- Medical Superintendent of Koshi Zonal Hospital – member (secretary)

*** This provision was possibly proposed in the draft version of the Act but the version published in the Government Gazette, the legally binding version, mentions that the chairperson will be nominated by the government from among reputed social workers. That is why the present chairperson is from outside the medical community.

The Committee's provisions related to personnel management in the hospital

- Create medical or administrative positions as necessary and fill them with (i) personnel deputed from the MoHP and/or the Teaching Hospital, or (ii) contracted personnel paid by the committee from its own sources of funds.
- The government's HR policies and practices concerning pay and perks, transfer and promotion, and

disciplinary actions will apply to all the government staff working in the hospital. The committee can, however, pay special allowances to its staff for special services. Transfer or deputation of the government staff can be done after informing the committee. The committee can also, with adequate justification, recommend transfer and disciplinary actions for the staff. The committee can sanction all leaves as provided by the government, except unpaid leave and study leave.

Other provisions

- The committee should meet at least three times a year.
- The committee can delegate all or some of its authorityto the secretary general, a sub-committee of members, or to an officer if necessary.
- The committee can formulate rules for its operation with the approval of the government.

BHARATPUR HOSPITAL DEVELOPMENT COMMITTEE (FORMATION) ORDER (BS2059)

Committee Members

- A person nominated by the government – chairperson
- Municipality President or VDC Chairperson of the area where the hospital is located – member
- Representative of the DDC – member
- Representative (officer level) of DAO – member
- President of FNCCI – member
- Chairperson of District Red Cross Society – member
- A woman representative of the ward where the hospital is located – member
- A woman involved in health services nominated by the committee – member
- Medical Superintendent of Koshi Zonal Hospital – member (secretary)

The Committee's provisions related to personnel management in the hospital

The committee hires all necessary staff and determines the terms and conditions of their employment.

Other provisions

- The committee should meet at least three times a year.
- The committee can delegate all or some of its authorityto the secretary general, or to a member if necessary.
- The committee can formulate rules that will be operational with the approval of the government.

KEY FEATURES OF THE MOHP CIRCULAR CONCERNING FREE HEALTH SERVICES TO SELECTED TARGET GROUPS

Provision of free health services began following the MoHP circular dated 059/08/25 BS. The circular directs hospitals to set aside five percent of their total income from government grants and hospital services for free health services. The following target groups were identified for the free health services:

- Disabled persons
- Vulnerable persons
- Ultra-poor persons

- Persons without home and income
- Abandoned women
- Street children

This government order also specified the following working procedures:

- Every hospital needs to keep a separate account of expenses from the free treatment fund and report monthly to the DoHS and MoHP.
- The prescribed form must be completed for providing free treatment. Free treatment must be recommended and approved within the prescribed basis for the free treatment. (Regular supervision and monitoring will be carried out by the MoHP, DoHS and RHD to ensure proper utilisation of the free treatment fund).
- The impact of free treatment will be reviewed annually to identify ways of improvement.

The directive also outlines the responsibilities of the local bodies: VDCs, municipalities and DDCs for providing grants to the fund and assisting the target group access the fund. Similarly, the hospital's responsibilities have been outlined as the following:

- Ensure auditing of the fund by the Office of the Treasury.
- The Superintendent or the Director should follow up on the persons treated for free.
- Provide up to NPR 5,000 per person for treatment from the fund; if more is required, obtain it from other sources.
- Patients who cannot be treated in the hospital should be referred to another appropriate hospital.
- The free treatment service should be prompt, efficient and of quality.
- The expenses should be within the budget set aside for free treatment by the hospital.
- Service items that were exempted should be clearly shown in separate columns, and separate bills kept for identification.
- Maintain a board at a place easily visible to the patients indicating the contact place (room), name of the responsible person, and the process for accessing the free treatment.

"A person who can pay may not take advantage of free service, and those who do snatch the pie of the ultra poor, disabled and homeless. Therefore, let us be civilised citizens and make a habit of paying fees. Let us help the helpless." (This slogan is part of the MoHP circular that is outlined here. It is untitled and appears in the same position as is shown here.)

The following are eligible free treatment:

- Downtrodden, abandoned women and children;
- Street children and helpless orphans;
- Disabled persons;
- Persons without home and income; and
- The ultra poor and people with extremely low incomes.

The circular also prescribes a form to be completed when free treatment is provided. The form requires assessing and indicating the patient's socio-economic status. A monthly reporting form is prescribed as well, requiring information regarding the total number of patients served and referred, the expenses incurred and the type of treatment provided.

ANNEX-3: TERMS OF REFERENCE FOR THE STUDY

1 BACKGROUND

Health as a fundamental right is assured in the Interim Constitution of Nepal 2063 BS (2006), which states that "every citizen will have the right to free basic healthcare services as provisioned by the State." As a result, the Ministry of Health and Population (MoHP) has recently launched several initiatives, the largest of which is its free essential health care services to all citizens at Primary Health Care Centre (PHCC) level and below.

At district hospitals, certain target groups including the ultra-poor, vulnerable, poor, senior citizens, people living with physical and psychological disabilities, women and children affected by conflict, and Female Community Health Volunteers (FCHVs) are treated either free of charge, or at partially subsidised rates depending on their particular needs and circumstances.

In addition, and with a view to promoting access by underserved groups to services at secondary and tertiary level facilities, MoHP proposes to pilot Social Service Units (SSUs) in five zonal or regional hospitals following its Social Service Unit Implementation Guidelines, which were developed in 2010.

In this particular regard, it should be noted that NHSSP consultations with hospital management teams have found that many facilities have been subsidising treatment costs for poor and vulnerable groups for many years. These include Bir Hospital, Maternity Hospital, Koshi Zonal Hospital, Patan Hospital and Bheri Zonal hospital. However, it appears that government has received little information on these schemes and that they may not have been considered during development of the SSU Guidelines. For this reason, it appears important, prior to establishing the SSUs, to carry out a rapid assessment of current subsidy practices at three broadly representative hospitals.

Findings from this rapid assessment will then be used to inform further discussions on SSU planning at the five pilot hospitals proposed and, subsequently, to support effective implementation of the SSU Guidelines.

2 PURPOSE OF THE ASSIGNMENT

The overall purpose of the rapid assessment is to:

Conduct close observation and documentation of existing subsidy practices, processes and provisions for poor and marginalised target groups in the Koshi and Bheri Zonal hospitals and at Bharatpur hospital. This will include tracking existing coordination and facilitation practices.

The specific objectives are to:

- Carry out close observation and documentation of current practices and processes for:
  (1) identifying target groups eligible for subsidies,

  (2) assessing whether and how much subsidy to provide to each patient, and

  (3) approving subsidies and the manner of providing them.

- Efforts should be made to capture the views and reactions of patients (e.g. men, women, the chronically ill, the disabled, children and the malnourished etc.) and their attendants. The behaviour and views of service providers administering the subsidy schemes should also be sought, including their assessment of the challenges to be faced in serving eligible patients and managing the demands of non-eligible patients.
- Identify gaps in service delivery at the health facilities and challenges related to implementing

government's Free Health Service Guidelines (2011) and Social Service Unit Implementation Guidelines (2010).

- Share and validate the findings, and related documentation, from the assessment with concerned members of the hospital management team.
- Present the assessment report at a national workshop and, following feedback, finalise the report to include recommendations on SSU operational mechanisms and procedures.

3 TASK/ OUTPUTS AND METHODOLOGY

The consultant will work in close coordination with the health staff and management officials at Koshi, Bheri and Bharatpur Hospitals, and NHSSP's GESI specialists in the Eastern, Central and Mid-Western Regional Health Directorates. NHSSP's GESI/EAP Advisor at MoHP/DoHS will oversee the study, which will be carried out in the following stages:

- Desk review of relevant GoN and MoHP policy and guideline documents including the Free Health Service Guidelines (2011) and Social Service Unit Implementation Guidelines (2010) related to supply of free health services for targeted groups;
- Development of facility observation and documentation plans including checklists, to be shared with the NHSSP team;
- Consultation meeting with Population Division and PPICD officials of MoHP;
- Consultations with key stakeholders including service providers, NGOs involved in facilitating the social service processes, users and their visitors/attendants;
- Observation, assessment and documentation of existing service delivery practices and processes related to the provision of subsidies to target groups;
- The assessment should start from the patient's entry into the hospital and track registration procedures, access to information, identification of target patients, facilitation and coordination among health staff and management officials in determining the level of subsidy, the manner in which the subsidy is provided, and end with the exit of the patient after treatment has been received;
- Identification of gaps in service delivery in the light of the Free Health Service Guidelines (2011) and Social Service Unit Implementation Guidelines (2010);
- Documentation and sharing of the findings for validation with each hospital and finalisation of the report;
- Presentation of the assessment report at a national workshop and, following feedback, finalisation of the report to include recommendations on SSU operational mechanisms, procedures and reporting guidelines.

4 KEY INFORMANTS

Key informants will include:

- Doctors, nurses and administrative staff of each hospital;
- Members of each hospital management committee;
- Representatives of NGOs/civil society organisations who have been, or are currently, coordinating and facilitating the provision of subsidised services to target groups in hospitals;
- Patients and their visitors/attendants.

5 TIMEFRAME

The senior consultant will be contracted for a total of 24 working days between 12 February and 30 March 2012. These days break down as follows:

- Preparation (review of the Guidelines, prepare checklist and meet with MoHP and NHSSP): 2 days
- Field work in three hospitals: 15 days
- Preparation of draft report: 4 days
- Presentation of study findings with proposed framework in a national workshop: 2 days
- Finalisation of report (incorporating feedback from workshop): 1 day

Total: 24 days

6 DELIVERABLES

A consolidated report (with individual reports on the three hospitals as annexes) on the rapid assessment of how health services are being provided to target groups with the full, partial, or non-provision of subsidies.

7 COMPETENCIES AND SKILLS REQUIRED

The consultant should hold a master's degree in Management or Sociology/Anthropology and have provenexperience of conducting organisational studies in the health, or other, sectors.