Federalism and the Health System in Nepal

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Introduction

Nepal is at a crucial stage of its history. The Constituent Assembly (CA) was elected in 2008 to write the Constitution which will detail the future federal structure of the country. In the past two years the members of the CA elaborated eleven thematic concept papers which will form the backbone of the future Constitution. The three draft reports of the Committee on Fundamental Rights and Directive Principles , the State Restructuring Committee and the Committee on Natural Resources, Economic Rights and Revenue Sharing have special relevance to the health sector. The Ministry of Health and Population (MoHP) has been at the forefront of bringing together health sector specialists to comment and improve these draft reports with the aim to bring its technical experience to the political process of drafting the new Constitution. This feedback has been shared with the relevant CA members.

This publication summarises preparatory work undertaken by the GTZ commissioned consultant Professor Detlef Schwefel, who compared health care in various federal countries with the objective to draw important conclusions for the health system in a future federal Nepal and focuses specifically on the health provisions of the Fundamental Rights draft committee report. These issues were discussed in various workshops in Nepal.

This publication is a joint venture of MoHP and GTZ and is intended to provide food for thought for decision makers and health professionals alike to ensure that health is adequately reflected in the new Constitution.

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Acronyms

AA	Auswärtiges Amt, Federal Foreign Office of Germany
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
CA	Constituent Assembly
CD	Compact Disc
COFOG	Classification of the functions of the government
DECC	Development Consultancy Center
DFID	Department for International Development, UK
e.g.	exempli gratia (Latin) = for example
Ed.	Editor
Eds.	Editors
et alii	(Latin) and other (authors)
FSP	Federalism Support Programme
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Support Programme
i.e.	it est (Latin) = this is
MoHP	Ministry of Health and Population
NRP	Nepalese Rupee (109 NR - 1 Euro)
PDF	Portable Document Format
PPICD	Policy, Planning and International Cooperation Division (of MoHP)
RTI	Research Triangle Institute, Consulting company contracted by DFID
STE	Short-term expert
UNICEF	United Nations Children Fund
VAT	Value added tax
WB	The World Bank
WHO	World Health Organization

Federalism and Health in Nepal

Background information and policy comments on fundamental rights and functional responsibilities

Detlef Schwefel[1]

In 2008, the Federal Foreign Office of Germany commissioned the German Technical Cooperation (GTZ) to support the federalism process in Nepal through the Federalism Support Programme (FSP). FSP works with its partner the Secretariat of the Constituent Assembly (CA), political stakeholders, civil society, Local Bodies Associations and supports among other activities the reorganization of service delivery in the framework of a federal set-up. The current second phase of the Federalism Support Programme continues to strengthen good governance in Nepal by focusing on transitional aspects to ensure a smooth transition from a unitary government to a federal one. In cooperation with the Health Sector Support Programme (HSSP) of GTZ, FSP previously commissioned a report *Health care organization and financing in eleven federal countries.*[2]

1. Health care organization and financing in eleven countries

A summary of the above mentioned report is given in the Annex. Eight issues are dealt with:

- Explicit mentioning of health in the constitution of federal countries
- Federal history and set-up
- Organization of health care in federal countries
- Responsibilities of the federal level
- Responsibilities of states/provinces and lower levels
- Health financing in federal countries
- Stewardship and governance
- Federalism and welfare

The main messages are:

- The length of a Constitution does not necessarily presume good governance nor does it guarantee a good performance of the health system, i.e. of all institutions contributing to improve the health status of the population. Some well functioning federations have very short constitutions and do not even mention health (care).
- Federal states develop and change over time. Constant changes may occur in the structures and functions of the state

1 The author wishes to express thanks to. Dr. Yasho Vardhan Pradhan – Director General of the Department of Health Services and Dr. Laxmi R. Pathak – Chief of the Policy, Planning and International Cooperation Section of the Ministry of Health and Population. Good and value-driven guidance was given by Friedeger Stierle, Dr. Susanne Grimm and Sudip Pokhrel, from the GTZ Health Sector Support Programme.

2 Schwefel, Detlef: Health care organization and financing in eleven federal countries. A compilation of knowledge to benefit the "Federal Democratic Republic" of Nepal, Berlin (GTZ) 2009 available at http://www.detlef-schwefel.de/253-Schwefel-Nepal-federalism.pdf

apparatuses. Therefore, harmonization mechanisms among the various actors and layers are needed to create and maintain solidarity among economically, ethnically and otherwise divergent units.

- Federal states organize their health systems quite differently and not all federal states have good health systems. Good and poor health systems can be found all over the world. These provide important lessons on failures and successes of health systems.
- Some federal governments entrust the main health care responsibilities to lower government levels. Some have a clear division of labour between provincial, regional and national layers of government and between public and private health care provision.
- In well performing federal countries health care provision and health care financing are organized according to federal legislation but not managed by the federation itself. Provision *and* financing are not managed by one and the same institution. Therefore there is no disintegration and fragmentation of the health system.
- Developed federal countries keep out-of pocket payments (at the point of delivery) for health quite low and mobilize other sources of health care financing, especially through pre-payments for health protection or insurance. Asking poor families to pay in cash whenever they need help leads often to postponement of health care, especially for the children and mothers.
- Good health system performance is an asset of many federal countries - exceptions are India and Nigeria - but even developed countries still need to improve, e.g. USA. Indicators of 'voice and accountability' – i.e. participatory democracy - are relatively high in federal countries. Good governance drives socioeconomic development and good health is a key driver of social and economic development while health financing is a key issue of health systems' management and good governance.
- The welfare of the people should not be caught in competitive battles between provinces or parties. Superimposing a national mandate for uniformity of living conditions and supporting contribution based social protection would give welfare and social health protection sustainability. Best basic health and best basic education should be granted to all Nepali, whatever region or province they happen to live!

2. Federalism and the Health sector in Nepal

Nepal's Constitution is being drafted through different committee reports. The following will look specifically at the Fundamental Rights Committee report which was released early December 2009. The other two reports which comprise health provisions are the State Restructuring Committee report and the Natural Resources, Economic Rights and Revenue Allocation report.

2.1 Fundamental rights

The right to health is one of the fundamental rights spelled out in the draft of the Constituent Assembly's (CA) Committee on Fundamental Rights and Directive Principles.

Fundamental rights in Nepal

1 Right to live with dignity
2 Right to freedom
3 Right to equality
4 Right to mass media
5 Right to justice
6 Right of the victim of crime
7 Right against torture
8 Right against preventive detention
9 Right against untouchability and discrimination
10 Right to property
11 Right to religious freedom
12 Right to information
13 Right to privacy
14 Right against exploitation
15 Right regarding environment
16 Right to education
17 Rights regarding language and culture
18 Right regarding employment
19 Right regarding labour
20 Right to health
21 Right to food
22 Right to shelter /housing
23 Rights of women
24 Rights of children
25 Rights of the Dalit community
26 Right to family
27 Right to social justice
28 Right to social security
29 Rights of the consumer
30 Right against exile
31 Enforcement of fundamental rights, and right to constitution remedy

Constituent Assembly. Committee on Fundamental Rights and Directive Principles: Report on thematic concept paper and preliminary draft. Draft relating to fundamental rights. English translation_TU_ 171109. Kathmandu December 2009

Only a short part, i.e. 1.7% of the committee report is dedicated to the right to health which is spilt into five specific rights.

Right to Health

1 Every citizen shall have the right to free basic health services and nobody shall be deprived from emergency health service.
2 Every person shall have the right to reproductive health.
3 Every person shall have the right to informed health services.
4 Every citizen shall have the right to equal access to health service.
5 Every citizen shall have the right to access to safe drinking water and sanitation.

2.1.1 The right to health

The Committee's report was presented during the Federalism and Health Conference in Kathmandu – 02.12.2009 – by Hon. Gagan Thapa. Each of the rights was further specified by him as follows :

- Emergency care includes: Immediate treatment of accidental injury and victims of criminal acts, treatment of snake bites, treatment of victims of natural calamities.
- Reproductive health includes:

- Right to reproductive health without gender discrimination is ensured to every person.
- Right to highest possible maternal and child health (sexual, physical and mental, safe motherhood, pre-natal, perinatal and neo-natal care, safe abortion and family planning)
- Right to control and treatment of HIV/AIDS, sexually communicable diseases and infertility
- Right against sexual abuse and forced prostitution
- Right to information about sexual health
- Right to comprehensive sexual health education
- Right to secrecy of health

- The right to informed health services includes:
    - This provision ensures the right of an individual to make informed decisions regarding his/her own health.
    - To be informed means:
        - Every person commencing for treatment should be provided all the information by the health institution.
        - Information should be disseminated in the way to assist an informed decision.
        - Every person should be provided with information regarding the alternatives and technologies for treatment.
- The right to equal access to health services ensures equal access to health service to all citizens of any region of Nepal irrespective of gender, group or any social class, physical state or disability without any discrimination.

Such specifications are useful and dangerous at the same time. They clarify the committee members' understanding of the issue. Regarding emergencies – for example – many questions can be asked: why are only snake bites mentioned but not dog bites or the emergency of a child trampled by an elephant. This is the problem of over-specification which – once included in the Constitution which is meant for "eternity" – will be difficult to change. A similar reasoning can be used for "informed health services": why is it not mentioned, that information regarding prevention of health care or educated self-help is much more important than information on a specific treatment, which certainly has its merits, too. Sometimes and according to specific psychological situations it might be wise to fine-tune or reduce "all" information – if "all" information can be provided at all. Such detailing of human rights is a good starting point for political and professional discussions and dialogues. Nevertheless, they should not be included in a Constitution because of misleading over-specification while under-specifying essentials.

An analysis of the length of Constitutions in various federal countries of the world and their mentioning of health showed quite clearly that federal countries with good governance are not those with the longest Constitutions or chapters on health. India has the longest Constitution in the world with 471 pages and Brazil explicitly mentions health in the Constitution with 996 words. Both countries suffer from deficiencies in their health system performance.

2.1.2 Basic health services

Internationally the term "basic health services" is being used quite differently. Many assume that it is the same as primary health care[3]. Others - like a working group of regional health directors in Syria[4] - included even dental and mental care in a basket of "basic" health services, i.e. services that are excluded through many insurance companies of highly developed countries. Many healthcare providers try to include everything in this basket. Many governments try to exclude many things from this basket of "basic" or essential public health services. International organizations contribute to this confusion. The next table shows what the Asian Development Bank for example understands under this term.

3 "Health care that is provided by a health care professional in the first contact of a patient with the health care system" Source: Princeton University at http://wordnetweb.princeton.edu/perl/webwn?s=primary%20health%20care

4 Personal experience of Detlef Schwefel.

A basket of basic health services of the Asian Development Bank

i. Strengthening community health services
   a) constructing or renovating health centers,
   b) providing equipment and essential drugs
   c) maintaining selected health facilities.

ii. Strengthening district health offices
   a) improving their management capacity
   b) strengthening the supervision of health centers, and
   c) strengthening selected referral hospitals.

iii. Introducing health sector reforms by pilot testing the following innovative approaches to health care delivery:
   a) contracting out health services
   b) contracting in management services, and
   c) setting up community loan schemes for health emergencies

iv. Providing support for central office management support by
   a) setting up a project coordination unit
   b) carrying out benefit monitoring and evaluation, and
   c) strengthening equipment maintenance and repair capabilities

Source: Asian Development Bank: Project completion report on the basic health services project (loan 1447-Cam[Sf]) in Cambodia. Manila (ADB) 2004

In Nepal a pragmatic definition of basic health services is currently being used: all health care below the district level is considered to be part and parcel of the free health care policy.

The fundamental rights committee of the Constituent Assembly presents a different basket depicted in the following table.

Basic health services according to the fundamental rights committee

Reproductive health
Immunization
Treatment of leprosy and tuberculosis
Pediatrics health
Maternal and child nutrition
Treatment of prolapses
Primary dental, ENT/Ophthalmic treatment
Primary mental health
HIV/AIDS treatment
Infectious diseases/epidemics
Malaria and Kalazar

Thapa, Gagan: Proposed right to health in the draft of the New Nepali Constitution. PowerPoint presentation. Kathmandu (MoHP, GTZ) 02.12.2009

Several questions and comments arise – just to give examples:

- Primary mental & dental but not physical care, e.g. for diarrhoea?
- Vaginal prolapse or all prolapses, e.g. rectal, too?
- Personal health care seems to be predominant, what about 'public health functions'[3]?
- Pediatric treatment can be extremely expensive and HIV/AIDS treatment is always expensive
- It is not specified if consultations, treatments AND drugs are included in the basic health services
- The list is less comprehensive than the current free health care granted to the population in Nepal
- Reproductive health is a right per se not declared to belong to the "free" basic health services – see 2nd right to health

5 A definition of public health functions is given below.

The current free health care practices and the Constituent Assembly's (CA) definition differ. This is good as it offers the way towards rationally discussing delineation and financial implications of basic services. The current free health care approach has an institutional bias. The public health care supplied below the level of district hospitals is considered to be basic, whatever the problem or the illness is and whatever the demand or need is. The CA offers an eclectic listing of services for certain groups (mothers and children) and diseases and services, e.g. immunization. The Assembly's approach is risky. It is very easy to argue that important issues are missing and that issues mentioned might be unfeasible to be tackled by existing public health care provision.

From a health economics point of view and from a re-structuring perspective for the health system a different approach would be chosen: basic health services are those

- that the market fails to provide, i.e. special public goods (environmental control, vaccination, health education, etc., i.e. public health functions) and
- those that a family cannot pay for without the risk of going bankrupt, i.e. catastrophic health expenses and non-expenses[6].

This would support a social market economy approach with economic and social responsibilities of the market, regulated and supervised in the public interest and based on the principle of subsidiarity[7]. Under these circumstances the government has to assume functions that private and public providers are not sufficiently capable or willing to perform. Subsidiarity does not refer to government layers only. This concept also refers to relationships between government and citizens and between government and the market.

- Government responsibilities refer first and foremost to so-called public health functions[8]:
  1 Prevention, surveillance and control of diseases
  2 Monitoring the health situation
  3 Health promotion
  4 Occupational health
  5 Protecting the environment
  6 Public health legislation and regulations
  7 Public health management
  8 Specific public health services (school health, emergency disaster services, and public health laboratory services)
  9 Personal health care for vulnerable and high-risk populations

  These functions are typically performed by a national health authority and its regional and local institutions. In principle they could be contracted to private or public providers. What matters is that the central government takes over the responsibility that these duties are performed well and without discrimination for social groups or territories.

- Catastrophic health expenditure is a fact of life many families in poor countries have to deal with. 24% of Indian families go bankrupt and impoverish after one of their relatives leaves hospital[9]. Close to 16% of Nepali families are exposed to catastrophic expenditures[10] and for 73% of rural families in Nepal medical treatment is just

6 WHO definition: if health spending is higher than 40% of income after subsistence needs have been met. "Non expenses" refer to the fact that health care is not affordable for many poor (73% in one survey in Nepal), i.e. necessary treatments are avoided or postponed.

7 Subsidiarity is a basic principle of good governance. The European Union defines subsidiarity as follows: "The principle of subsidiarity is defined in Article 5 of the Treaty establishing the European Community. It is intended to ensure that decisions are taken as closely as possible to the citizen and that constant checks are made as to whether action at Community level is justified in the light of the possibilities available at national, regional or local level. Specifically, it is the principle whereby the Union does not take action (except in the areas which fall within its exclusive competence) unless it is more effective than action taken at national, regional or local level. It is closely bound up with the principles of proportionality and necessity, which require that any action by the Union should not go beyond what is necessary to achieve the objectives of the Treaty." Source: European Union according to http://europa.eu/scadplus/glossary/subsidiarity_en.htm

8 World Bank, World Health Organization, United States Agency for International Development: Guide to producing national health accounts. Canada (WHO) 2003

not affordable[11]. All this data shows that the market and private healthcare providers fail to provide affordable health care for many in need. This is a market failure government needs to correct. This failure does not affect the sick and the ill, only. It affects entire families and family networks and has severe impacts on entrepreneurial behaviour. It affects members of all population groups, e.g. the poor AND the wealthier as the World Health Survey in Nepal shows quite clearly.

Central government should then be responsible to grant these two specific rights: the right to effective and efficient public health services and the right to be protected against impoverishment due to catastrophic health expenditure. These two special rights deserve special mentioning in a new Constitution.

2.1.3 "Free" basic health services

In principle and in the Nepali context "basic health services" cannot be defined rationally before it is clear what the term "free" basic health services means. Reviewing all fundamental rights in the draft of the Constituent Assembly Committee it is just basic health services and primary plus secondary education which are considered to be "free" or "free of cost"; free higher education is to be given to citizens from deprived groups, additionally. Regarding all other human rights, the word "free" is not mentioned, as for example "every citizen shall have the right to food".

In the current practice of "free health care" in Nepal the patient or client does not pay at the point of delivery of health services. This also includes free access to essential drugs. Free health care at the point of delivery of health services is a universal aim of good governance in health care. Just minor co-payments should prevent moral hazard, i.e. the overstretching of demand and supply in view of "free" services. All the rest should be pre-paid, either by general taxes or by pay roll-taxes and social health insurance contribu tions. This would bring affordable health care for all in need. Pre-payment means that everybody should pay regularly a small contribution for the health system – for example through a mandatory social health insurance – according to affordability and that the poorest and the most vulnerable people should be exempted for paying for health care.

Free health care does not mean that nobody pays for it. Currently half of the expenditure for health care in Nepal originates from private households, one quarter to a third from government and the rest is shared by international donors and to a smaller extent by the private sector in Nepal. Most government revenues originate from taxes, i.e. nearly all what is being provided as "free" health care is being pre-paid by taxes from Nepali citizens and entrepreneurs. This is by far not sufficient to grant good and comprehensive health care for all or even just for those most in need. It would not be sufficient to make public health care provision more efficient and rational – even if this is urgently needed. Somebody has to pay additionally for granting "free" health care, e.g. by raising collectable taxes, realigning the national budget of the government or getting more international funds. A gradual shift from out-of-pocket payments for health towards regular pre-payments of all citizens for health is a mandate when mentioning "free basic health services" in a Constitution. Social health protection policies are a corner

9 Peters DH, Yazbeck AS, Sharma RP, Ramana GNV, Pritchett LH, Wagstaff A. Better health systems for India's poor: findings, analysis, and options. Washington (DC): World Bank; 2002.

10 World Health Organization: World health survey. Report of Nepal. Geneva (WHO) 2003

11 Subba, Nawa Raj: Health seeking behaviour of Rajbanshi community in Baijanathpur and Katahari of Morang Nepal. Kathmandu (Nawa Raj Subba) 2001

stone of Nepal's road towards a new federal Constitution and towards good governance.

2.1.4 Responsibilities

It is not spelled out in the fundamental rights committee report who will be responsible for granting the rights. We assume that implicitly it is the government which is assumed to provide the "free" services without specification which layer of the government it may be, communities, provinces, regions or the central level. Theoreti cally this could be shared by other partners, too, which do not belong to the public sector. In some countries it is through legal regulation or a professional mandate that also the private sector allocates or has to allocate a certain share of resources for the benefit of the poor, e.g. a certain number of beds in a hospital. In other countries special 'charitable' taxes or practices of alms giving – e.g. Zakat as one of the five pillars of Islam – contribute to a fair division of labour between the private, charitable and public sectors for health care, especially for the poor and the vulnerable.

The discussion in Nepal should not assign government responsibilities to the implementation of the fundamental right to "free" basic health services too prematurely. It should explore, first,

- what kind of traditional solidarity mechanisms exist and could be activated in the different cultures and religions,
- what could be contributed by the private sector and
- how non-governmental not-for-profit organizations could be strengthened and empowered to support the financing of a health system that acts to the benefit of all.

It should not be overlooked, for example, that private firms and companies currently allocate considerable resources for the social health protection of workers and employees and often also to their families in the formal employment sector and that non-governmental organiza tions support some outstanding initiatives towards community drug and health insurance for the benefit of families in the informal sector. Such approaches are fragmented and need strengthening, empowering and harmonizing. Finally it has to be stressed in all discussions that each citizen has a certain responsibility for prevention and educated self-help before demanding health services and that even the poorest should contribute through token payments – e.g. 10 Rupees – so that they feel the pride and ownership of the system and have the right to demand quality. This principle is called the avoidance of a dole-out mentality.

2.1.5 A right to equity and uniformity

A right to health is rather futile if social, economic, ecological and other factors influence health in a persistently negative way. Unnecessary and avoidable risks for the health status of special groups have to be minimized. This refers to the principle of solidarity or equity. [12] *"Angleichung der Lebensverhältnisse"* or uniformity of living conditions is one of the basic federal responsibilities of the highest level of governance in Germany, for example. Such a principle and corresponding equalisation mechanisms also need to be mentioned in the new Constitution of Nepal to ensure a harmonization of living standards for the whole population. With equalisation mechanisms the richer groups or territories (should) support the poorer ones without endangering their own willingness to perform better. This is a complicated and complex but very essential issue in building up a good federation.

2.2 Functional responsibilities

All restructuring has to take into account the socio-economic and cultural system of a country and not just the government tiers. With some selected functions the matrix refers to at least four restructuring perspectives:

- Government tiers – reasonable application of the principle of subsidiarity
- Economic system – free, planned or transition towards a social market economy
- Peoples' responsibilities – balance of rights and responsibilities
- Federalism versus decentralization

The main restructuring question is: which partner or stakeholder in the social system is best capable to perform which duties and how can the public interest be best defended and by whom?

Tasks / Agents	Federal	Market	Province	Local Government	Community	Family
Foreign policy		...	...	...	...	...
Police services						
Law courts						
Food provision						
et cetera						
Public health						
Primary health						
Secondary health care						
Tertiary health care						
Prevention	...	...	...	...	...	
et cetera						

2.2.1 The state and the citizen

In the table above two cells are marked in grey. In most countries of the world foreign policy is an intrinsic duty of central government. Prevention of diseases, on the other hand, is mainly a responsibility of the family. The family is the most important agent or production factor for health. "Health in the hands of the people" was a battle-cry of one of the most charismatic health leaders in the Philippines. This presumes a good health literacy which has to be built up especially among women and girls. This in turn rests on primary education which includes health issues. Awareness creation and knowledge dissemination on prevention and educated self-help is a basic public health function. It is one of the most essential functions since about 70% of diseases can be prevented and 70% of illness episodes can be handled appropriately by educated self-help with just a few drugs and (quality tested) traditional recipes. This usually neglected issue could contribute considerably to a more effective and efficient health system. The health system is not under-financed but under-

12 "The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society." Whitehead, Margaret: The concepts and principles of equity and health. Copenhagen (WHO) 1990

educated. Empowerment of its people is a main responsibility of a federal country.

2.2.2 The state and the government tiers

The typical response to restructuring state functions is to assign functional responsibilities to the different tiers of government. The mentioned table contains some examples. Such listings and other more detailed ones[13] can be a starting point to try to assign responsibilities to various levels of government according to the principle of subsidiarity. *"The principle of subsidiarity is … intended to ensure that actions to respond to a given problem are taken at the most appropriate level of government."*[14] Different needs, capacities and (potential) performances of the government layers need to be taken into account considerably.

This poses a particular challenge to assign state functions to the most appropriate level according to understandable and commonly accepted guidelines.

Functional assignment also has financial implications. Money follows functions means that when allocating functions to an agent, i.e. a government tier, it has to be clear how this tier will fund its responsibilities. Equally important is that the allocation of functions to a government tier conditions staffing requirements and the organizational structure of a government tier (form follows functions).

Responsibilities, financing and organization need to match. In many (federal) countries money does not follow functions completely. In this situation political bargaining is needed. The table on the right gives the example of Germany. Taxes are collected at various levels and for various purposes. Some taxes can be used exclusively at certain levels of governance. Other taxes are "shared taxes", i.e. their distribution is proportional according to a formula prescribed in the Constitution. Apart from this, there is horizontal compensation between richer and poorer states and there is a vertical equalisation from the federal government level to lower levels in need. This is based on the principle of solidarity which enjoys a dominant position in the Constitution of Germany as a social AND democratic unity. Solidarity has to be one of the fundamental principles of a federal set-up in Nepal, too.

Taxation in Germany

95% of all taxes are imposed by the federal level. The income of these taxes is allocated to the Federation and the states as follows:

- The Federation can exclusively use the revenue of:
  - customs
  - taxes on alcopops, distilled beverages, coffee, mineral oil products, sparkling wine, electricity, tobacco and insurances
  - Supplement on income taxes, so-called solidarity surcharge (*Solidaritätszuschlag*)
- The states can exclusively use the revenue of:
  - inheritance tax, real property transfer tax
  - taxes on cars, beer -fire protection tax, gambling tax
- The municipalities/districts can use exclusively the revenue of:
  - real property tax
  - trade tax (Gewerbesteuer)
  - taxes on beverages, dogs, inns and other things

Most of the revenue is earned by income tax and VAT. These taxes are used by the Federation and the states by quota. The municipalities get a part of the income of the States.

Source: http://en.wikipedia.org/wiki/Taxation_in_Germany

13 The United Nations propose a 'Classification Of the Functions Of Government' (COFOG). See: http://esa.un.org/unsd/sna1993/introduction.asp, http://unstats.un.org/unsd/cr/registry/ regcst.asp?Cl=4&Lg=1

14 Definition of subsidiarity according to MetaGlossary http://www.metaglossary.com/meanings/507018/ and originally info.wlu.ca/~wwwsbe/faculty/rwigle/ec639/ref/terms.htm

The feasibility of collecting and channeling taxes in Nepal is a crucial issue and deserves systematic study. Ear-marked taxes and specific levies to benefit health or to alleviate poverty have to come under additional scrutiny. Study results could heavily influence decision making on the new structure of government in Nepal.

Whatever structure will be proposed, it will have to stand the test of implementation. In this context we can cite the truisms of health management and health economics, namely that regulation, financing and provision of health care should be separated and that politicians, customers and (private and public) providers play different roles which should not be intermingled.

2.2.3 The state and the market

In a globalised world individual states seem to be weak against national and especially international market forces. This is especially the case for a country wedged between two super-powers, China and India. For the time being market forces can overpower even rather strong groups of countries as for example the European Union. Yet even in a globalised world good governance means that individual governments assume stewardship. A new Constitution has to specify quite carefully the regulatory powers and potentialities of central and regional governments vis-à-vis the market, i.e. for example regulation and supervision of local private service providers, national private companies, transnationals and foreign actors.

2.2.4 Towards a federal state

Federalism and decentralization differ[15]:

- "Federalism entails a level of political autonomy, even sovereignty, for constituent communities that rest uneasily, even threateningly, with traditional or elite conceptions of national unity. Federalism involves a polycentric non-centralized arrangement in which neither the constituent governments nor the general government can unilaterally alter the constitutional distribution of power."

- "Decentralization involves a central power possessing authority to decentralize or devolve functional and administrative responsibilities to lower levels of government. The authority to decentralize, however, also includes the authority to recentralize power. Decentralization is concerned with administrative efficiency and functional efficacy in an otherwise unitary system."

The empowerment of all co-equal partners to build up a federal state of Nepal needs knowledge, cooperation and patience. Federalism and a new Constitution cannot be finalized in a rush. A lot of dialogue is still needed. It makes no sense to consider the drafts of the Constituent Assembly as untouchable "points of no return". The debate has to go on.

15 Kincaid, John: Introduction to the handbook of federal countries. In: http://www.forumfed.org/en/federalism/introductiontohandbook.php, Internet 2008

3. Conclusion

Restructuring Nepal into a federal polity is a challenging and potentially rewarding task. It starts with a well written Constitution which has to spell out the basics and the most essential issues without going into too much detail. The Constitution has to ensure first and foremost that safeguarding of public interests, such as basic health service delivery, basic education and the compliance with human rights is a major task of the central government. Reassigning responsibilities between societal partners – different government tiers, the private sector and the citizens – is a second step, especially if sustainable and equitable basic needs satisfaction for all cannot be satisfied in the current constellation of functional assignments. Key topics to assess and measure the success of restructuring are: social protection and social health protection.

Health care in federal countries

Background, organization, financing and stewardship

Detlef Schwefel[16]

About 40% of the world's population live in 25 federal countries: Argentina, Australia, Austria, Belgium, Bosnia and Herzegovina, Brazil, Canada, Comoros, Ethiopia, Germany, India, Malaysia, Mexico, Micronesia, Nigeria, Pakistan, Russia, St. Kitts and Nevis, South Africa, Spain, Switzerland, United Arab Emirates, United States of America, and Venezuela. Some sources add Palau and Congo (Democratic Republic) to the list of federal countries. Nepal, Iraq, Sudan, and Sri Lanka are considering or preparing a federal set-up.

Federalism is a form of government: "... emphasizing both vertical power-sharing across different levels of governance and, at the same time, the integration of different territorial and socio-economic units, cultural and ethnic groups in one single polity." [McLean 2008] A certain degree of autonomy of two or more levels of government is an essential aspect of federalism. A "binding partnership among coequals", "an enduring, even perpetual, relationship" is considered to be a characteristic of federations. [Kincaid 2008] The democratic accountability of political decision-making and implementation is an important principle of federalism.

Some countries are federal but do not like this label, like Spain. Some are quite centralized, like Malaysia. In some countries

Federal countries of the world

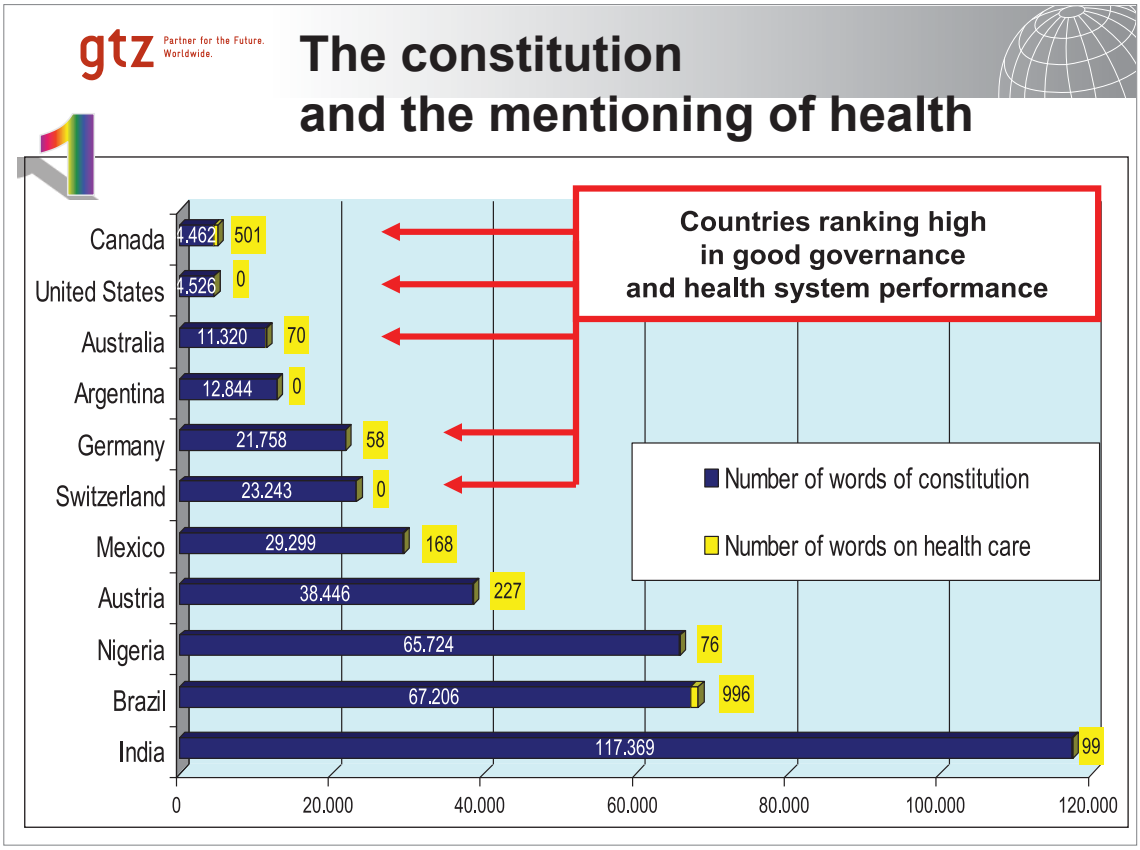
[Wikipedia: Federal countries marked in green]

16 I appreciate the partnership and advice of Friedeger Stierle and Sudip Pokhrel, German Technical Cooperation, Nepal. This article is a synthesis of my knowledge on health care organization and financing in eleven federal countries – see [Schwefel 2009] – www.detlef-schwefel.de / detlef.schwefel@berlin.de

the federal level can override the lower level of government. Some non-federal countries are more decentralised than federal countries; they can have rather strong regional governments like Colombia, Italy and Japan. In the United Kingdom a region – Scotland – achieved considerable power on education, health and local affairs, more than Wales and Northern Ireland. [Anderson 2008] In some countries – like the USA – power shifted somehow from the states to the national government with the approval of the Supreme Court. In Belgium there are only two constituent units of the federation, the Dutch and the French speaking population. There is a de-facto federation in China. The same applies to the European Union.

"Federalism entails a level of political autonomy, even sovereignty, for constituent communities that rests uneasily, even threateningly, with traditional or elite conceptions of national unity. Federalism involves a polycentric non-centralized arrangement in which neither the constituent governments nor the general government can unilaterally alter the constitutional distribution of power." [Kincaid 2008]

"Decentralization involves a central power possessing authority to decentralize or devolve functional and administrative responsibilities to lower levels of government. The authority to decentralize, however, also includes the authority to recentralize power. Decentralization is concerned with administrative efficiency and functional efficacy in an otherwise unitary system." [Kincaid 2008]



[Own calculations; good governance see Kaufmann 2008]

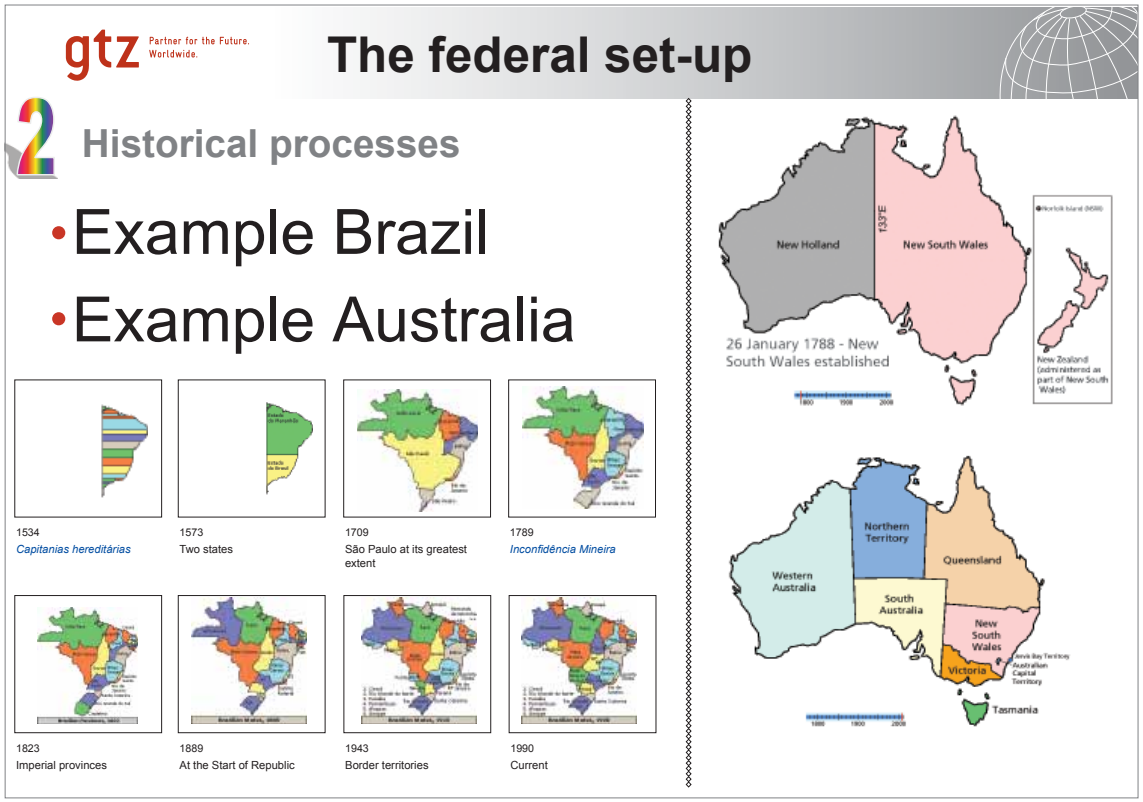
1. Explicit mentioning of health in the constitution of federal countries

Constitutions of federal countries vary considerably. Some are very short like those of Canada and the United States of America. With close to 500 pages the Constitution of India is the longest in the world. Some Constitutions give many details on health care – like the Constitution of Brazil – other Constitutions do not even mention the word health or similar terms like for example hospitals or medical care.

A short Constitution or no mention of health in it does not mean that a country has bad governance, as measured by an index proposed and used by the World Bank. Changing a Constitution is a very difficult task. Therefore, it might be wise not to go into too many details of health care organization and financing but rather include general issues in regulations and bylaws. The basic values, nevertheless, deserve to be underscored: human dignity and rights, non-discrimination of social groups, communities and territories – for example.

2. Federal history and set-up

Most federal countries developed over long periods of time. The Portuguese King partitioned Brazil's territory to give the land to noblemen or merchants. For 475 years Brazil developed step by step into the current shape of 26 states and one federal district. States collect their own taxes and receive shares of federal taxes but have much less autonomy than the states of the United States of America for example. Similarly Australia shares a comparable history, namely that adding, splitting and joining of states or territories was frequent.

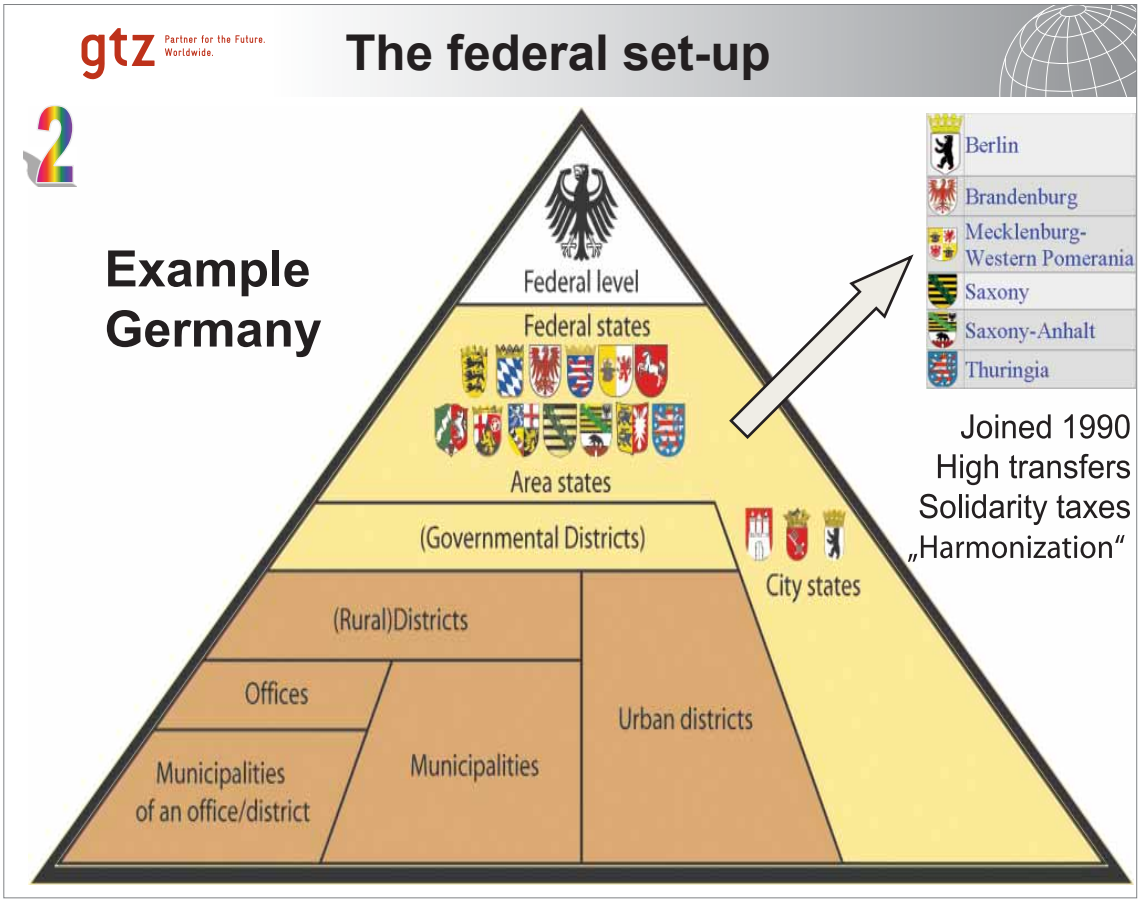


[http://en.wikipedia.org/wiki/States_of_Brazil] [http://en.wikipedia.org/wiki/States_of_australia]

In federal countries with different cultures, ethnic groups and languages territorial and power mapping usually crosses constituent units, like in Switzerland. Internal migrations and economically attractive development centres contribute to this. In Belgium the federation is split essentially into two language groups; additionally a very small German speaking community is given a certain degree of autonomy. Such groupings within federal countries change over time and can give rise to conflicts and even contribute to secessions of federal republics. One of those cases is Yugoslavia where the former Kingdom was in 1945 converted into a Socialist Republic which disintegrated since 1991 and fell apart into seven new countries with continuing separatist movements, mostly along religious and linguistic lines.

History strongly influences the set-up of many federal countries – some shrink, some collapse, some grow. Following the economic collapse of the German Democratic Republic and the peaceful people's revolution six new states joined the Federal Republic of Germany in 1990. All new states were much poorer than the federal states of former West Germany. High financial transfers based on debts and solidarity taxes levied on West German tax payers contributed to a long-term and gradual harmonization of the living conditions which now – even after 20 years has not yet been fully achieved. Such measures towards harmonization create quite some conflicts all over the world. Federal states develop and change over time, they are not enduring per se. Harmonization mechanisms are needed to create and maintain solidarity among economically, ethnically and otherwise different units.

[Wikipedia and http://www.srpska-mreza.com/MAPS/Ethnic-groups/map-State-Dept.html]



[Wikipedia and http://www.srpska-mreza.com/MAPS/Ethnic-groups/map-State-Dept.html]

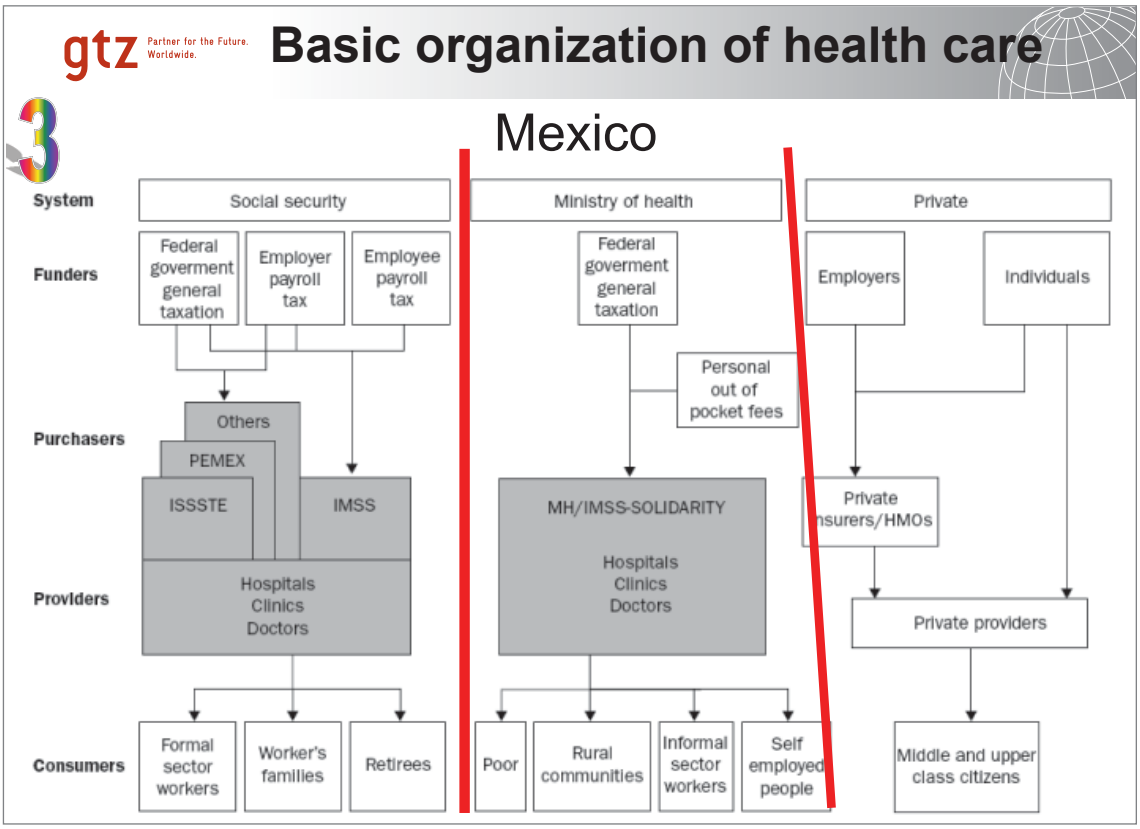
3. Organization of health care in federal countries

The organization of health care is quite different in federal countries. Federalism does not prevent the existence and persistence of outdated models of health care provision. Mexico is an example of a highly fragmented health system:

- The private sector caters for the wealthy population which pays with out-of-pocket money or through private health insurance. This allows to purchase good quality health care.
- Mandatory health insurance has for a long time existed for the employees in the formal public and private sectors and they offer health care at an intermediate quality level.
- The Ministry of Health is responsible for those not covered by one of the two other systems, i.e. especially the poor and vulnerable at a low quality level.

There are nearly no interactions between these three rather isolated subsystems and current national reform endeavours have brilliant strategies but have been slow in delivering results.

Germany's health care system is not perfect either. The federal government defines the legal framework of health care provision and consults with the federal states which approve or reject reform laws. The federal government does not provide health care – it is just the regulator and has supervisory powers. Federal states let municipalities engage only in those health programmes which are not included under private and social health insurance which covers 100% of the population.



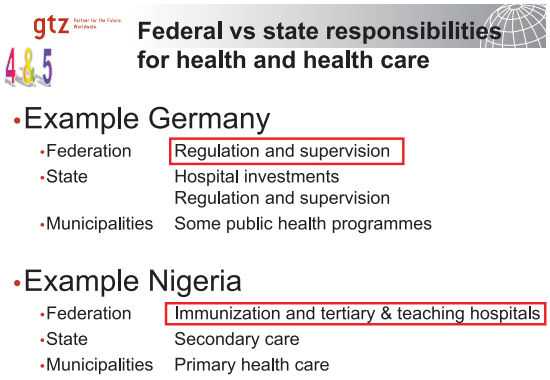
[Frenk, Julio et alii: Evidence-based health policy: three generations of reform in Mexico. In: The Lancet, Vol. 362, November 15, 2003, 1667-71]

Health insurance in Germany is not organized at the levels of the federal tiers, i.e. federation and/or federal states – some work nationally, others regionally, others locally or even at the level of individual companies, i.e. there is no direct link between the organization of the health insurances and the federal set-up of Germany. Equalisation mechanisms are nationally mandated. They diminish economic differences of the clientele of the legal health insurances. About 90% of the population are covered by legal insurances. Insurances are run democratically by employers and employees, i.e. those who finance health insurances. Providers affiliated with legal health insurance have a mandate to guarantee economically reasonable outpatient and inpatient care at a high quality. They are organized and elected democratically. There is a rather strict split between outpatient care and inpatient care. This system is already quite old and is being reformed continuously and incrementally. The basic principle of organizing health care in Germany is the subsidiarity principle: the federation should not do what others can do and the federal states should follow this principle, too.

An analysis of details of organization and financing of health systems in federal countries and its synthesis shows that there are good and poor health systems all over the world, not only in federal settings. We can learn from their failures and successes. Comparative health system analysis is a crucial tool to prepare reforms.

4. Responsibilities of federal level

Germany's health care system shows that it is following the 'modern' advice of health economics: the need to split regulation, financing and provision of health care and assure that individual states are not able to modify national equalisation measures across patients, populations and territories. Regulation and supervision is the task of the federal government. Federal states contribute to this and have to act as backstop for what other agents, e.g. legal health insurances cannot do.

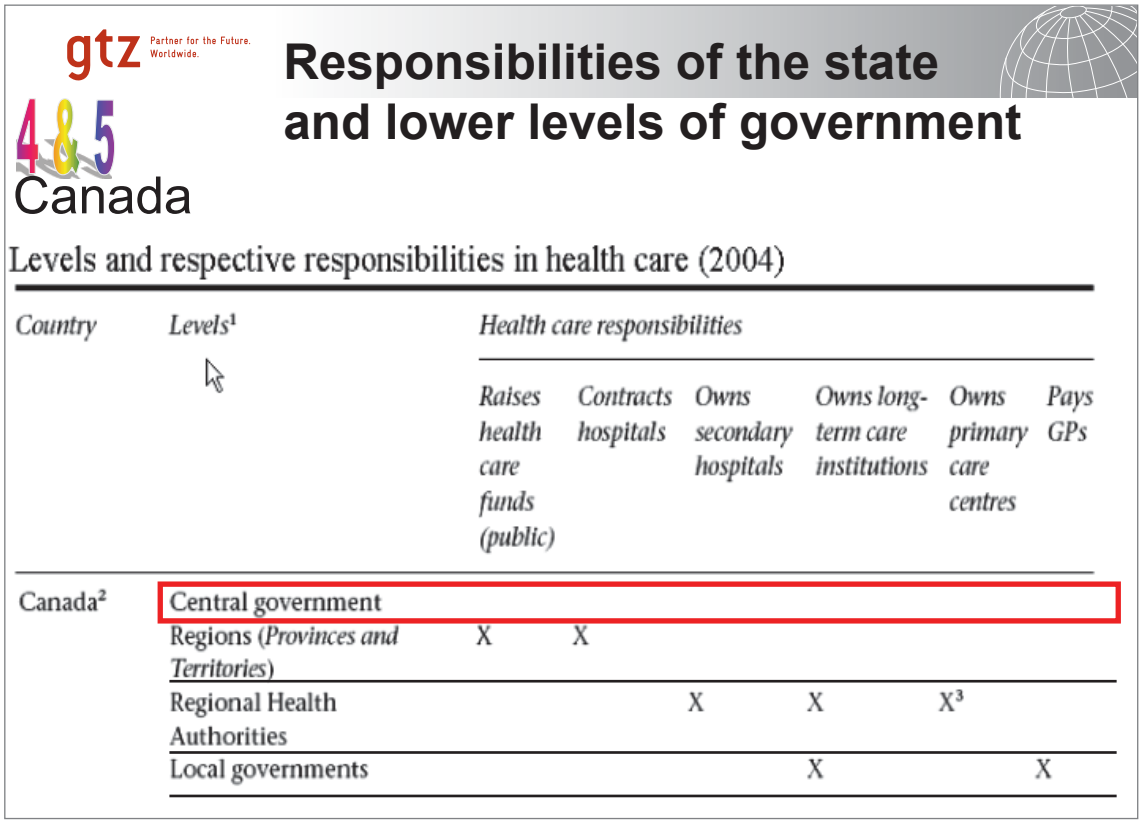


Nowhere in the world can contributions of employers and employees fully finance a health system. Therefore the state has to finance the investment costs whereas the insurances pay the current costs. Federal governments delegate responsibilities and assume these if they cannot be borne by lower levels or entrusted agents. This principle is implemented in many developing countries, like for example Nigeria – even if it is questionable if for instance immunization campaigns, tertiary health care and teaching hospitals cannot be commissioned cost-effectively to other agents.

5. Responsibilities of state and lower levels

Canada gives the example of a country where the central government has nearly no health care responsibilities. In a clearly structured division of labour federal provinces/ territories, regional health authorities and local governments are responsible for certain essential functions and tasks. This assumes of course the capacity of lower level agents to fulfill their obligations. This principle cannot be applied all over the world.

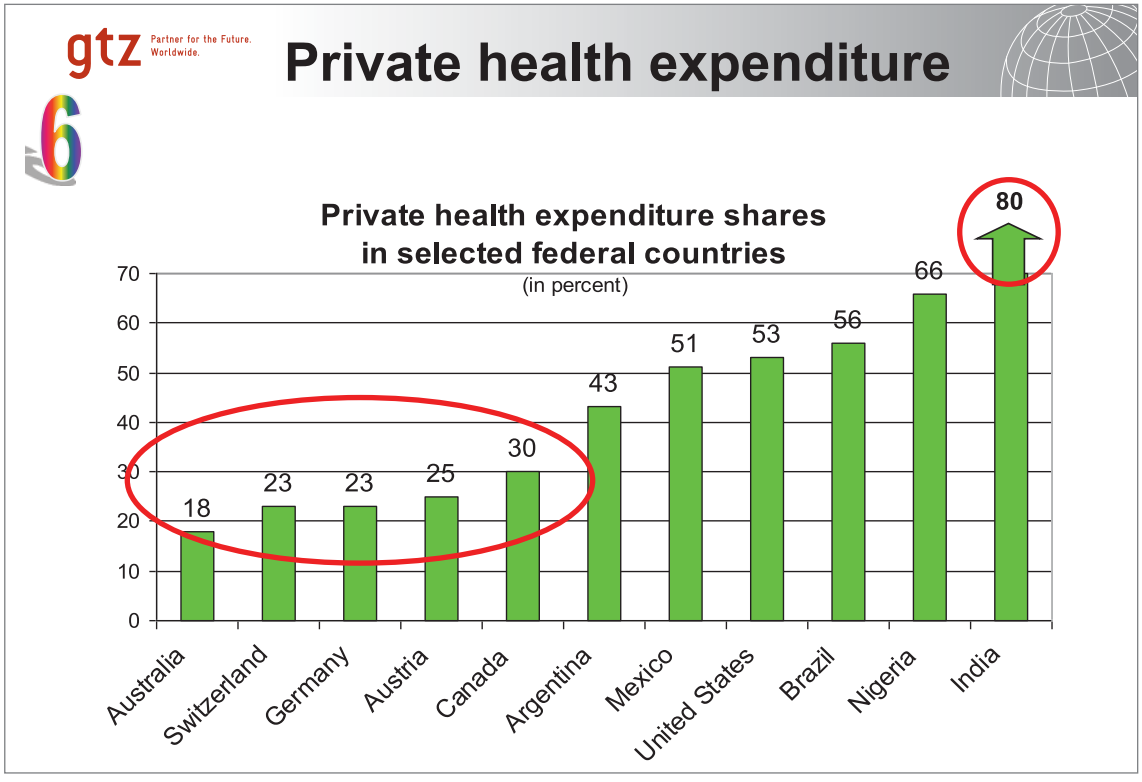
Some federal governments entrust the main health care responsibilities to lower government levels and some do have a clear division of labour between different layers of government and between government and health care providers. What matters most is that health care provision and health care financing are not mixed up and that there is no fragmentation of the health system.



[Bankauskaite 2007]

6. Health financing in federal countries

Federal countries differ considerably in health care financing. Less than 2% of the national health expenditure is given by the Union government in India whereas out-of-pocket payments of the people account for 80% of the whole amount that is spent for health and health care. A high share of private health expenditure – this is 'voluntary' spending of households, nongovernmental organizations and companies – is typical for less developed countries; the share of households typically ranges between 80% and 95% of private health expenditure. A high out-of-pocket payment of the poor and medically less educated can be considered to be a government failure – it is an irrational allocation and waste of scarce resources. A rather high private expenditure[17] for health characterizes the national health accounts in underdeveloped countries. In most Latin American countries this share is close to 50% because of the long existing health insurances for the formal employment sector which covers relatively small parts of the population. In the United States this share is shrinking and the share of federal government is increasing. In Australia and Europe it is essentially the existence of mandatory health insurances for the majority of the population which keeps the private shares in health expenditure quite low. The allocative power of spending for healthcare is quite different between the federal and the state levels in the eleven countries of the study. The federal shares are high in Australia, United States and Mexico, whereas the federal states of Canada are much more empowered to allocate resources. In Central European countries with high developed social health insurance systems the share of central and local governments for health care financing is much lower. Developed federal countries keep out-of pocket payments (at the point of delivery) for health quite low and mobilize other sources of health care financing, especially through prepayments for health insurance. Health financing is a key issue of managing health systems and good governance.



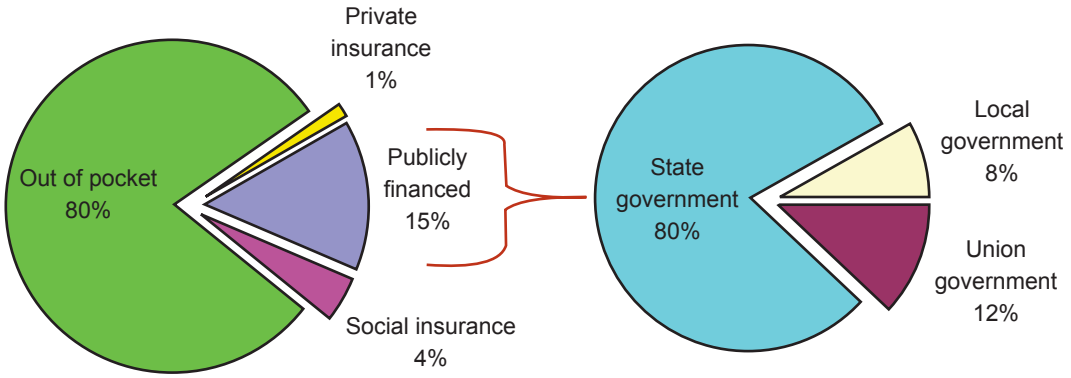
[WHO national health accounts website]

17 N.B.: nearly all health expenditure originates from private households which pay taxes to local and national government tiers and contributions to insurances. Here we speak about the allocative powers and capabilities. Mandated contributions to health insurances are not private health expenditure.

Financial contribution of federal government for health

India

- Total health expenditure
- Public health expenditure



[Shukla 2006]

Federal shares in health expenditure

	Federation	States	Private	Other
Australia	41	27	18	14
United States	34	13	53	0
Mexico	32	13	51	4
Argentina	28	26	43	3
Brazil	22	19	56	3
Austria	3	25	25	50
Switzerland	25		23	52
Nigeria	12	7	66	16
Canada	5	65	30	0
India	6	17	70	7
Germany	8		23	69

Very preliminary table : This data does not tally with other data, since sometimes social health insurance contributions are attributed to private expenditures, sometimes not.
The separation of European data according to federation and states is still missing

[Schwefel 2009]

This assumption is based on the very principle of 'subsidiarity'. It means that higher levels of government should be active only if lower levels cannot deliver services. It refers not only to levels of government but also to institutions between people and government, i.e. families, communities, and other groupings. The notion of federalism is closely linked with lower levels of governance.

The World Bank developed and uses a general index of good governance. The World Health Organization compared its entire member countries according to the 'performance and fairness' of their health system. Except for Nigeria all federal countries analyzed enjoy a high rank in terms of good governance and the Latin American transition countries are close to the world average. In terms of health system performance two Latin American countries – Mexico and Argentina – are considered to do quite well. Countries with very large populations – Brazil and India – perform less well. Good governance and health system performance in Nigeria are a disaster.

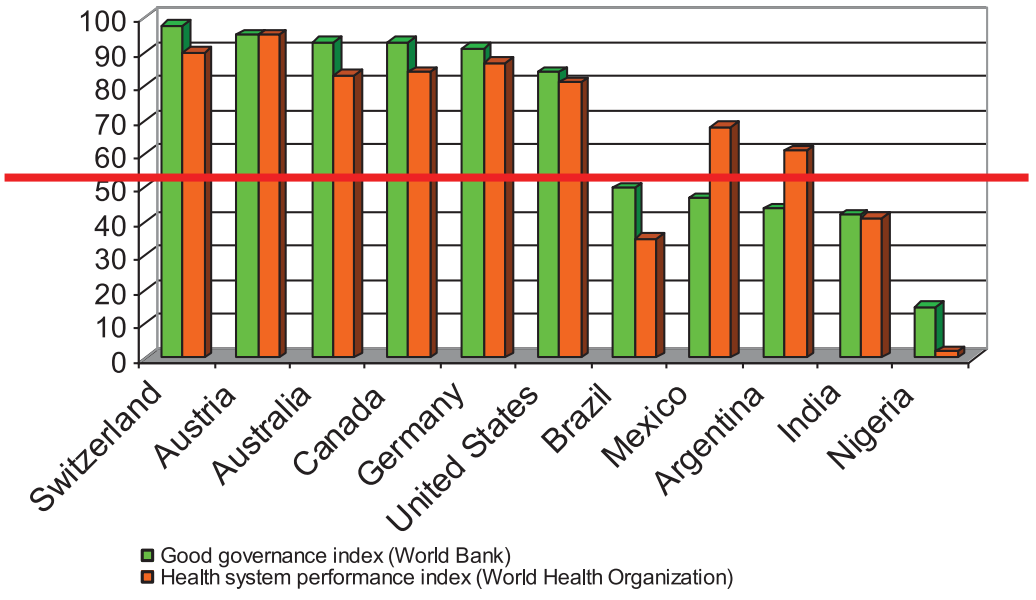
The World Bank index on good governance is composed of six components:

1. Voice and Accountability – measures the extent to which country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media
2. Political Instability and Violence – measuring the likelihood of violent threats to, or changes in, government, including terrorism
3. Government Effectiveness – measuring the competence of the bureaucracy and the quality of public service delivery
4. Regulatory Burden – measuring the incidence of market-unfriendly policies

gtz Partner for the Future. Worldwide.

Good governance and health system performance in federal countries

(percentile ranking)



Data taken from [World Health Organization 2000] and [Kaufmann 2008]

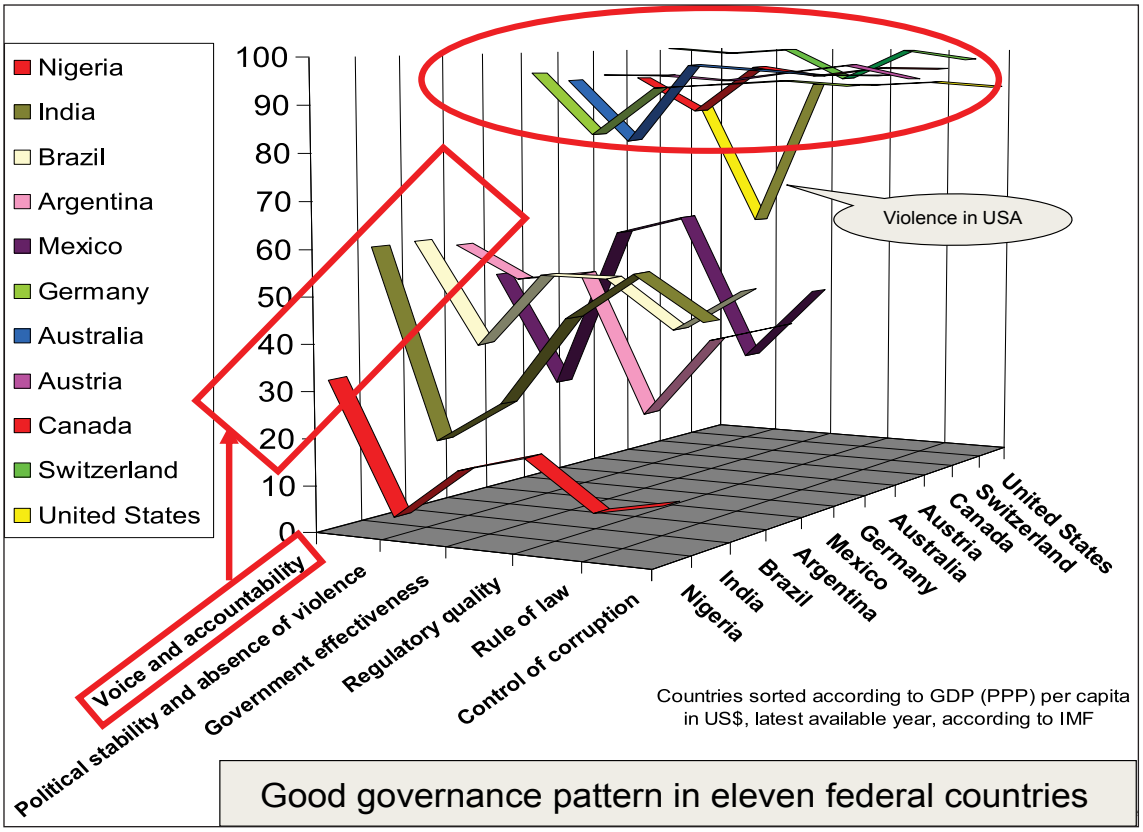
5 Rule of Law – measuring the quality of contract enforcement, the police, and the courts, as well as the likelihood of crime and violence

6 Control of Corruption – measuring the exercise of public power for private gain, including both petty and grand corruption and state capture

The following graph compares eleven federal countries according to these six criteria.[18] The countries are grouped according to their economic development. Highly developed countries are scoring high regarding most of the good governance indicataors, except regarding the absence of violence in the United States. All underdeveloped and transitional federal countries rank relatively high in terms of 'voice and accountability'.

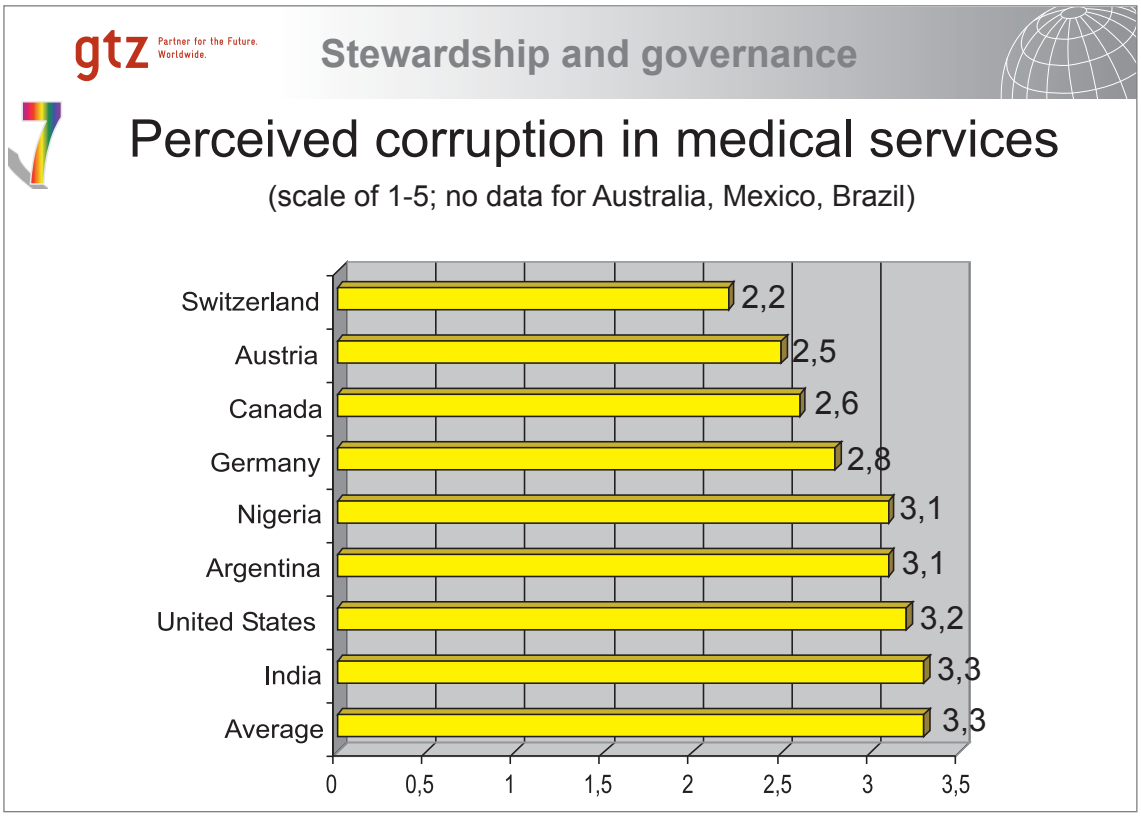
The status and control of corruption is another indicator of governance or stewardship. Regarding perceived corruption in the medical services there do not seem to exist extreme differences. The graph on the following page demonstrates that federal countries do not automatically score well – Nigeria and the United States are not that far apart. When a specific indicator of good governance in public health is used – the measles immunization coverage – then Latin American federal countries are doing better than European states.

Good health system performance is an asset of many federal countries, except India and Nigeria but even developed countries still have to work hard, especially USA. Voice and accountability are relatively high in federal countries. Good governance drives socioeconomic development and good health is the best driver of development. High development is concurrent to good governance. Good governance reduces private and especially out-of-pocket payment for health and converts it into regular rather small prepayments for health insurance for (nearly) all citizens. Good governance and social health insurance/protection are strongly linked.

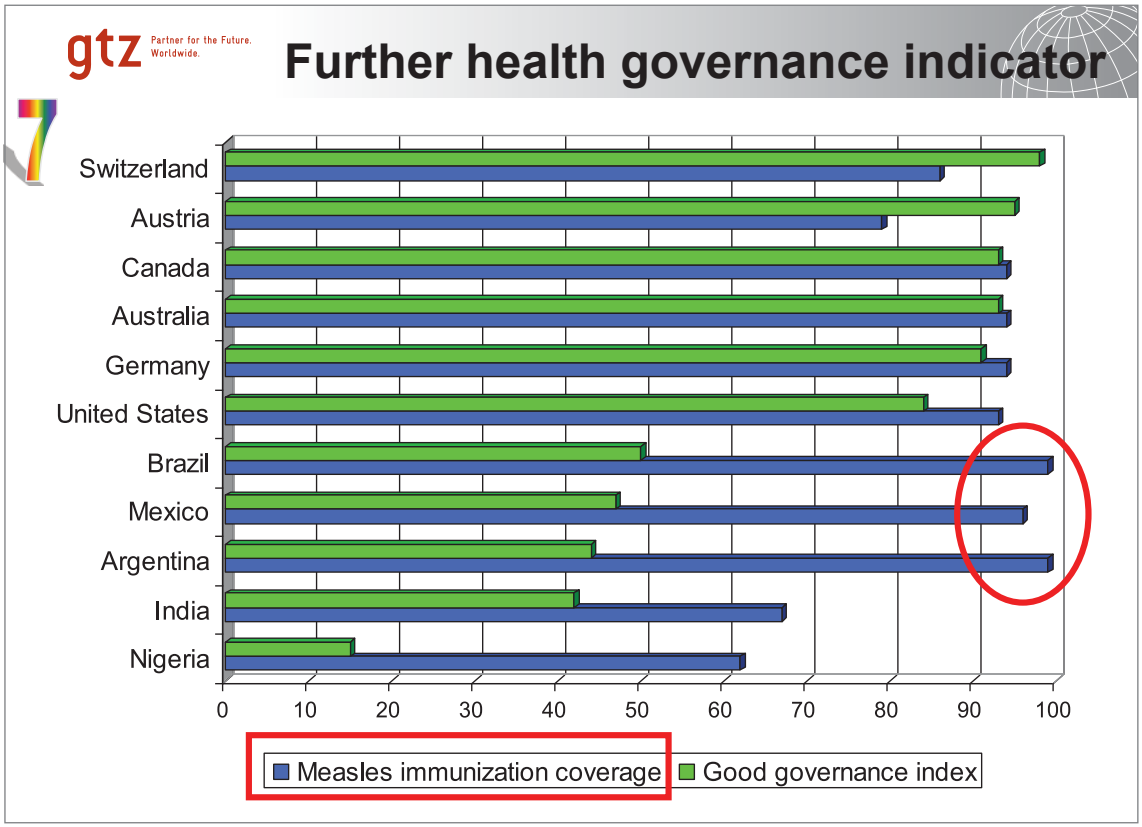


Data taken from [Kaufmann 2008] and [Wikipedia 2009]

18 It would be interesting to compare all federal countries with other countries regarding stewardship performance and other indicators



Data taken from [Transparency International 2008]



Data taken from [World Health Organization 2007] [Kaufmann 2008]

gtz Partner for the Future. Worldwide. One tentative result

Relation between

- Good governance
- Health financing

	Federation	States	Private	Other
Australia	41	27	18	14
United States	34	13	53	0
Mexico	32	13	51	4
Argentina	28	26	43	3
Brazil	22	19	56	3
Austria	25		25	50
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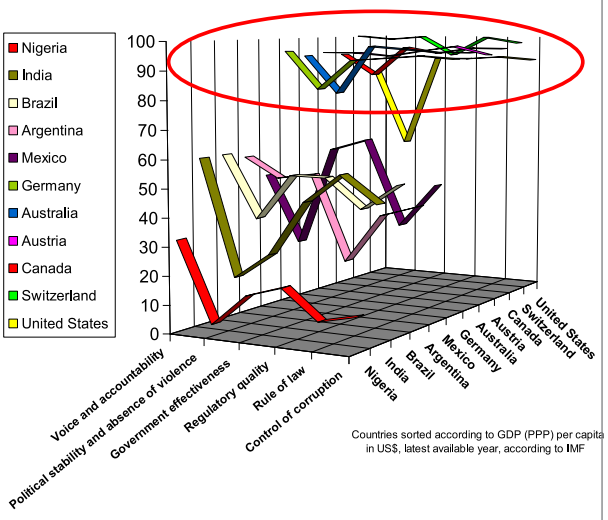

First hypothesis: Development ⇔ good governance
= low private payments for health = good social health protection

[Schwefel 2009]

8. Federalism and welfare

Theoretically there is a dilemma in the relationship between federalism and welfare. Multiple veto powers within a federal state can easily block reforms and the competition of jurisdictions tends to prefer cheap solutions. Both problems lead to reduced welfare.[19] In this context it seems important to distinguish between cooperative versus competitive federalism. Competitive federalism can be overcome by superimposing nationwide tax and transfer systems and equalisation mechanisms as they exist in continental Europe but not in Anglo-Saxon federations. Social insurance schemes for pensions, work injuries, health, unemployment and long-term care contribute to a certain sustainability of the welfare state. Such social insurance schemes are overwhelmingly national schemes. Often they are organized at territorial levels that do not correspond to federal delineations. They are less influenced by 'vested interests' of municipalities, states and the federal level. Another important factor would be if the Constitution assigns the main responsibility to the national federal government in regard to the harmonization or equalization of living conditions. Besides defining individual human rights the Constitution would have to guarantee a certain uniformity of living conditions and non-discrimination of social groups, communities and territories. Welfare and redistribution should not be handed over to competitive battles between provinces. Welfare needs and deserves sustainability.

9. Conclusion

There are many forms of federalism. What matters are the basic and universally shared

19 "Conventional wisdom strongly suggests that federalism is inimical to high levels of social spending. Two arguments are prominent in this context: a veto-point thesis and a 'competition of jurisdictions' thesis. The veto-point thesis is quite straightforward: federal systems have more veto points than unitary systems ceteris paribus. This increases the probability that groups opposed to welfare state expansion can exert some influence in the legislative process. Veto points would then give these groups the opportunity to block or substantially water down redistributive legislation. 'Competition of jurisdiction' arguments hold that welfare redistribution is limited in federal systems because those who would pay more than they would gain in a given jurisdiction (high income earners, 'capital') can credibly threat to exit highly redistributive and join less égaliste jurisdictions. At the same time, those who gain more than they would pay (e.g. low income earners) are attracted to regions with higher level of redistribution and these would therefore develop into 'welfare magnets'. Thus, a re-distributional policy stance is self-defeating in a federal context." [Manow 2005]

values of people and politics being shaped by history, the democratic traditions, and the political culture. Popular participation contributes a lot. Voice and accountability are symptoms and drivers of good governance. Good governance shapes good health systems, which leads – through an evolving social health protection system – towards sustainable fair and good health care for all, opposing discriminatory practices against the poor and the vulnerable. The basic principles and values behind good governance are: subsidiarity and solidarity.

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