

Nepal's quest for Universal Health Coverage

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Universal Health Coverage (UHC) is one of the 13 targets under the third goal of Sustainable Development Goals (SDGs).^[1] While the progress towards UHC in many Low and Middle Income Countries (LMICs) has often been feeble due to inadequate fiscal capacity, lack of governance structures and political commitment, the Himalayan nation Nepal is making some progress. The National Health Policy 2014 and National Health Insurance Policy 2013 of Nepal have UHC as one of the policy strategies. However, Nepal's quest for UHC is fraught with many challenges.

Nepal has a growing burden of Non-Communicable Diseases (NCDs) and increasing number of deaths and injuries due to road accidents and climate induced disasters, notwithstanding to its high prevalence of communicable diseases.^[2,3] The rising burden of NCDs is a major public health concern. The World Health Organization (WHO) member states including Nepal have set a target to reduce premature deaths due to NCDs by a third, as a part of the 2030 Agenda for SDGs.^[1,4] In Nepal, the healthcare delivery system that has already been struggling to manage the burgeoning burden of NCDs is constrained by inadequacy in human resources, medicines supply and infrastructures to deliver NCD services.^[2,4] Further, the institutional arrangements under Ministry of Health currently do not give enough space and priority for addressing the increasing burden of NCDs.

However, in a laudable move, Government of Nepal in the Interim Constitution of 2007 as well as in the recently promulgated Constitution of Nepal 2015 addressed health

as a fundamental right.^[5] The clause 35 of Constitution of Nepal ensures that every citizen shall have 1) right to free basic health services from the state, and no one shall be deprived of emergency health services, 2) right to get information about his or her medical treatment, 3) right to equal access to health services and 4) right of access to clean drinking water and sanitation.^[5] The National Health Policy 2014 also ensures fundamental right to health via UHC by ensuring access to quality basic health services free of cost. The National Health Sector Strategy (NHSS) 2015-2020 of Nepal articulates nation's commitment towards achieving UHC which stands on four strategic principles: Equitable access to health services, Quality health services, Health systems reform and Multi-sectoral approach.^[6]

NHSS outlines the way to move towards UHC which consists of basic packages and social health security. Basic package defined in NHSS includes defined free medicines (at present 70 items in less than 25 bedded public hospitals/health facilities), laboratory services, delivery tier identified at all level of public health facilities and social health security which includes national health insurance and integrating other social health security schemes. However the concept of UHC is not new in Nepal as many public health programs have been rolled out over past years including immunization, family planning, safer motherhood (Aama Surakshya) program covering free institutional delivery and incentive for mothers and health workers, free antenatal and postnatal care at primary health facilities and district hospital, community-based integrated management of neonatal and childhood illness (CB-IMNCI), HIV prevention and



treatment program, Treatment, care and support for TB patients including Multi Drug Resistant/Ex DR, malaria prevention, treatment, and kala-azar and leprosy elimination program. Despite these efforts, Nepal so far has been unable to ensure effective UHC to the population. The government in 2007 initiated free health care program for primary health services and access to a number of essential medicines at the public-sector health facilities. Such health coverage package – that includes minimal health services and medicines – though has increased service utilization in public-sector health facilities but haven't been able to decrease out-of-pocket (OOP) payments for other general and specialist services in absence of risk pooling structures in both the public and private sectors.^[7] Studies indicate that, in Nepal, there exist huge socio-economic and rural-urban inequities in terms of healthcare service delivery and availability of healthcare workers.^[7] Furthermore, only 61.8% of population has access to health facilities within 30 minutes, with wide variation between the people living in urban and rural areas.^[8]

In February 2015, the Government of Nepal constituted a Social Health Security Development Committee (SHSDC) aimed at providing health security coverage and ensuring access to quality-assured healthcare services at an affordable cost.^[7] The committee is tasked to develop a legal-enabling framework to expand the healthcare provision, and to procure and deliver health services and medicines. Traditionally, the health insurance systems charge an enrollment fee to the beneficiary population (risk pool) in the form of insurance premiums or in the form of taxes to bear the cost of health services. However the financing mechanism to be adopted by the SHSDC in Nepal – a country with over a quarter of population living below poverty line – is yet unclear; the government has indicated that premiums for the poor and marginalized population will be paid by the government while those with financial ability will bear their premium cost.^[7] We would like to highlight few issues which the Government of Nepal would need to consider while drafting the legal framework for Social Health Security (SHS) program in order to ensure the improved access to healthcare.

1. Inclusive measures to ensure larger risk pool for sustained financing

Based on experiences from the earlier community-based health insurance initiatives in Nepal, it will be imperative that the SHS program should be able to ensure the enrollment of all citizens so as to distribute the health-related risks and costs over to a larger population. The risk pool should be sufficiently large to allow cross-subsidy

or complete exemption of premium for poor. For that, a higher enrollment rate in the insurance is essential over the years. However, in past, such initiatives served only the rich and those who had better access to public-sector health facilities thus suffering a low enrollment.^[7] Such a condition if persists might have implications for the financing of the SHS program as well as UHC. Therefore, alongside planning the design and roll out of the nationwide SHS program, the government need to assess the strengths and limitations of the healthcare facilities at all levels followed by capacity building for improving health service delivery.

2. Incorporation of the private-sector in SHS program for increased access

Traditionally, in various LMICs, the governments' planning to improve healthcare access has been limited to the public sector. However due to public sector's lack of resources and the emergence of the private sector as a widespread healthcare provider, governments and researchers in recent years have urged the private sector to help meet the unmet healthcare needs.^[9] In Nepal, 78% of health expenditure is incurred by privately contracted services and increasing population now seeks healthcare services in the private sector. Currently, in the absence of a comprehensive health insurance and security program, the OOP expenditure constitutes nearly three quarters of total private payment.^[7] The Nepalese private-sector healthcare consists of a mixed cadre of healthcare providers ranging from unskilled village doctors to trained community health workers and skilled health professionals and at an institutional level from village level pharmacy to private hospitals. Given that these private-sector healthcare professionals are an integral part of healthcare service delivery in Nepal, the government can take measure to incorporate private-sector services in the SHSD. As suggested by Sharma *et al*, such initiatives in LMICs would require training and accreditation programs for the private-sector healthcare providers, along with efficient resource sharing mechanisms which will include incentives for the private providers (especially pharmacists and nurses) to help improve evidence-based healthcare services.^[9-10]

3. Expansion of the healthcare services package

Nepal, alike other LMICs, is experiencing an increasing burden of NCDs which calls for provision of newer treatments as well as expanded community health services for the purpose of continued disease monitoring and management. However, the current public-sector healthcare provision in Nepal includes a limited set of medicines and treatment services. If the planned SHS program fails to

expand the healthcare services provision, an opportunity to expand insurance coverage and stride to achieving UHC would be lost. In order to ensure improved access to healthcare services, Nepal would need to better understand its disease burden situation followed by evidence-based expansion of the health services package to be offered under the SHS scheme. Further, strengthening referral networks, greater focus on human resource management and its competency, service protocol for treatment, medicines, and laboratory and supply chain are imperative. The insurance package needs to be crafted taking lesson from past experiences and periodic evaluations and researches. For that, an information management system deems necessary to be built alongside to the data related to treatments and procedures and pharmaceutical dispensing.^[4]

In summary, Nepal's move towards SHS would be a great opportunity to ensure UHC to its population. This will require measures to ensure comprehensive population enrollment in SHS, expand healthcare provision and incorporate private-sector providers through proper regulation. This would be possible with political commitment as well as systemic data generation and sharing to be able to plan and monitor the progress of SHS program over time.

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