

Free Basic Healthcare in Nepal: Can the Dream be Turned into Reality in the Pursuit of Universal Health Coverage?

Krishna K Aryal^{1,2}

¹Editorial Board, Journal of Nepal Health Research Council, NHRC, Kathmandu, Nepal, ²Bergen Centre for Ethics and Priority Setting in Health (BCEPS), University of Bergen (UiB), Bergen, Norway

Access to basic health services (BHS) free of cost has been enshrined in the Constitution of Nepal 2015 as the fundamental right of the citizens of Nepal. The limit and extent of what is included in the BHS package and how the access to that is ensured to the people can vary across countries and can have several determining factors including the country's economy, growth, and development, in addition to the level of priority the health sector gets from the Government, including the political commitment. Besides all these factors, governance within the health sector including efficiency of the health systems¹ will also play a major role in ensuring the availability of defined services at the designated service delivery platforms and thereby facilitating the access to the BHS. As it is obvious to first define what interventions are included in it, to then make sure how that is ensured Nepal has attempted to define the BHS through the public health service regulations 2020.² Accordingly, the health sector, with Federal Ministry of Health and Population (MoHP) playing the central role, has been attempting to make sure the defined interventions (services) are available through the designated health care delivery units in coordination with the provincial and local level governments (LLGs), more so through the health facilities within the LLGs. The delivery of those interventions under BHS has been attempted to be facilitated by publishing the standard treatment protocol.³ However, it is not clear if the health sector has done enough to make sure people of Nepal can realize the fundamental human right on access to BHS. In addition, one can only get an ambiguous answer to a question on how much (to what extent) of the aspiration of ensuring access to BHS has been accomplished, which is partly due to the lack of an explicit implementation plan for translating BHS into delivery and partly due to lack of an appropriate and adequate monitoring & evaluation (M&E) mechanism for carrying out required M&E.

In general, the health sector policies have two major aims:

to ensure access to and uptake of health interventions and to ensure quality of delivery of health interventions. This is further aided by the intersectoral policies that aim to reduce behavioral and environmental factors.⁴ Nepal's health sector has attempted to make sure health sector policies are in place and the required plans and strategies are made and accordingly implemented to ensure availability of and access to BHS. In addition, there have been constant efforts to ensure that the intersectoral policies support the health sector policies. What we call BHS in Nepal, is more commonly referred to as essential package of health services (EPHS) globally.^{5,6} As such the term essential health services is not new to Nepal, the government of Nepal (GoN) defined its first Essential Health Care Services (EHCS) in the Second Long Term Health Plan (SLTHP) 1997 - 2017 and identified key issues and policies related to implement EHCS.⁷ The Health Sector Strategy: An Agenda for Reform, 2004, the first sector strategy since the GoN adapted sector-wide approach (SWAp) in health focused on prioritized EHCS (safe motherhood and family planning, child health, control of communicable diseases, and strengthened outpatient care) considering the whole package of EHCS with twenty broad areas outlined by the SLTHP being not immediately affordable by the country.⁸ With the next sector strategy - the Nepal Health Sector Programme 2 (NHSP2) 2010 - 2015 the EHCS was further expanded with additional programmes on mental health, oral health, environmental health, community-based newborn care, community-based nutrition care and support programme, and an additional component of non-communicable diseases control to better address Nepal's health care needs in the context of demographic and epidemiological transition.⁹ The GoN considered implementation of EHCS as its medium to achieve universal health coverage (UHC). Then, with the country moving towards federalism, the National Health Policy 2014 transitioned to use BHS as the terminology for minimum EHCS and aimed to avail free of cost BHS that remains as a fundamental right of the citizen.¹⁰ In accordance, the subsequent sector

Correspondence: Krishna K Aryal, Bergen Centre for Ethics and Priority Setting in Health (BCEPS), University of Bergen (UiB), Bergen, Norway

strategy - the Nepal Health Sector Strategy (NHSS) 2015 - 2020 (later extended to 2023) continued to commit to accelerate UHC to ensure equitable access to quality health services for the population with BHS at the core.¹¹ In addition to further clarifying the nation's strategy to avail free-of-cost BHS, the GoN has also planned for other services beyond the BHS package to be provided at an affordable cost through targeted subsidies and various social health protection schemes. Amidst this and following the promulgation of Constitution of Nepal 2015, GoN released the new National Health Policy 2019 in accordance with the federal context which continued to state the national commitment to ensure free BHS with a plan to make specialized services easily accessible through health insurance.¹² And as the country approaches to the target year of sustainable development goals (SDGs), the key documents currently guiding the health sector are National Health Policy 2019 and Nepal Health Sector - Strategic Plan (NHS-SP) 2023 - 2030.¹³ These national guiding documents aspire to help the citizens of Nepal realize the fundamental human rights towards access to free BHS and guide the health sector to progressively realize UHC as outlined by global guiding documents.

Despite having all relevant policies, plans, strategies and other supporting documents, the access to BHS has not been optimum with still a gap to achieve the targets of several interventions targeting more than 90% of coverage in line with the SDGs. For example, percentage of women having four antenatal care visits as per protocol 56% (target 2030 - 90%),¹⁴ percentage of institutional delivery 79% (target 2030 - 90%),¹⁵ percentage of population aged 15 years and above with raised blood pressure who are currently taking medication 9.5% (target 2030 - 60%).¹⁶ The overall UHC service coverage index is also not optimistic either (53 out of 100) and is far below than the global average (67 out of 100).¹⁷

Further to this, the interventions/services covered under BHS that are defined in the public health regulations are not very explicit² and seem to require further exercise to clearly define the interventions. There also appears to be an inadequate linkage of the services to be offered under BHS with the implementation mechanisms, and probably a missing dedicated implementation plan of BHS package. A series of overlaps with other publicly funded programs (vertical or various programs under several social protection schemes) further complicates the implementation of interventions under BHS.¹⁸ A subsequent gap of unavailability of clear M&E mechanism and plan prevents the opportunity to carry

out a thorough review of progress on periodic basis to help take course correction measures on time.

While we cannot forget the specialized care (services beyond minimum basic) which needs to be planned in an overall health benefit package (HBP) that the country sets with an appropriate plan of financing mechanisms between free-of-cost, cost sharing and cost recovery, the government must ensure near universality of minimum EHCS, in other words the most feasible BHS interventions. The way forward could be defining the BHS precisely not just by specifying the interventions arbitrarily, but by identifying the interventions in line with the global standards of UHC compendium and interventions proposed by disease control priorities 3rd edition (DCP3)^{4,19} both of which are the most evidence informed set of recommended interventions for LMICs to help achieve UHC. And at the same time projecting the outcomes that would result from the implementation of package of interventions which would help understand the relationship of the interventions with the population health impact that the country aims for down the line. Then developing a clear implementation plan across the health system building blocks, aligning the implementation plan to the periodic strategies and annual plans of each level of governments with a clear delineation of responsibilities would be required. And last but not the least, having a clear and measurable M&E plan to periodically measure how we are progressing in expanding the access to BHS and the distance to cover to the defined level of universality is important, without which one would not be able to ever see if we are on track and plan for a course correction if we feel we are not doing enough.

In attempts to realize UHC, countries across the world have started defining EPHS more precisely along with setting priority categories using several evidence including that on economic evaluation. Ethiopia revised its essential health services package in 2019 to replace its package developed in 2005 to define appropriate priority health services and identify the minimum set of healthcare interventions that people can expect to receive.²⁰ Similarly, Pakistan used the global review of evidence by DCP3 to define its essential UHC benefit package in 2020 that includes a clearly defined EPHS.²¹ No country in the world can provide everything to everyone with public funding, and hence there must be hard choices made on what to include or exclude in the list of EHCS that is to be provided with the public funding. And hence, creating an explicit HBP encompassing the complete list of health services that the country aims for, which would be required to achieve the population

health impact that it aspires to will be crucial.²² This package should include in general three subsets within it, one a minimum package of EHCS that is provided free-of-cost, the other provided through cost sharing, and the rest with cost recovery. While doing so, for e.g., in Nepal the MoHP should ensure minimal to no overlaps in the services in these three subsets and also make sure all the interventions and services that are currently provided through different vertical programs and social protection mechanisms are included within this bigger set of comprehensive national HBP which can then act as the essential UHC package as recommended by DCP3.⁴

Thus, to turn the dream of universality in healthcare into reality by fulfilling the nation's responsibility to ensure the Nepalese people realize the fundamental right to BHS, it is important for the Nepal MoHP to have a clearly defined HBP that aims for a continuous progress on all three dimensions of the UHC cube with a goal to achieve: explicitly defined EHCS (BHS in its context) that is scaled up with periodic revision and expansion starting with a very minimum that is affordable to the country; more people included or covered with the defined services; and out-of-pocket payments reduced or eliminated for all EHCS.

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