Policy Brief

Towards Universal Health Coverage: Addressing Financial Hardship and Improving Access to Healthcare in Nepal

Introduction

Universal Health Coverage (UHC) is about ensuring that people have access to the quality health care they need without any financial hardships. It includes the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. Financial risk protection is a key component of UHC (1). Empirical data from the 2010 World Health Report demonstrates a substantial correlation between the occurrence of financial catastrophe and impoverishment brought on by out-of-pocket expenses (OOPE). Financial hardship or poverty is uncommon where OOPE make up less than 15%–20% of total health expenditures (2). OOPE places people in financial hardship, which frequently leads to a lack of access to health care, expose them to significant health risk and causes them to become impoverished. Global experience indicates that if OOPE account for more than 30 to 40% of total health spending, patients are unlikely to be sufficiently protected(3-16).

The government of Nepal is committed to achieving UHC where financial protection is part of Sustainable Development Goals (SDGs). The target of SDG 3.8has broadly two indicators 3.8.1 coverage of essential health services and 3.8.2 financial protection for all(17). Nepal has several financial risk protection mechanisms including free basic health services, health insurance, and other schemes designed to reduce financial hardship. However, the OOPE has been high since last two decades contributing financial hardship while accessing health care (18).

With the adoption of a new constitution in 2015, there has been a political transition from a unitary to a federal system of governance. The constitution has devolved the power and responsibilities to sub-national governments. The constitution mandates basic health as a fundamental right and directs that it be provided free of costby sub-national governments, particularly local governments are responsible for delivering basic healthcare services, while all tiers of government share responsibility for managing healthcare resources. The National Health Insurance Scheme came into existence to reduce the high out of pocket spending on health in Nepal. The health insurance has expanded to the entire country however;proportion of the population enrolled, and isstill lower.

In the macro-economic context, Nepal is graduating from the least developed country in 2026. This developmental transition may result in a reduction in foreign aid (11).The state's policy as outlined in the constitution stresses that the domestic investment in health shall be increased (6).

In the 1990s, the predominant burden of diseases was related to communicable, maternal, child, and nutrition. Now, the situation has shifted towards non-communicable diseases (NCDs) including mental health, disaster, and accident-related injuries. Besides these, infectious disease epidemics and pandemics remain as unforeseeable threats (7). As the total fertility rate declines, the child mortality rate decreases, and life expectancy at birth increases, the population is being aging (8-11).

Ensuring access to quality healthcare and financial protection for all is critical for Nepal to achieve universal health coverage (UHC) as per the SDG, particularly as the country transitions to a federal system of governance and confronts new health challenges and opportunities.This policy brief aims to provide policymakers with a comprehensive understanding of the healthcare financing landscape in Nepal, including the financial obstacles associated with accessing healthcare services and their underlying causes. Additionally, the brief proposes potential policy options that can be integrated into future strategies to achieve UHC.

Methods

This brief reviewed health expenditure and household consumption data from Nepal to determine the incidence of catastrophic health expenditures and impoverishment.The policy recommendations were informed byevidences gathered from the data analysis and literature review. Besides this, feedback and suggestions have been collected through several consultations with concerned stakeholders.

Context and evidence Analysis

Nepal's health financing system has undergone significant changes in the federal context. The primary sources of health financing in Nepal are government funding, external aid, out-of-pocket payments, and premium from health insurance. The government funding comes from the federal, provincial, and local governments, with the majority of the funding coming from the federal government (18). External aid is also an important source of health financing in Nepal.The major donors are ForeignCommonwealth and Development Office(FCDO) UK, United States Agency for International Development (USAID), World Bank, Asian Development Bank, and also include various other bilateral and multilateral agencies which provide financial and technical support to the health sector(18). While the prepaid funds for health such

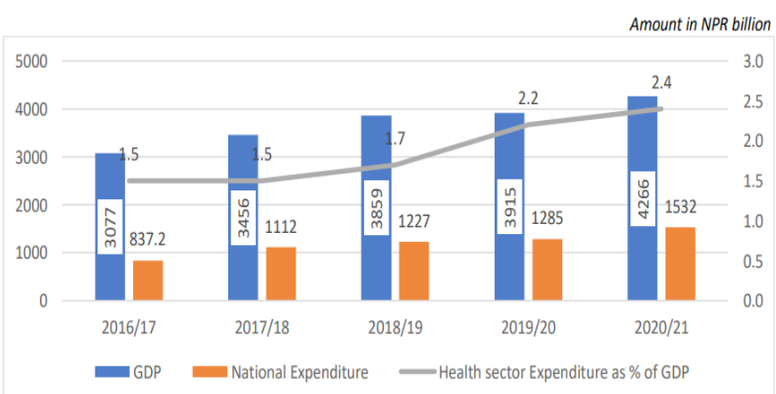
as government sources, health insurance and external aid are important to reduce the direct payments for health care, i.e. however it is lower pushing the financial burden towards households.

The Nepal's health system is heavily financed by the OOPE which is accounted for 57% of Current Health Expenditure (CHE) in 2018 (4) and the situation has been stagnant since last two decades, irrespective of various approaches made to reduce the OOPE. As a result, it has negative impact on financial wellbeing while accessing health care. In this context an estimate of catastrophic health expenditures and impoverishmentrevealed that approximately 10.7% of the total population (around three million Nepalese) faced financial hardship due to their health expenditures, with a higher incidence of catastrophic expenditures in households in the lower quintiles. Additionally, around 0.6 million people were pushed into extreme poverty (at a poverty line of Purchasing Power Parity (PPP) $1.90 per day) and approximately 0.9 million people were impoverished at the relative poverty line of 60% of median consumption or income, while 3.7 million people who were already poor were further pushed into poverty due to their health expenditures (16). A detailed analysis using the 2010/11 Nepal Living Standard Survey identified several factors that could lead to catastrophic health expenditures, such as households with a larger number of children under five and elderly, Dalit households, Terai residents, larger household size, households in the three poorest income quintiles, and lower educational attainment of the household head (14).

There are several health system and financing challenges that contribute to the financial hardship faced by the people in Nepal. At the system level, a common challenge is that the ability of the government and other pooled prepaid funds to adequately finance health care is compromised in the context of escalating health care costs, epidemiological and demographic transitions, technological advancements, a growing private sector in the health care industry, and consumer expectations for quality health care (15).

Government health expenditure as a percentage of the Gross Domestic Product (GDP) for FY 2020/21 is 2.4%. There is a 0.7 percentage increase compared to the Nepal Health Sector Strategy baseline year (1.7% for FY 2016/17). The figure below provides the trend of government health spending as a percentage of the GDP. Over the years, government spending on health as a share of GDP is increasing, albeit marginally. The government spending on health includes the budget allocated to the Federal Ministry of Health and Population (MoHP), other line ministries, and the health budget from provincial and local governments (5).

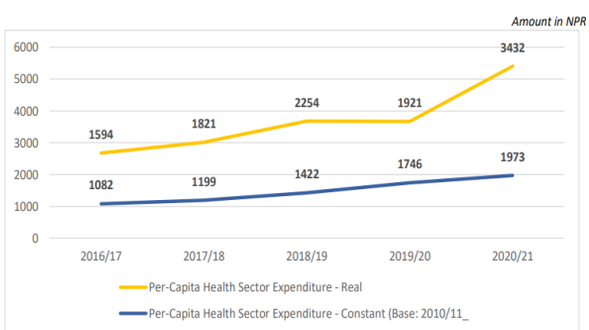
Figure1: Trend on government health sector spending as a percentage of GDP



Source: Health Sector Budget Analysis: First Five Years of Federalism, 2022.

The Chatham House report of 2014 recommended that countries should strive to spend 5% of their GDP for progressing towardUHC. There is a wide range of evidence and comparisons across countries that support the target of at least 5% or more of the GDP. The 2010 World Health Reportstated that public spending of about 6% of the GDP on health will limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible. Government spending on health of more than 5% of the GDP is required to achieve a conservative target of 90% coverage of maternal and child health services. The same Chatham House report recommends low-income countries to spend USD 86 per capita to promote universal access to primary care services.The figure below shows trends in per capita government spending on health. Between FY 2016/17 & FY 2020/21, the per capita government spending has gradually increased from NPR 1,594 to NPR 3,432 in real terms. However, during the same period, government spending on health increased at slow pace from NPR 1082 to NPR 1973, in constant terms (base year fixed to FY 2010/11). This shows that Nepal is spending far behind the recommended amount to achieve universal access to primary care services (5).

Figure 2: Per capita government health spending



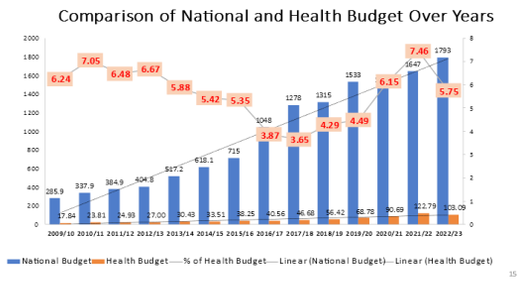
Source: Health Sector Budget Analysis: First Five Years of Federalism, 2022

In the past fourteen fiscal years, the percentage of the national budget allocated to health has shown a fluctuating trend, mostly remaining below 7% of national budget as shown in Figure 3. It indicates that investment in health has not been considered as a return of investment. It also shows that there is need of strong advocacy with policymakers for adequate budget allocation in health(20).

The Health Insurance Board (HIB) was established in 2016 and aims to provide UHC through a social health insurance program (SHIP). The program legally targets formal sectors with progressive premium and mandatory enrollment for everyone. However, implementation was initiated only to cover informal

sector and poor families.Now, it is planning to cover the formal sector and their dependents. The SHIP is currently being implemented in all districts with 25% population coverage, and it is expected to be cover all population nationwide by 2030 (21).

There are multiple social health security programs in Nepal, both within and beyond the health sector, including free basic health services, health insurance, and various free health schemes. The existence of multiple programs has led to duplication and inefficiencies in health financing (18).



The federal governance system, which has devolved power and responsibilities to subnational governments, has created an opportunity for increased decision space at the provincial and local level, closer to the community. However, the low share of the health budget and the existence of fragmented schemes create inefficiencies in health financing and result in a heavy reliance on out-of-pocket payments.

Health Financing Modalities: Lessons from Global Practices

The health financing modalities are largely influenced by the political and socio-economic contexts of a country. Around the world, various nations have adopted different types of health financing modalities. Here are some examples.

The Cuban healthcare system follows a socialist model, where healthcare is provided as a public service to all citizens free of charge. The system is financed primarily by the government through taxes and other state revenues (22). In Cuba, OOPE is9% of Current Health Expenditure (CHE) (23). Cuba's socialist health care financing system can provide insights into prioritizing primary care, prevention, and health promotion, and the use of community health workers to enhance access and quality of care, particularly in rural and remote areas.

Thailand's Universal Coverage Scheme (UCS) aims to provide basic health services to all citizens regardless of their ability to pay. It is funded through general tax revenues, payroll taxes, and out-of-pocket payments, with about 75% of the funds coming from general tax revenues. With over 98% of the population now covered under the scheme, the UCS has been successful in expanding access to healthcare in Thailand (24). The OOPE of Thailand is 11% of CHE (23). Nepal can learn from the UCS about the benefits of a risk-adjusted capitation payment system that ensures equitable distribution of financing to healthcare providers. Nepal can also learn about using general tax revenues, payroll taxes, and out-of-pocket payments to finance the system, as well as addressing challenges related to ensuring financial sustainability and regional disparities.

The UK's National Health Service (NHS) is a publicly funded healthcare system that provides medical services to all legal residents of the UK, regardless of their ability to pay (25). The OOPE of the UK is 14% of CHE (23). From the UK's NHS, Nepal can learn about the benefits of a tax-funded system that provides universal coverage to all residents, including preventive, primary, and specialized care.

The German healthcare system is based on a mandatory social health insurance model, covering all residents, with 85% of the population covered by statutory health insurance and the remainder covered by private health insurance. Health Financing system is through contributions from employees and employers, set as a percentage of gross salary (26). The OOPE of the Germany is 13% of CHE (23) From Germany's Social Health Insurance system, Nepal can learn about the benefits of mandatory health insurance and the cost-sharing mechanism involving contributions from employees, employers, and the government. Nepal can also learn from Germany's experience with risk adjustment mechanisms and regulation of the insurance industry to ensure equity in access and quality of care.

Policy Options

Based on the country context and available evidence, Nepal can adopt following health financing policies for achieving universal health coverage.

1. **Adopt best fit health financing model in Nepal:** Nepal can tailor a system that addresses its unique needs and challenges through expanding fiscal space for health either by adopting health taxation and/or by implementing social health insurance that is mandatory to all and has progressive premium systems and efficient payment mechanisms. In addition, enhancing the efficiency of healthcare expenditure can be attained through measures such as strengthening health information systems, generating evidence, implementing effective regulatory mechanisms, and developing and functionalizing standard operating procedures.
2. **Increase Government Allocation to Health:** Historical data shows that there is consistently inadequate allocation of funds for healthcare. Therefore, the government should consider raising the budget for healthcare by a minimum of 10% at the federal, provincial, and local levels.
3. **Alternative Resource Mobilization:** Considering the current economic status of country, Government can improve resource mobilization by leveraging external aid, exploring public-private partnerships, innovative health financing mechanism like earmarked and sin taxes etc. and encouraging philanthropic contributions.
4. **Strengthen Health System Governance:** Improving health system governance can also help strengthen the health financing system of Nepal. This includes enhancing transparency and accountability, strengthening regulatory frameworks, and improving coordination among three tiers of government and stakeholders.

5. **Promote Health Equity:** Based on periodic equity analysis, health financing polices need to be adjusted so that health services are accessible and affordable for all, regardless of socioeconomic status or geographic location.

Conclusion and Recommendation

In conclusion, strengthening the health financing system of Nepal in the federal context requires a multi-pronged approach. Thorough analysis and planning are required to choose the best fit model of health financing in Nepal in the federal context because effective implementation of the policies lies on multi stakeholders' ownership and investment interest in health. Policymakers should prioritize health investment as it yields a return on investment. It is expected that suggested policy options will enhance the health financing system in Nepal, addressing the current issues and challenges on the path towards achieving UHC so that all citizens have access to affordable and quality health services.

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