Nepal's transition toward universal health coverage: A challenging pace for implementation

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The quest of universal health coverage (UHC) has gathered momentum over the last decade and increasingly receiving priority goal to overcome the inequalities in access to essential health-care services.[1] Since the ratification of sustainable development goal 3.8, UHC impetus is further galloping as a big global push. The transition toward UHC is primarily based on political negotiation, and built on the principle of equity that makes the state to ensure a fair health financing system.[2] By its very nature, the collaboration of various line agencies within the government along with external development partners is inevitable for ameliorate it.[3] However, despite the strong commitment from home countries and big efforts from international agencies, globally, over 100 million people are pushed into poverty every year on account of tremendous financial burden as result of increased out of pocket health-care cost. The World Health Organization (WHO), South EAST Asia region, harbors more than 130 million people who are dearth in access to essential health care services owing to health expenses.[4] An estimated 43% of the poorest Nepalese did not seek care for their last illnesses in 2012 due to anticipated out-of-pocket expenses.[5] Highly competitive and complex political environment, a 10 years civil war with armed Maoist group, and a likely transition to federal structure including the implementation of the constitution are situation that made demand of National Health System in Shadow. Even though, Nepal has embarked on the long journey toward UHC following a bottom-up approach, with a special focus on the poor and vulnerable. The newly promulgated constitution (2015) of Nepal[6] ensures that every citizen shall have (1) the right to free basic health services including emergencies services, (2) the right to equal access to health services, (3) the right to have clean drinking water and sanitation, and (4) the right to get information about his or her medical treatment. The National Health Sector Strategy (2015-2020), National Health Insurance policy (2013), and National Health policy (2014) are also in the same line toward achieving UHC by ensuring access to free quality basic health services. In addition, various programs have been introduced that provide health services and enable free access to a number of essential medicines at the public sector health facilities (e.g., the Safe Motherhood Program, which was introduced in 2005, and the Free Health Care program, which was introduced in 2007).[7] This has increased the service utilization in the public health sector even though out-of-pocket payments for other general hospitals and specialties services are not reduced because of the lack of risk pooling mechanism. Successful roll out of UHC may, therefore, require more "upstream" dialogue about its design, funding, and implementation as it is progressively introduced.[8] Consistent political commitment, strong leadership in the health sector, and supportive multi-stake holder's partnerships are the key instruments for a successful implementation of UHC campaign. In a more competitive political environment, policy design and adoption can be frustrated by vigorous interest group and/or politics.[3] Research from overseas suggests that countries with politically dominant elites tend to make better progress toward UHC rather than countries where there is a greater degree of political competition.[2] Therefore, fundamentally, the decision to implement UHC is a political one; its implementation is a political process.[9]

The Himalayan country, Nepal, has made a steady and impressive gain in its health outcomes over the last two decades despite long insurgency, turmoil political situation, 20 years vacuum of elected representatives in subnational and local level. For instances, there has been a dramatic and rapid improvement in life expectancy (38 years in 1960-69 years till date) and reproductive, maternal, newborn, and child

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Health.[10] However, weak health governances with unequal distribution of health-care services, poor withholding of health professionals in remote areas, down-and-out regulated private health providers, and inadequate budget allocation in health sector still remains challenge.[11] The ratio of health human resources in Nepal is less than that recommended by WHO. For instance, doctors and nurses per 1000 population ratio in Nepal is only 0.67 whereas that of Global standers is 2.3.[12] After the economic liberalization and political transformation in Nepal, private health providers, most of the which are concentrated in urban part of the central region, are growing rapidly and provide more than 50% all the health services in Nepal.[13] Out of pocket expenditure has remained the principle means of financing health care in Nepal. Despite the Government's laudable move toward health as a fundamental right in constitution, only 61.8% of the Nepalese households have access to health facilities within 30 min walk. This contributes to marked discrepancy between rural and urban.[14] The total health expenditure in Nepal is also below the global average of 9.2%. For instances, in 2012, total health expenditure accounted for 5.5% of country's gross domestic product (GDP). Since 1951, both the official and unofficial foreign aid had a central role in the provision and shaping of health care and development process of Nepal. For example, in 2012, the country had a fifth of its total health sector expenditure financed by donors. This was lower than the low-income countries average of 28%.[11] However, since a few decades, the health-care spending per person has significantly increased 11-40US$ in terms of the purchasing power parity. The main reason for increased health catastrophic expenditure is due to increased burgeoning of noncommunicable diseases (NCDs). For instance, NCDs in Nepal have risen from 51% in 2010 to 60% in 2014.[15] However, the priority from the National budget and development assistance from international agencies for NCDs still remains low.[16,17]

In this paper, we raise the issue of how Nepalese socio-political landscape evolved to support UHC, examining how key factors such as social solidarity, ongoing dynamic political pressure, economic growth, and people's satisfaction can play a major role for the full achievement of UHC. We aim to highlight the determinants of socio-political forces on health services welfare expansion as mentioned by Wang and his colleagues[18] and reports from Chatham House.[2]

INTERCONNECTEDNESS AND SOCIAL SOLIDARITY

Social solidarity, prerequisite for achieving UHC, has been considered to be a collective property of a specific socio-political culture, based on shared expectations and developed as part of a communal, historical learning process. Greater social cohesion is associated with low levels of income inequality, crime, government corruption, and rising per-capita GDP.[18,19] Although it is difficult to measure the positive effects of the interconnectedness and solidarity at the basis of UHC, studies have shown the positive consequences, both at the individual level and at the community level.[20] However, in the case of Nepal, the social solidarity after the civil war from 1996 to till now is downgrade; hence, inequalities and corruption index are rising sharply. International experiences show well organized and redistributive social security scheme may be one of the tools for strengthening solidarity of the society. Hence, it is, therefore, currently implemented pilot phase social health security program should be able to ensure the enrollment of all citizens so as to distribute the health-related risks and costs over to a large population.

ECONOMIC PRESSURE

Most of the current debate on UHC is on its economic sustainability. Attention appears to be focused on how to collect sufficient resources to sustain health care system to persist UHC.[20] In particular, economic growth generates both resources and demand for expanded health care provision. As a result, countries dedicate increasing share of national income to health care services, more services are provided, and this contributes to better health.[21] After the end of the civil conflict in 2006, the country has embarked on a number of reforms and investments that have slowly improved the competitiveness of the country and reduced poverty. However, Nepal's path to development was struck by the devastating earthquakes that hit the country in April 2015 and long destructive politics. Strong financial health not only permitted the government to finance welfare expansion but also tempered objections from members of the finance ministry who favored greater austerity.

POLITICAL SUSTAINABILITY

Political sustainability appears to be an essential element, like economic and social sustainability, for a health care system to achieve UHC. Universal health-care reforms or active policies to sustain UHC are considered the testing ground for the type of political alignment that this dimension of sustainability entails.[19] Debates among political forces over UHC often imply an explicit declaration of objectives and values and, as such, are critical to distinguish who is on board and who is not, who shares a similar vision of society and of how to guarantee the health of a population, and who has a different perspective.[20] Sometime various interest groups, such as health care professionals, drug and technology manufacturers manage to exercise on health policy arena through lobbying and advocacy activities. In the case of Nepal, Health Governance system is in lethargic stage not only by lucrative beurocracy but also by crummy politics. Therefore, strong visionary leadership and passable politics in taking advantage of generalized economic and political pressures to archive UHC is obvious.

In summary, Nepal's move toward UHC would be the great opportunity to ensuring equity in every aspect. This will be possible with strong political commitment, successive economic growth and social solidarity in country.

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