Free Health Care in Nepal

Findings of a Rapid Assessment

Introduction

The Interim Constitution of Nepal of 2007 stated, for the first time, that: 'Every citizen shall have the right to get basic health service free of cost from the State as provided for in the law'. This makes "health for all" a fundamental human right and given this commitment, the Ministry of Health and Population has implemented a policy aimed at providing free health services. This has been progressively rolled out since December 2006.

In the first phase, free essential health care services were offered to poor and vulnerable citizens attending primary health care centres and district hospitals (up to 25-bed capacity). In addition to these, in 35 districts that ranked lowest in the Human Development Index, the programme provided additional free outpatient services to the same groups in the district facilities.

Since January 2009, under the "New Nepal, Healthy Nepal" initiative of the Government, all citizens are able to access District Hospitals (DH) and Primary Health Care Centres (PHCC) without having to pay for registration: they are eligible for free outpatient, emergency and in-patient services, as well as drugs.

A second universal programme commenced in January 2008, aimed at the provision of free essential health care services to all citizens, whether poor or not, at Health Posts (HP) and Sub-Health Posts (SHP) nationwide. There are no charges for registration or for the dispensation of 32 essential drugs at the HP level and of 22 drugs at the SHP level.

This study offers a rapid assessment of how the policy is being implemented. It examines the accessibility of services, the utilisation of free health care by targeted groups, expenditure per patient under the free health care programme and the financial impact of the policy on facilities. The report offers recommendations to strengthen the operation of the policy.

gtz

COOPERATION NEPAL GERMANY

Health Sector Support Programme (HSSP)
Ministry of Health and Population (MoHP) – Nepal
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

Study Methodology

The findings in this study are derived from the following activities, conducted between August and October 2008:

1. A literature review.
2. Data collection on utilization and costs in one SHP, one HP, one PHCC and one DH per district in each of 3 districts (Bardiya, Dailekh and Jumla). These are part of the nine districts of the mid-western development region in which GTZ cooperates with Ministry of Health and Population to promote Health Sector Reform. The three districts were selected because of the early implementation of the free health services policy within their boundaries, their low human development index, their greater accessibility and the extent to which they represent the eco-zones.
3. Focus group discussions and a short survey of patients from the target groups in those districts.

Key Issues Arising from the Study

1. Substantial increases in service utilisation

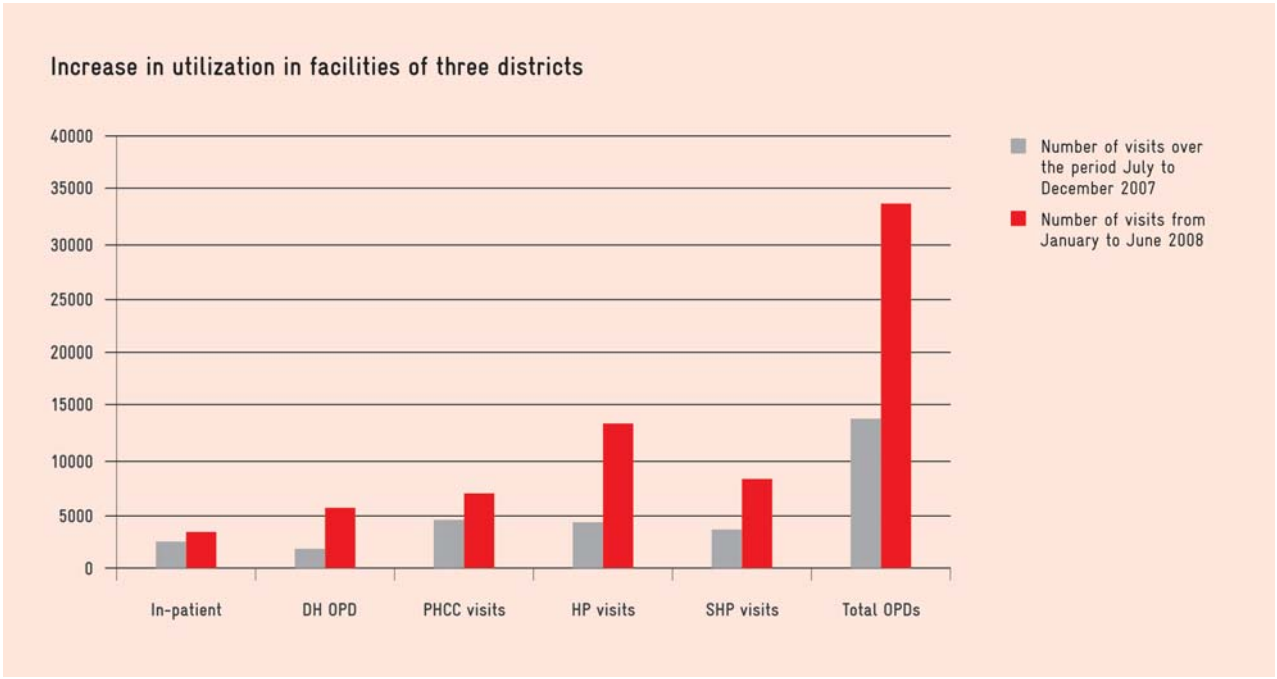
Data collected for sample facilities in our three districts show that utilization increased substantially after the policy was implemented: for example, it increased as much as 133 percent in SHPs, 215 percent in HPs, 57 percent in PHCCs, 200 percent for hospital outpatients, and 52 percent for in-patients, comparing the last six months of 2007 and the first six months of 2008 (Figure 1). The percentage of achievement of targets relating to the delivery of specific key services also increased substantially.

2. Health services not universally available and accessible

At present, there are shortages of doctors and of hospital beds. There is also a need for provision of additional training for all personnel. These resources are distributed unequally across the country, with a concentration in the central region. In the three districts surveyed, out of 100 positions sanctioned, respectively 61, 91 and 97 percent of the vacancies have been filled by doctors, nurses and auxiliary health workers. There were drug stock-outs in 29 percent of the cases. However, there were no stock-outs for key drugs, including contraceptive pills, oral rehydration solution packets, ferrous sulphate tablets, cotrimaxazole, albendazole, and paracetamol.

Although accessibility of services has improved significantly, challenges remain: for example, only 40 percent of the population in the mountainous areas and around 50 percent of the poorest in the country respectively live at a distance of less than 30 minutes' travel time to the nearest health facility.

Figure 1. Utilisation changes at surveyed district health facilities, 2007-2008



3. Long-standing inequalities of utilisation

Although in general terms free health care is equitable, access to services is not, given that many people remain unable to reach a health facility because of distance, cost of transport, and, for some, lack of knowledge that services are free of charge. Waiting times at facilities and poor quality of treatment at facilities may also remain as barriers for disadvantaged groups.

Inequality in utilization of health services remains a challenge, as evidenced by the fact that only 10 and 4 percent respectively of the poorest pregnant women had four antenatal visits and delivered in an institution, versus 60 and 55 percent of the richest quintile. We find similar inequalities between pregnant Dalit women and privileged Janajati women, women without education as compared to those with education, etc.

4. Budget for free care unlikely to meet full needs

Estimates of the cost of the free health care programme appear to have been based on conservative assumptions about growth in demand following the introduction of free health care and free drugs in the districts. If funding is inadequate, then limited staff and drugs will impose an upper ceiling to the level of utilization of services, thus reducing overall public benefits.

5. Financial impact on facilities should be manageable

Prior to the policy, user fees contributed relatively small amounts of funding to facility revenues at district level and below (9% at district hospitals and less than 2% at sub-district facilities, according to a study conducted in 2002-2003). The effects of removing user fees should therefore be quite limited.

However, analysis of expenditure in the surveyed districts suggests that spending on non-personnel costs (including utilities, operating costs, maintenance, training and capital expenditures) is extremely low, running the risk of long-term reductions in quality and effectiveness of care. These problems are not new but risk being exacerbated by the free health care policy.

6. Need to mitigate negative impacts on health staff

Some of the facilities which were visited were under-utilised, suggesting that there is scope to increase the provision of health services without adding new personnel. However, there are concerns about personnel motivation and salaries. Medical staff are now asked to work longer hours, while on the other hand their personal income has in some cases been reduced as their sales from private pharmacies have declined. There should be further investigation of the need for compensatory measures.

7. Need for more detailed monitoring of policy, particularly of impact on disadvantaged groups

The free health services policy aims in particular to benefit the poorest and the semi-poor. However, it is not easy to monitor against this goal as disadvantaged groups are not identified on the consultation registers or on hospital admission forms, making it difficult to evaluate utilization by these groups.

Recommendations

To provide free health care that is available and accessible to all, and of adequate quality, the ten priority actions are to:

1. Ensure **adequate budgeting** for the free health care programme, taking into account levels of increase of demand,
2. Make sure that **adequate drugs stocks** are available in the health facilities,
3. Ensure that the **national delivery exemption policy** and delivery incentive policy are fully funded and functioning,
4. Distribute funding and drugs provision based on a **formula which takes into account the differing needs** of districts,
5. Investigate different approaches to **compensating health workers** for lost income and to motivate them to cope with increased work loads,
6. **Orient Health Management Committees** on the operation of the free health care initiative,
7. Continue investments in **extending the network of facilities,** and improving the quality and numbers of health workers who are closest to the communities,

8. Provide health education and raise **awareness of the policy in the local language** of marginalized groups,
9. Monitor the policy by introducing information into the Health Management Information System that allows **tracking of services provided to vulnerable groups**, and
10. **Improve the Financial Management Information System** so that it shows all amounts spent on Essential Health Care Services.

For further details, see: Hachette F (2009). Free Health Care Services in Nepal: Rapid Assessment of the Implementation and Per Patient Expenditure, Report for GTZ/GFA Consulting Group GmbH, Health Sector Support Programme, Department of Health Services, Kathmandu, Nepal.

Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

- German Technical Cooperation -

Health Sector Support Programme
Department of Health Services
Teku, Kathmandu, Nepal
T +977 1 4261404
F +977 1 4261079
E hssp@gtz.org.np
I www.gtz.de/nepal

GFA Consulting Group GmbH

GFA Consulting Group

Editor: Sophie Witter
Photos: GTZ Archive
Design: Kiirtistudio
Print: Hillside Press

Kathmandu, November 2009