STATUS QUO OF NEPALESE HEALTH SECTOR AND APPLICATION OF HTA

Suman Dahal,
Student of HTA, GraSPP (2013)
& Joint Secretary of Nepal government
Presentation flow

- Overview of Nepalese health governance
- Public Health status quo in Nepal
  - Health related Policies
  - Major indicators
  - Major challenges/ problems
- Application of HTA to attain UHC
  - Introduction to HTA
  - Application of HTA
    - Nepalese context
Overview of Nepalese Health Governance
Geographically, Nepal facing obstacles

- **AREA:** 1,47,181 Sq.Km (Japan 2.5 times bigger)
  - mountain (3000 to up) 15%
  - hill (1000 to 3000 mtr) 67%
  - Terai (70 to 1000 mtr) 18%

- **HIGHEST MOUNTAIN:** Mt Everest, 8848 mtrs.
  (90 mountains above 7000 mtrs vs Mt Fuji 3776 mtr)

- **POPULATION:** 28 M (Japan 4.5 times bigger)
  - Mountain 7%, Hill 45%, Terai 48%
  - Rural above 80%

- **GDP Per capita** 450 USD (Japan 38000 USD)

- 126 different ethnicity / caste groups lives in different area
Politically, Nepal is in unrest from the beginning

- People’s revolution & demonstration occurred in 1990 for democracy establishment
- From 1995, civil war was happened for 10 years
- From 2005, revolution for anti-monarchy, federalism, proportional-inclusion have been running
- Huge Devastating Earthquake (7.8) on 2015
  - 800000 houses damaged, 9000 died; Reconstruction is going on
- 2015, New constitution promulgated but could not covered all peoples’ aspirations
  - That resulted 5 months customs point blockade and public agitation, economy shrink
Public Health Status in Nepal
Organization Structure of Nepalese Health Sector
Additional organization structure

- National Health Research Council
  - Executive Body
  - Implementing body

- Inconsistency in Name of Ministry
  - Ministry of Health & population (2006)
  - Ministry of Health (2015)
Nepalese Health Policies

- National Health Policy (2014)
  - Making effective and accessible to UHC
  - Make free basic health care

- National Health research Policy (2003)
  - To emphasize ethical practice in all health research
  - To conduct research prioritize by National Health Policy
  - To collaborate & networking with all stakeholders
## Major Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Maternal Mortality (on track)</td>
<td>170 from 850/100000</td>
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<tr>
<td>Newborn Mortality (on track)</td>
<td>33/ 1000</td>
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<tr>
<td>Physicians/ bed per 1000 people</td>
<td>0.21/ 50</td>
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<tr>
<td>Place of delivery Home/healthcare facility</td>
<td>70/30</td>
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<tr>
<td>Life expectancy</td>
<td>67 years</td>
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<tr>
<td>HDI, HDI rank</td>
<td>0.56, 154/180</td>
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<tr>
<td>GDP Per capita</td>
<td>450 USD</td>
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<td></td>
<td>(Japan 38000 USD)</td>
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<td>Population below poverty line</td>
<td>21.8%</td>
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<td></td>
<td>20% more Added by last earthquake</td>
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<tr>
<td>Total expenditure on health as % of GDP (2013)</td>
<td>6% (Govt 40% private 60%) Japan 10% ( 80% govt)</td>
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</tbody>
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Leading Diseases accounting for morbidity

- Pyrexia of unknown origin
- Headache
- Gastritis
- Acute Respiratory Infection
- Intestinal Worms
- Amoebic dysentery
- Falls/injuries
Problems/Challenges in Health sector

- Not enough health facility
- Lack of quality health technology and human resources
- Geographical hindrance
- Poverty
- Political challenges
- Procurement, storage, supply chain management, recording & reporting of drugs and equipment.
Problems/Challenges .............

- Insecurity and conflict
- Lack of human resources (high vacancy rates in rural locations)
- Lack of supplies and equipment at rural facilities
- Lack of sufficient infrastructure inputs
- Mismanagement of ‘poor funds’ and subsidies
- Mistrust and fear of government services
- Poor perceived quality of care and provider behavior
- Supply and demand centralized
- Inaccessibility
Challenges........

- Privatization of health services: increase quality in urban areas but challenging for remote and far people.
- Epidemiological transition: Still facing huge burden of communicable disease (Diarrhoea, ARI) with newly emerging Non-communicable disease along with some new concentrated epidemic (HIV/AIDS)
- Internal conflict: Negative impact on overall social development (Death, Violence, Handicapped, Disabled, migration, Rape)
- Human Resource for health: Urban centered highly skilled manpower
Application of HTA in support of UHC
Define HTA (WHO)

- Proliferation of Health Technology and its expanding uses have fueled to increase health care costs.
  - This proliferation demands HTA

- The systematic evaluation of properties, effects and/or impacts of health technology.
  - Of medicines, medical devices, vaccines, procedures and systems

- Is a multidisciplinary process to evaluate the social, economic, organizational and ethical issues of a health intervention or health technology.
Why HTA

- 20-40% of all health spending is currently wasted through inefficiency use of resources (WHR 2010)
  - Because; concerns of HTA are :- cost effectiveness, technical and financial feasibility, social and ethical

- Example:- Tobacco & alcohol generally have 3 impacts (health, social, governance) vs contribution to excise tax from sales
  - Consolidated monetary implication for society was more than double revenue earnings (Thai research)
Application of HTA in support of UHC

- Universal Health Coverage comprises
  - Equity in access to health services
  - Quality of health services should be good enough
  - People should be protected against financial risk

- Since Nepal is a fragile and low income country,
  - Although the middle and high income country focus HTA means guaranteed care packages and marginal analysis for additional package.
  - It tries to define HTA as essential services and primary health care packages

  *Country’s development correlates to Assurance more in health care system*
Application of HTA in support of UHC

- For a general decision
  - Of what is to included or not included in the benefit packages; medicine, diagnostic

- For a comparison of two technologies
  - In terms of financial feasibility & affordability of technology

- For advocating either sin taxes or prevention vs curative care
  - Eg; cost of alcohol & tobacco
Limited drugs available free of charge – history goes back many years

Constitution directed to provide basic health care services as free of cost

Nepal living standard survey 2011 data shows that drugs are the main drivers for out of pocket expenditure both for acute and chronic illness comparing with consultation and travel.

Free services started
- Emergency and in-patient (2006)
- Free OPD for all from low HDI district (2007)
- 40 medicines free (2009) and expanded to 70 (2014) in below 25 bed hospitals for all
National health insurance being planned
  - Covering the top up services not covered by basic health care services

Other social schemes: safe motherhood program, cash transfer, nutrition etc

Reviewed the current process of the Free Drug List and basic health care services by a workshop in Nepal on 2015. Findings are as below;
  - Needs for developing standard system of medicine classification
  - Refine drug list linking with disease category focus on basic
from the workshop, created a model for a revitalized FDL evaluation process involving four steps

- (1) nomination of medicines by the PHCRD during their quarterly review and pharmaceutical companies,
- (2) evidence generation lead by the NHRC,
- (3) decision making by a technical committee, and
- (4) implementation by the LMD, PHCRD, and NHEICC.

Once HTA capacity is developed in Nepal, it can be used for broader health programs with an eye towards achieving UHC for the country.
With the help of WHO,

- Focal person (senior Public Health Officer from Ministry of Health, Nepal) for HTA has been identified
- But, still not any agency has been identified for reporting HTA

For Medical Device procurement, distribution and management

- Logistic Management Division (LMD)
- Repair and Maintenance Section
Nepal has been facing many more inefficiency regarding drugs, equipment and facilities. (Around 50 pharmaceutical companies producing only 40% of domestic demands rest is importing)

- Frequent transfer and lacking competent personnel
- In-adaptable equipment delivered for the purpose originally planned
- Heavily centralized administration
- Quality of equipment is often not comply with international standards or quality is so poor that the equipment is often found to be out of order
- Low awareness of maintenance and repairing.
- Single procurement policy for all government procurement system
Thank you!