Political economy of health financing reforms towards UHC: Case of Nepal

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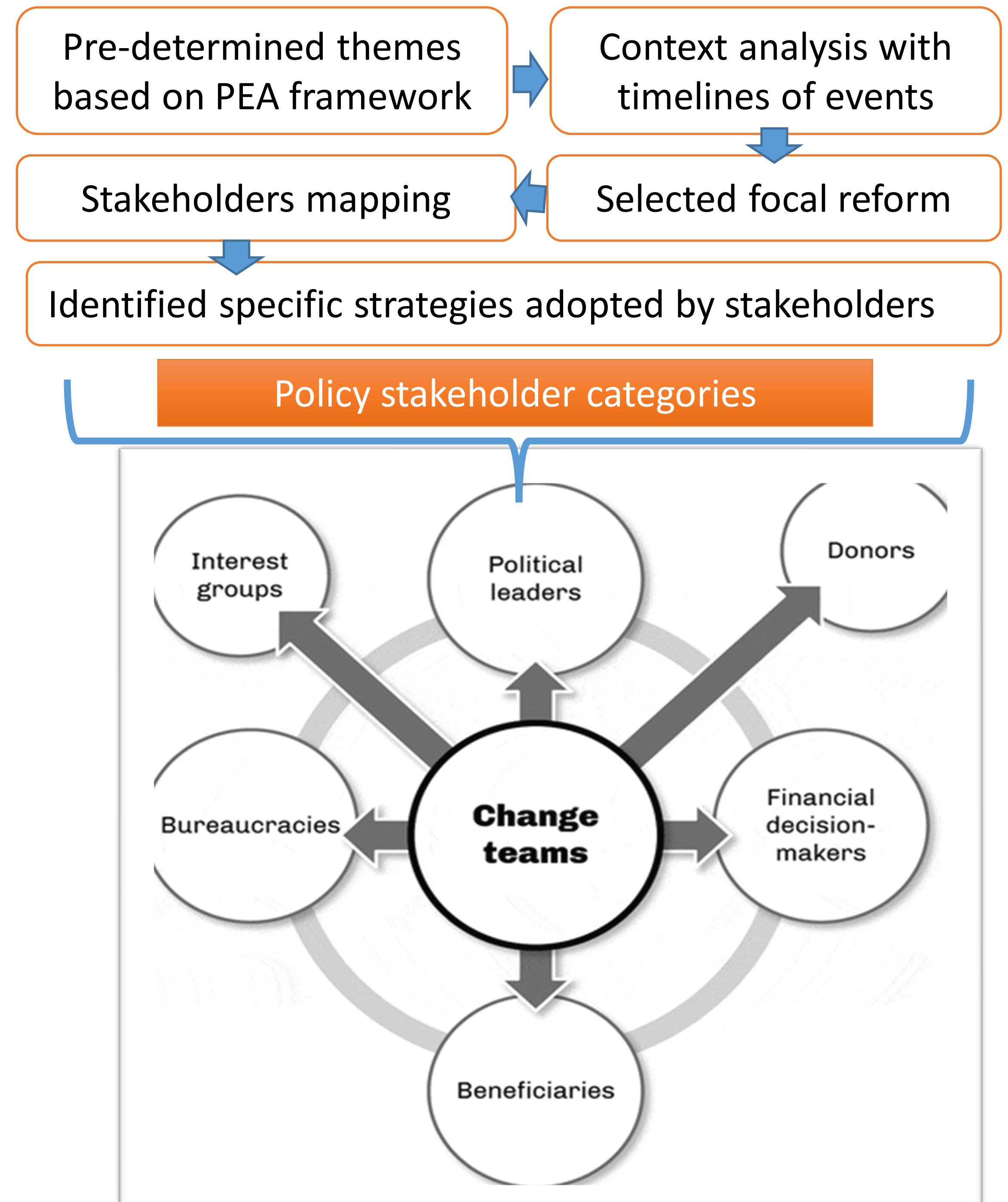
Objectives, methods and stakeholders

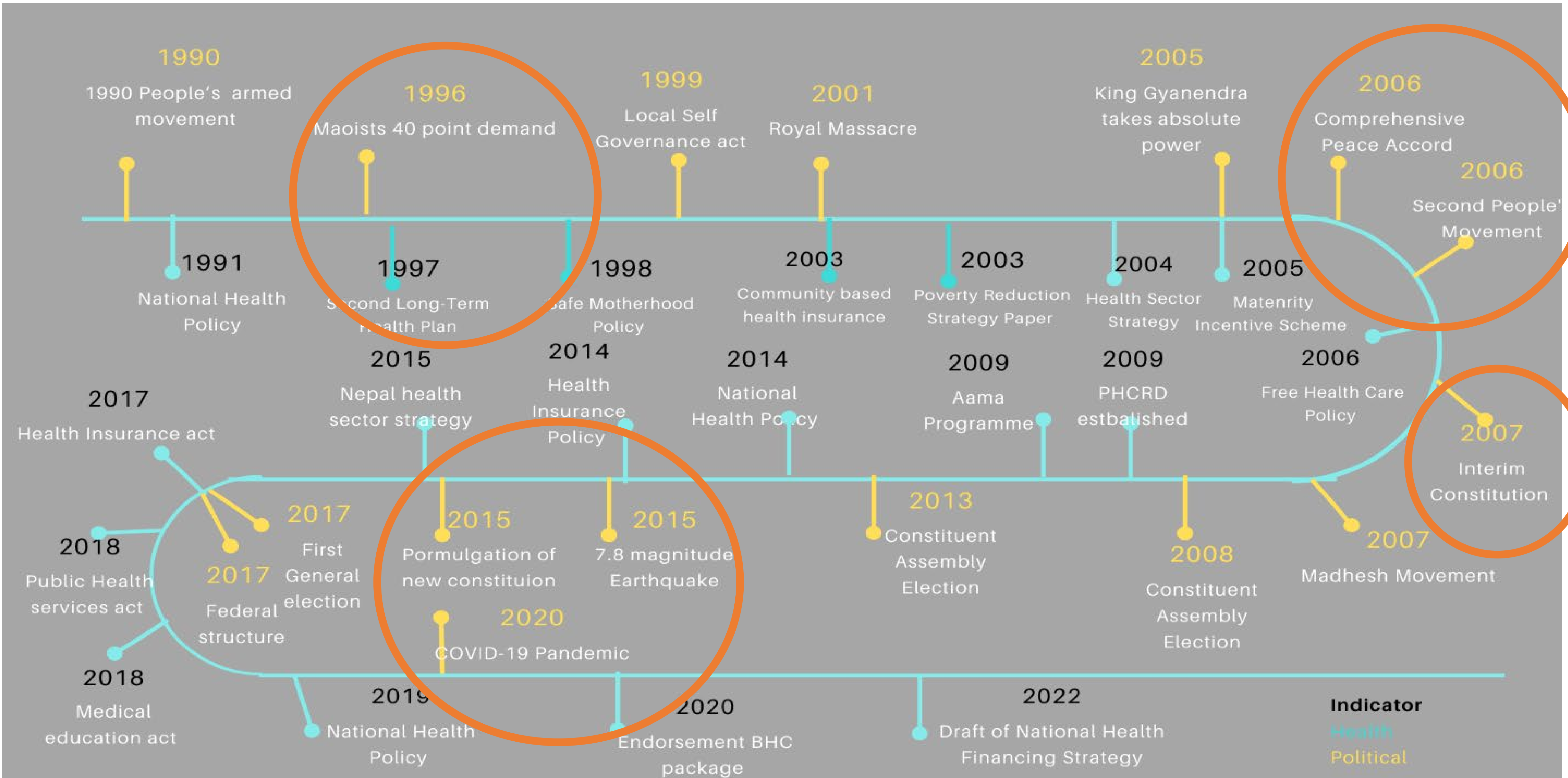
- **Aim**: retrospectively analyse the political economy with a focus on health financing reforms (mainly in time of crisis) over the past 2 decades
- Document review to summarise health financing and key contextual developments since 2000
- 12 key informant interviews, purposively selected for knowledge of reforms, interviewed March-April 2022



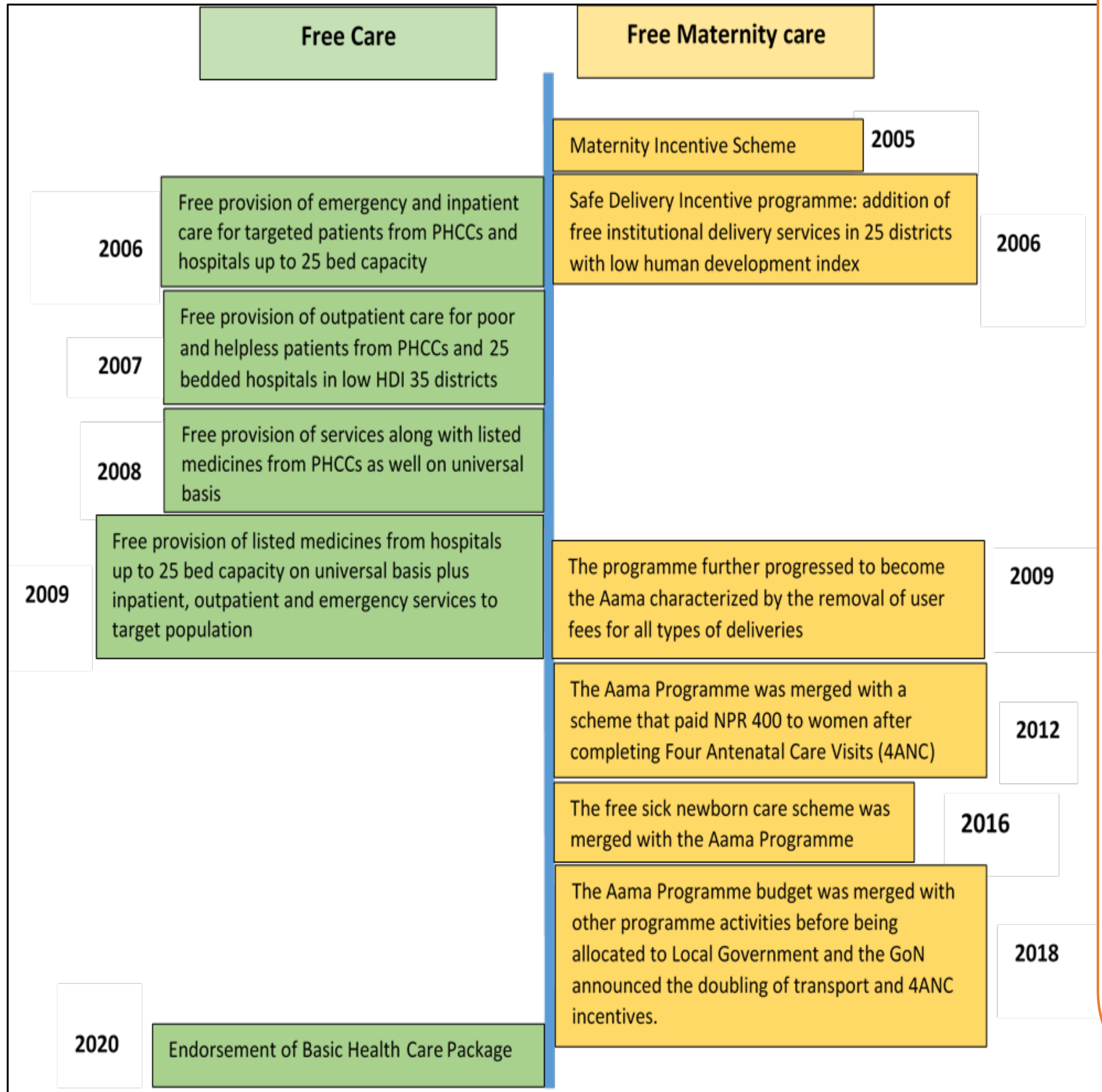
Economic and health financing context

- Per capita GDP, tax revenues and government expenditure have been growing; however Nepal's economy has become highly dependent on remittances - amounting to more than a quarter of the GDP
- COVID-19 has badly hit the economy and health systems – further increased vulnerabilities
- Health policy framed within an overarching goal of poverty reduction
- Nepal's spending in health has increased over the years, but remains low, reaching 53 USD per capita in 2019 (<1/3 of SEA average).
- Government health expenditure just 1.3% of GDP
- Out-of-pocket spending has been over 50% over almost all of the past two decades.
- Donor funding in health increased from 20.7% in 2002/3 to 50% in 2007/08, but decreased in later years
- Concerns remains high on good governance
- High migration, low employment rates
- Lowering fertility rate and a rapid demographic transition, with an ageing population

Nepal’s context – political transition and health systems reform



Focal reforms: Nepal



Safe Motherhood / Aama programme

- Reform was mainly driven by evidence and linked to MDG 5
- Initially focused on demand creation for institutional childbirth
- Initial donor funding with gradual uptake by domestic fund
- Gradual expansion nationwide
- Initially public providers/facilities only, later expanded to private sector
- Health facilities are reimbursed based on outputs (services they deliver to beneficiaries) on top of input-based budgeting
- Evolved as one of the flagship programmes of the MoHP
- This programme provides flexible funds to health facilities and hence contributed to autonomous management of health facilities and incentives to beneficiaries through conditional cash transfer

Free care services programme

- Mainly driven as a political agenda in the post-civil war context
- Started with free provision of listed essential medicines/services
- At the start, reform was basically a repackaging as most of the drugs of the free care were already provided for free.
- No explicit donor funding, but implementation support
- Later, categories of free drugs were expanded
- Service delivery is exclusively from the designed public facilities
- Health facilities are financed mainly through input-based budgeting
- Reform evolved as Basic Health Service Package (endorsed in 2020)- fundamental rights linked to constitutional provision
- Under the federal structure, local levels are mandated to provide services while financial resources are ensured through conditional grants from the federal level

Stakeholders: strategies and influence

Stakeholders category	Strategies used by 'change team', Nepal
Leadership politics	**Building a coalition:** Seized opportunity to deliver peace dividend in changed political context in favour of reform. **Evidence and information**: Used synthesized evidence to justify reform agenda
Bureaucratic politics	**Evidence and information**: Closely worked with supportive partners and technical assistance providers in generating evidence for reform. This was continued over time as the policy went through a series of iterations and expansions. **Enhancing the legitimacy of policy**: Advocated the leaderships as the strategy to achieve international commitment of MDGs and national goal of poverty reduction **Increasing organizational strength of supporters**: Led the discussion towards establishing the SWAp
Budget politics	**Increasing organizational strength of supporters** • Pool funding mechanism implemented, which allowed flexibility in the operationalization of donor fund • Donor made strong commitment to finance the initial phase of the implementation of the reform agenda.
External actors politics	**Evidence and information**: Evidence synthesis presented among EDP groups for consensus building • Mobilized technical assistance program to closely interact with government counterparts to get government buy in **Building a coalition and a consensus**: Mobilized global networks such as International health partnership, P4H **Persuade opponents to weaken their position, by adding desired goals or mechanisms**: Among pooled partners, supportive actors engaged actively to prevent opposition of non-supportive actors, by meeting some of their concerns in the policy implementation plan.
Beneficiary politics	**Encouraging participation, transparency and accountability**: Community empowerment and demand creation through mobilization of FCHVs, mother groups
Interest groups politics	**Evidence and information**: Evidence generation on supply side barriers and used evidence to advocate service strengthening. **Mobilize supporters in groups and communities**: Organizational empowerment of civil society **Encouraging participation, transparency and accountability**: Implementation of social audit, community hearing through engagement of civil society/NGOs to help promote accountability **Enhanced transparency and accountability** through citizen charter in public service provision **Coalition building**: Coalition of civil society organizations engaged with parliamentarians and political leaders to secure RH rights

Pre-requisites for reform effectiveness

- **Nepal has faced implementation challenges**, relating to lower levels of health system capacity, linked to its stage of development as well as the turmoil caused by federalisation.
- **Capacity enhancement measures: v**arious efforts were taken towards developing technical capacity on health financing and key reform areas - operational capacity of health sector was key to the successful outcome of the reform, which remained weak
- **Parallel and fragmented tracks of reform** suffered with operational challenges
- **Facilitation of policy dialogue -** Multiple forums were created to build consensus among the stakeholders towards streamlining the health financing reforms – a hard gain
- **Reform started from public facilities – expanded to the private sector under a partnership framework –** expanded service coverage but regulation and monitoring capacity of government was less intact

Key reflections and lessons

- **Timing of the reform:** fragile political scenario, poor health indicators - strong political drive complemented by partner coordination created a supportive environment for reform and its expansion
- **Strong evidence-base, igniting factor for the reform:** generation of evidence, their interpretation and engaging key actors with appropriate dissemination helped setting the scene for reform
- **Rights-based approach:** driving component to institutionalize the reform, advocacy from civil society and NGOs – their political linkages can add milage to reform
- **Partners coordination and aid harmonisation, supportive in shaping the reform:** shaping the reform with evidence generation, financial and technical support, setting conditions for good governance but not always on the same page – institutional objectives and attribution to reform
- **Twin track approach of the reform:** supply and demand side financing gradually expanded service coverage
- **Crisis and shocks: major turning points for the reform:** Nepal's health reform track shows strong linkages with crisis and shocks
- **Evolving agenda, changing actors –** needed a balanced approach in actor management
- **Stagnant share of out-of-pocket spending: indication of the shallow base of the reforms -** despite various social health protection schemes, the level of financial protection is relatively weak, challenging reform outcomes