Health Inequity in Nepal: Implications for Policy

Health Policy Research Unit
Institute of Economic Growth
Delhi

"Moving towards UHC in Nepal", 20-21 April 2014

Structure

- **Introduction**

- **Dimensions of Inequity in Health**
  - Outcome
  - Access
  - Utilization
  - -- Financing (Trend and pattern in OOP health spending)

- **A summary of findings**

- **Policy Implications**

Introduction – What is inequity in health ?

- Inequity defined as ‘differences [in health status], which are unnecessary and avoidable, but in addition, are considered unfair and unjust’ (WHO 2000)

- Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people’s access to, experiences of, and benefits from health care (WHO 2008)

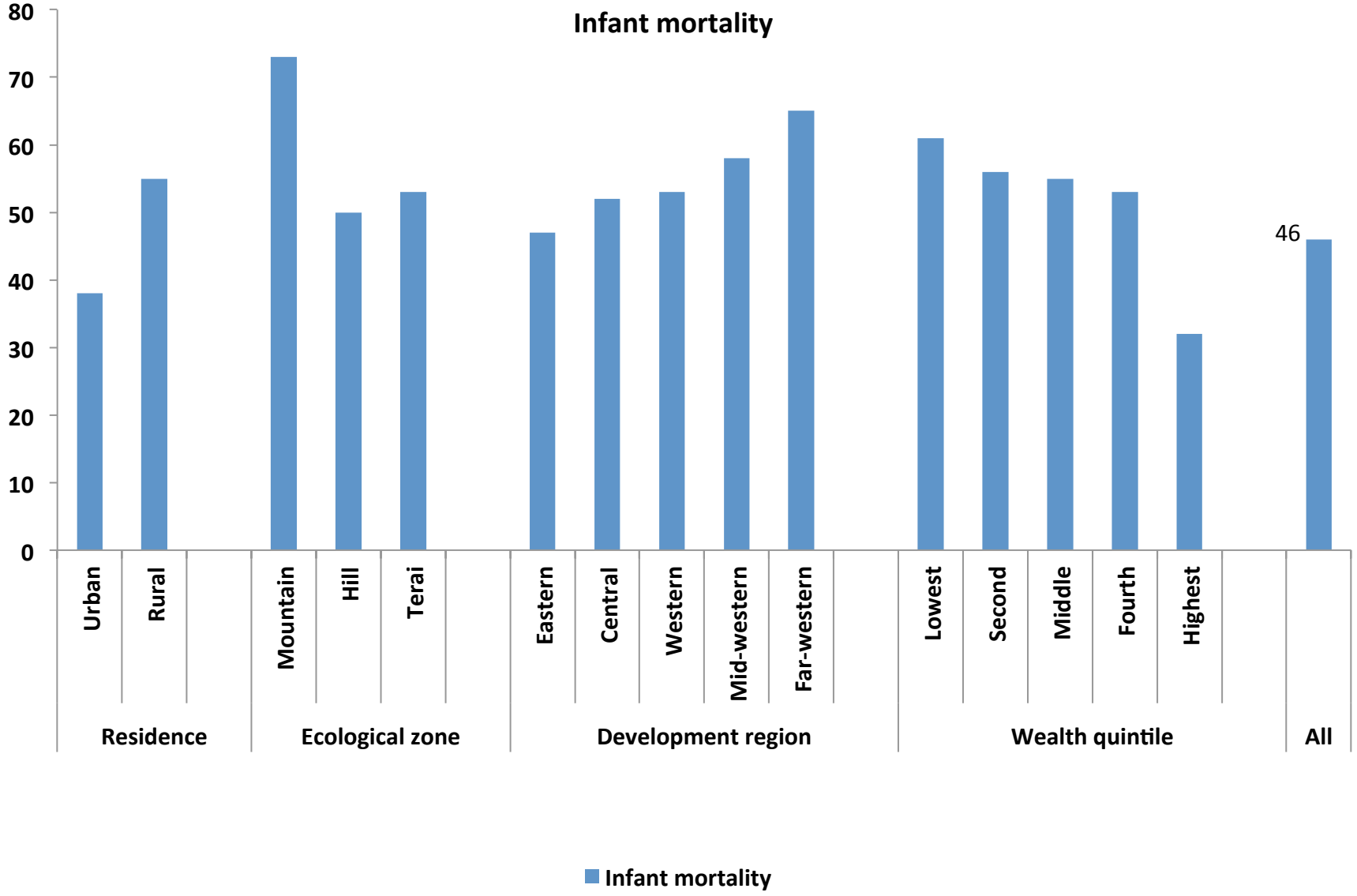
- Data presented according to social, demographic, economic or geographical factors can help to identify vulnerable populations and target health interventions

- Disaggregated data are useful to track progress on health goals, revealing differences between sub-groups that overall averages may mask (Health Equity Monitor, WHO)

Introduction -- Why health equity analysis could inform policymaking in UHC

- Health equity analysis would help in both the design and implementation of UHC
- UHC is implemented mainly to reduce health inequities in outcome, by impacting on inequities in access and financing
- Paying for health care from own resources remain an important source of burden on households which accentuates existing inequities (WHO 2010)
- Universal Health Coverage (UHC) a way forward in bringing down out-of-pocket (OOP) spending and addressing a significant source of inequity in financing and, therefore, in health outcomes
- The design of the specific package of essential health services (EHP) that would go into UHC would depend on
  - the disease burden and its distribution across various socioeconomic and geographic categories
  - where the gaps are in terms of availability and accessibility of services
  - which households are impacted the most from low financial protection and high OOPS

Inequity in Outcomes – Child Mortality



Source: Nepal Demographic and Health Survey, 2011

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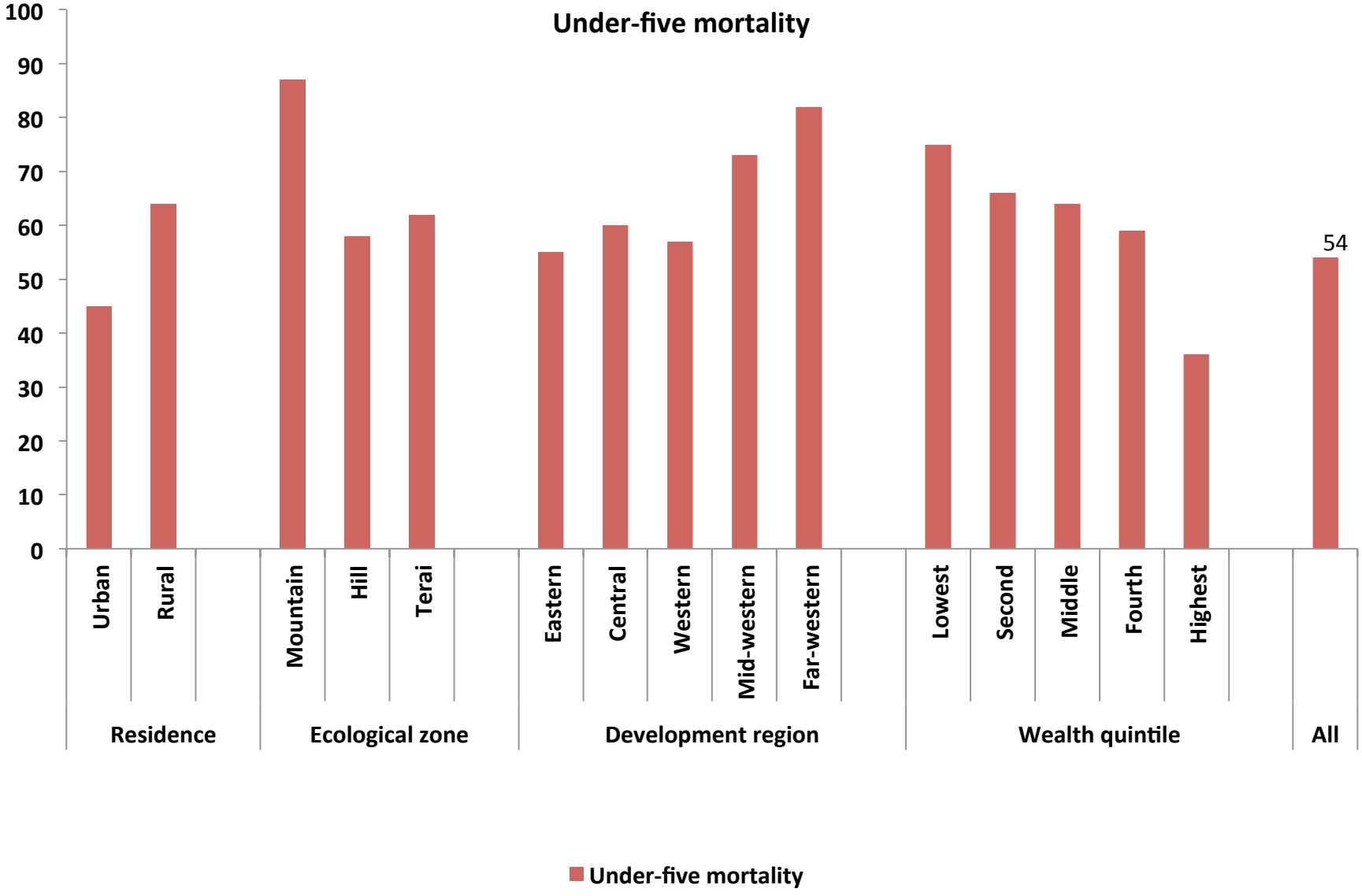

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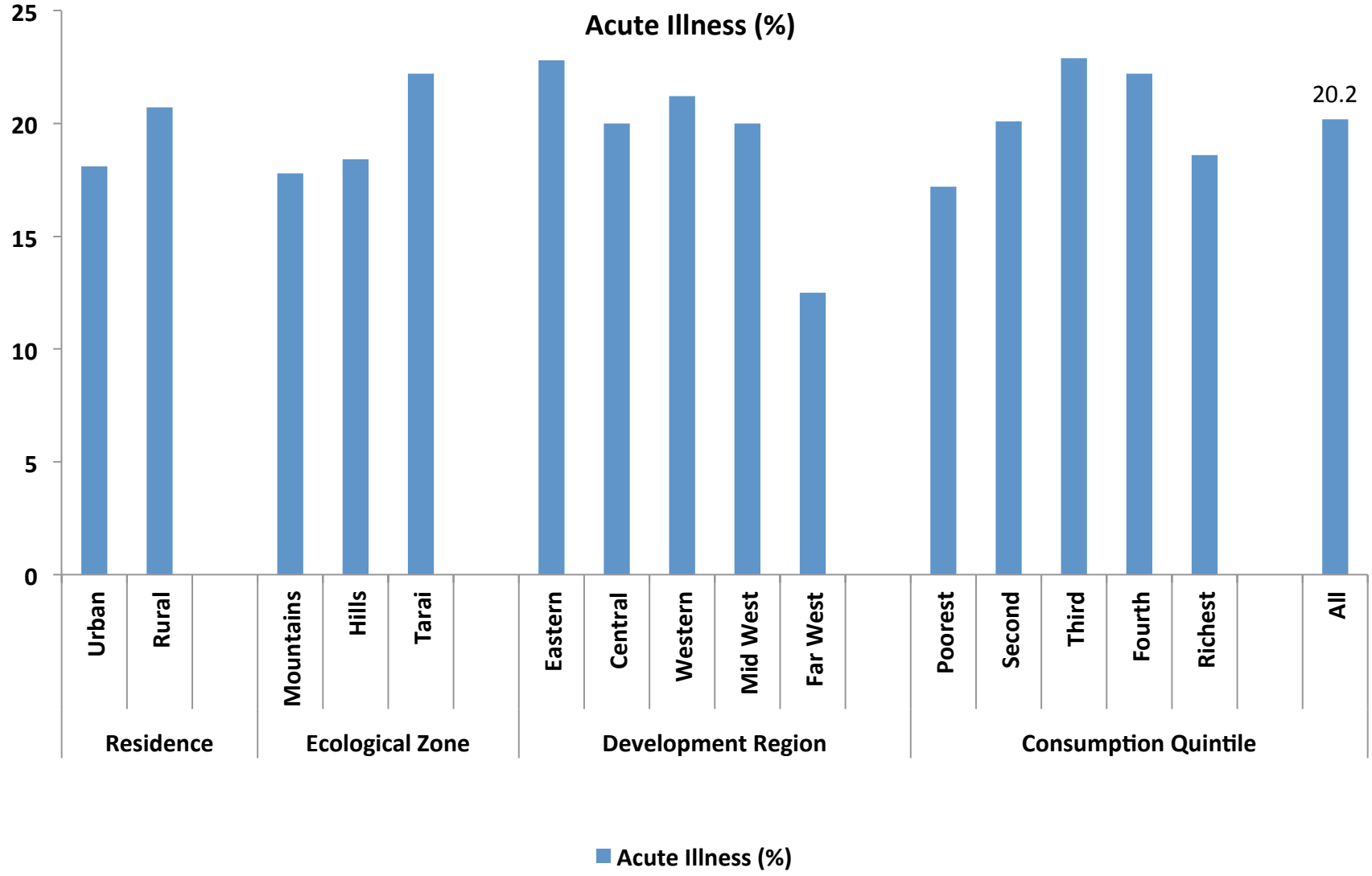
Inequity in Outcomes – Morbidity



Source: Nepal Living Standard Survey, 2010-11

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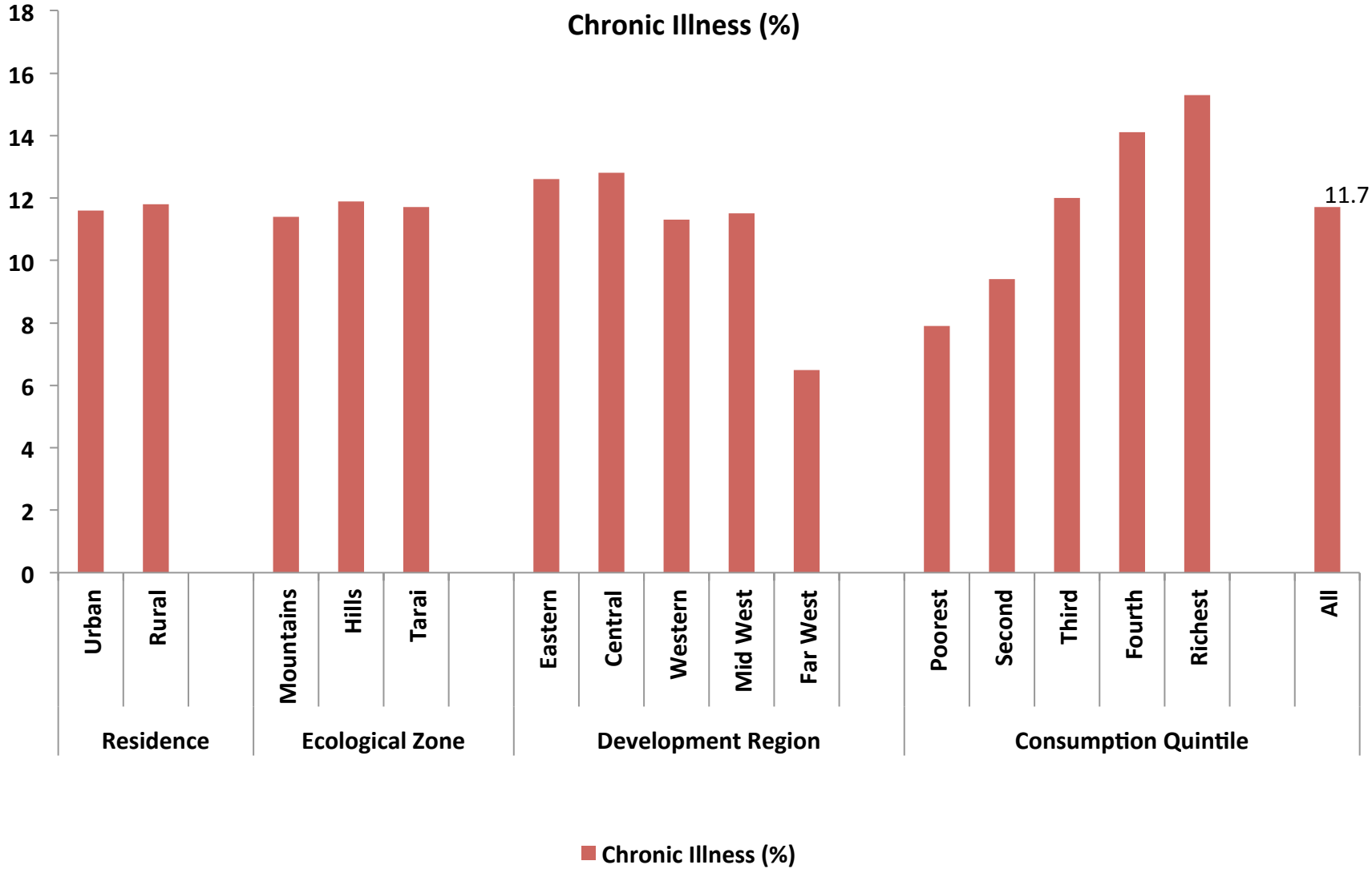
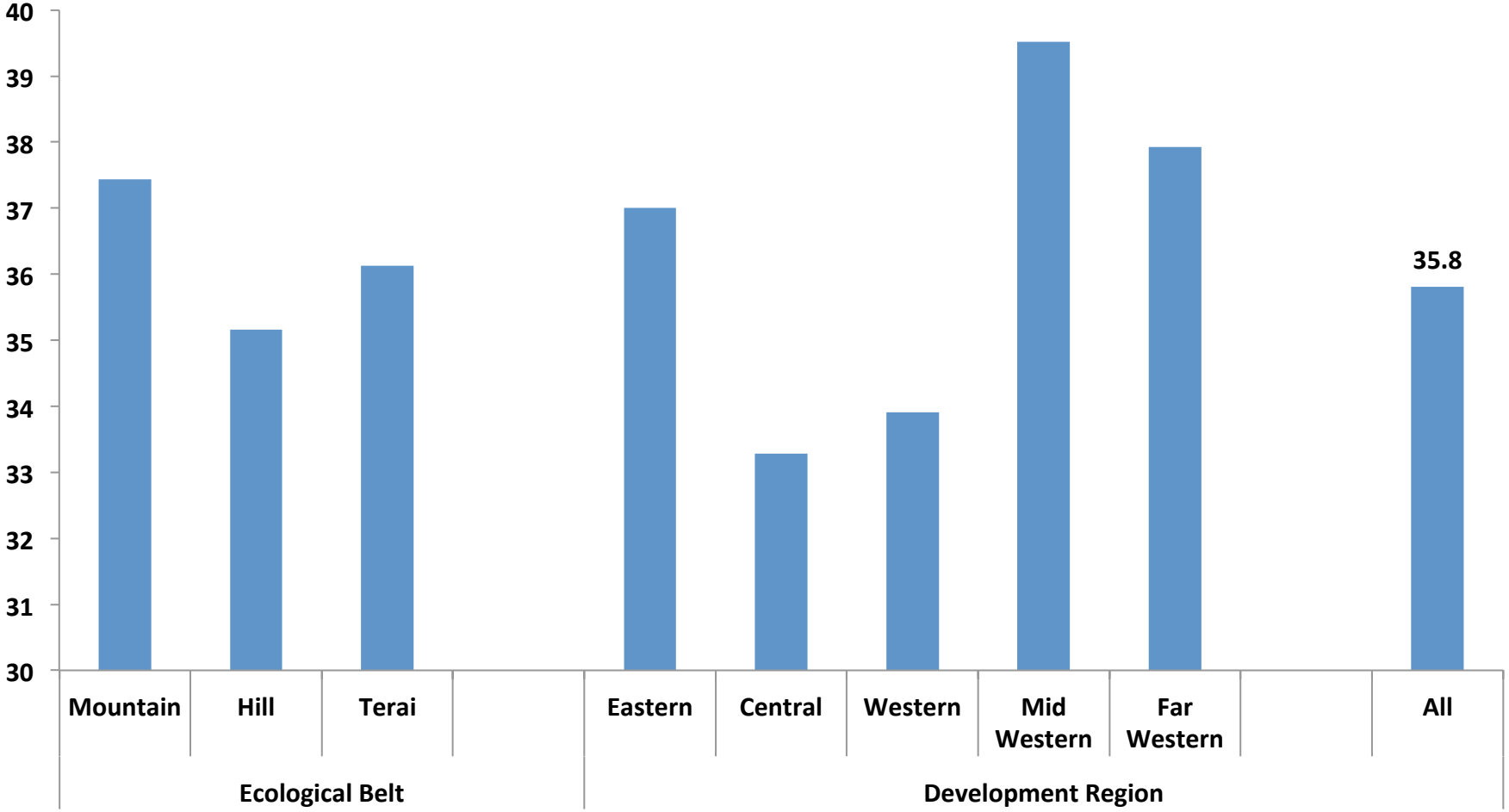


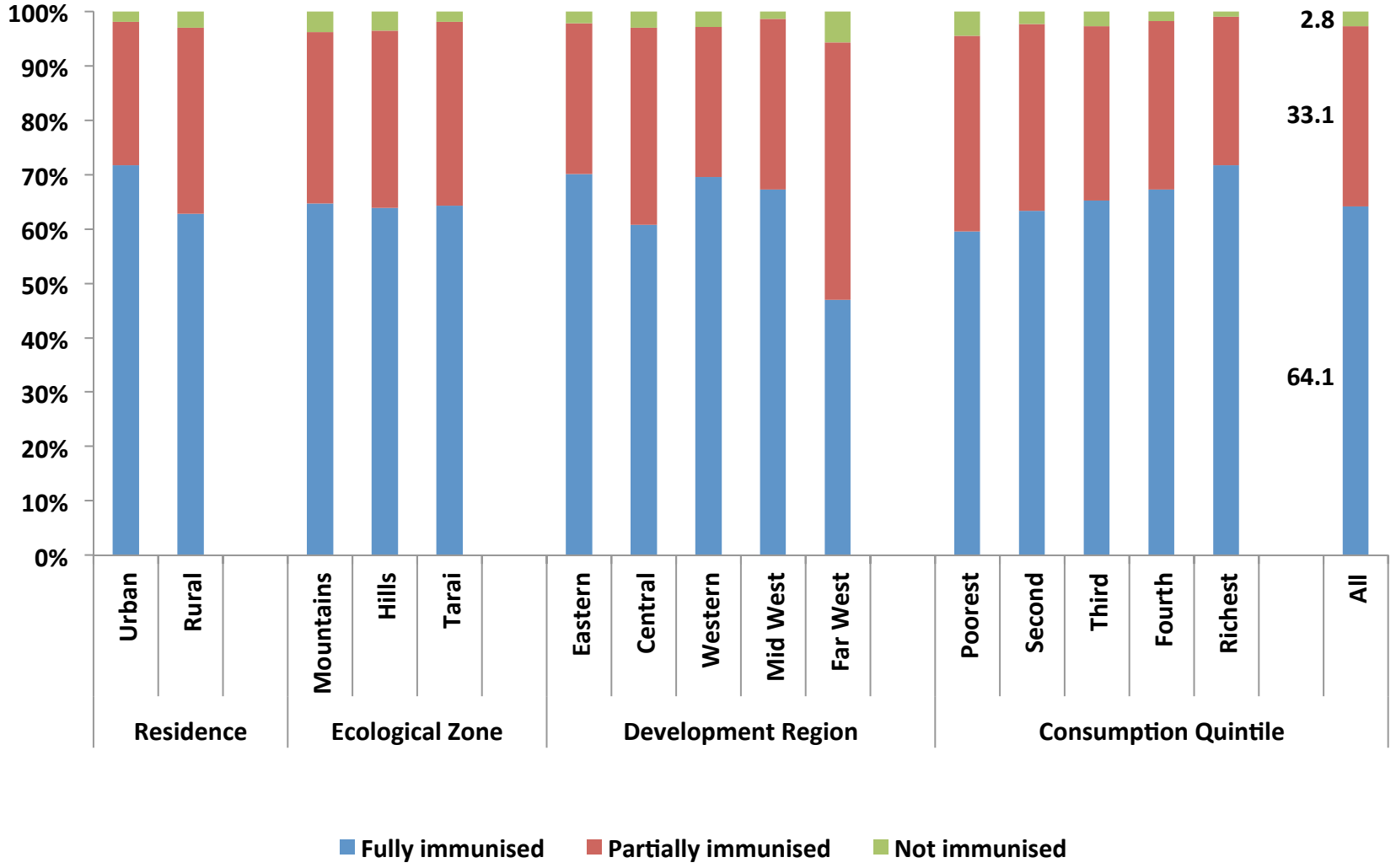
Source: Nepal Living Standard Survey, 2010-11

Inequity in Outcomes – Communicable Diseases (% of OPD visits)



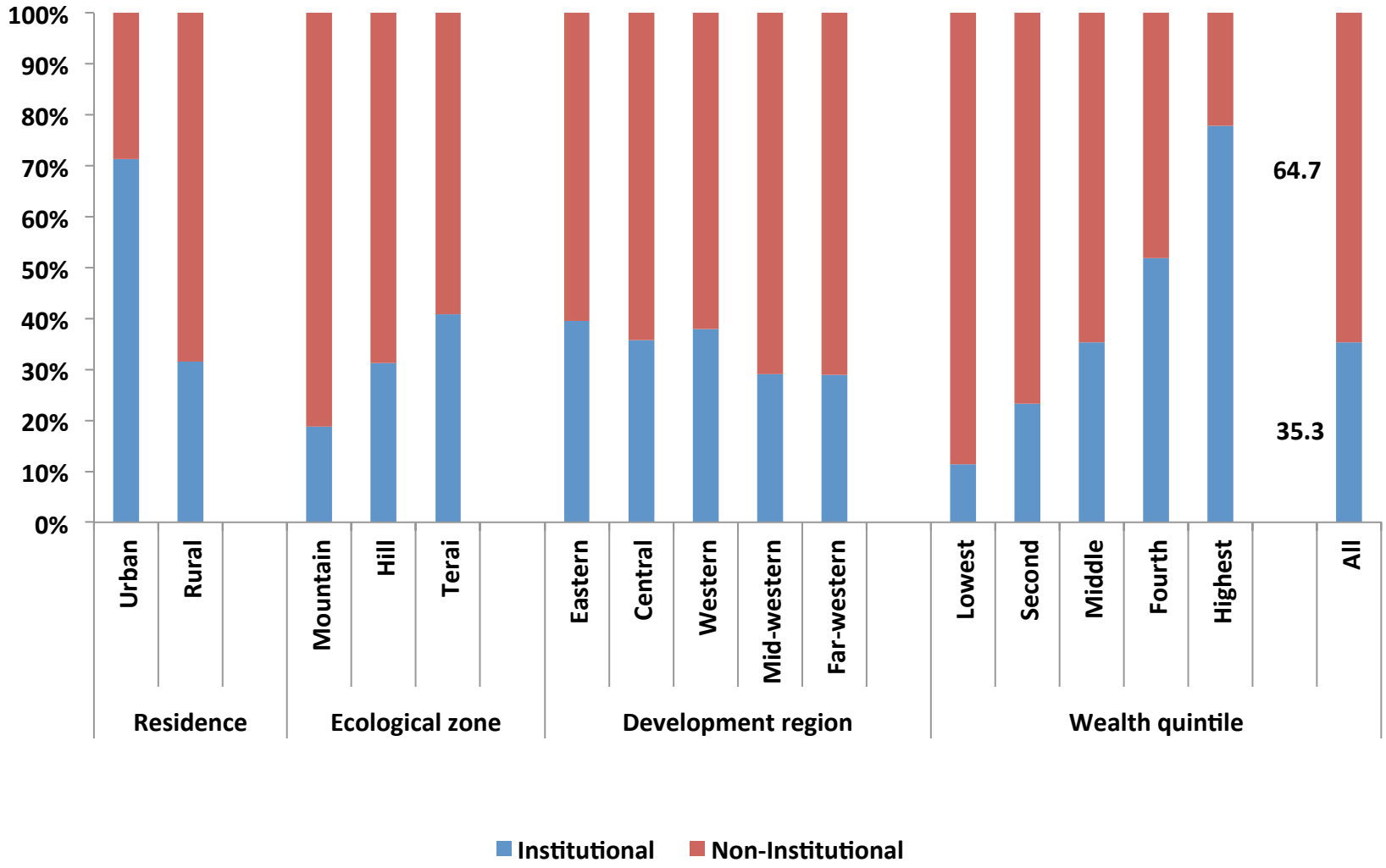
Source: Annual Report, Department of Health Services, 2010-11

Inequity in Outcome (Process) -- Immunisation



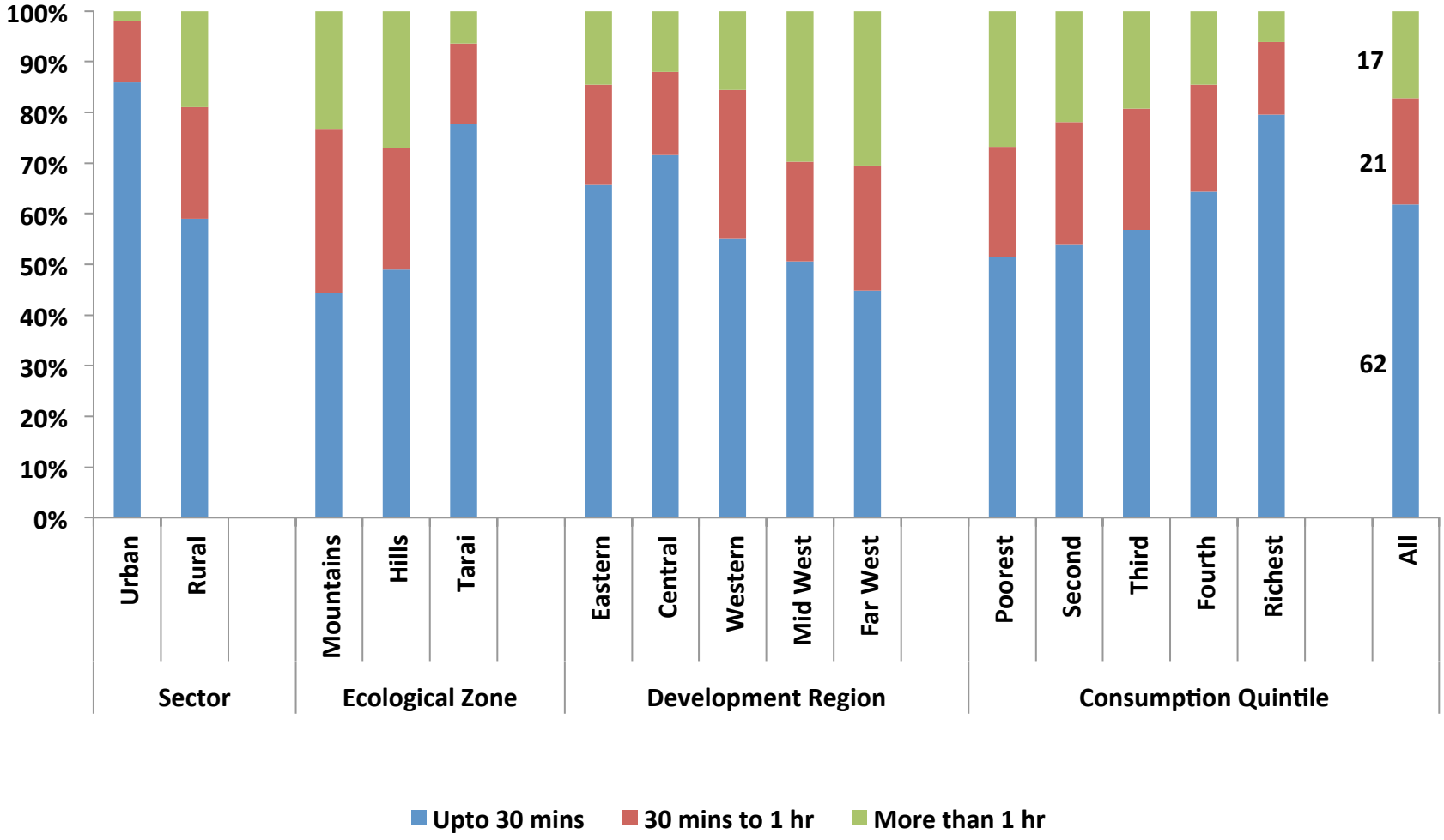
Source: Nepal Living Standard Survey, 2010-11

Inequity in Outcome (Process) – Institutional Delivery



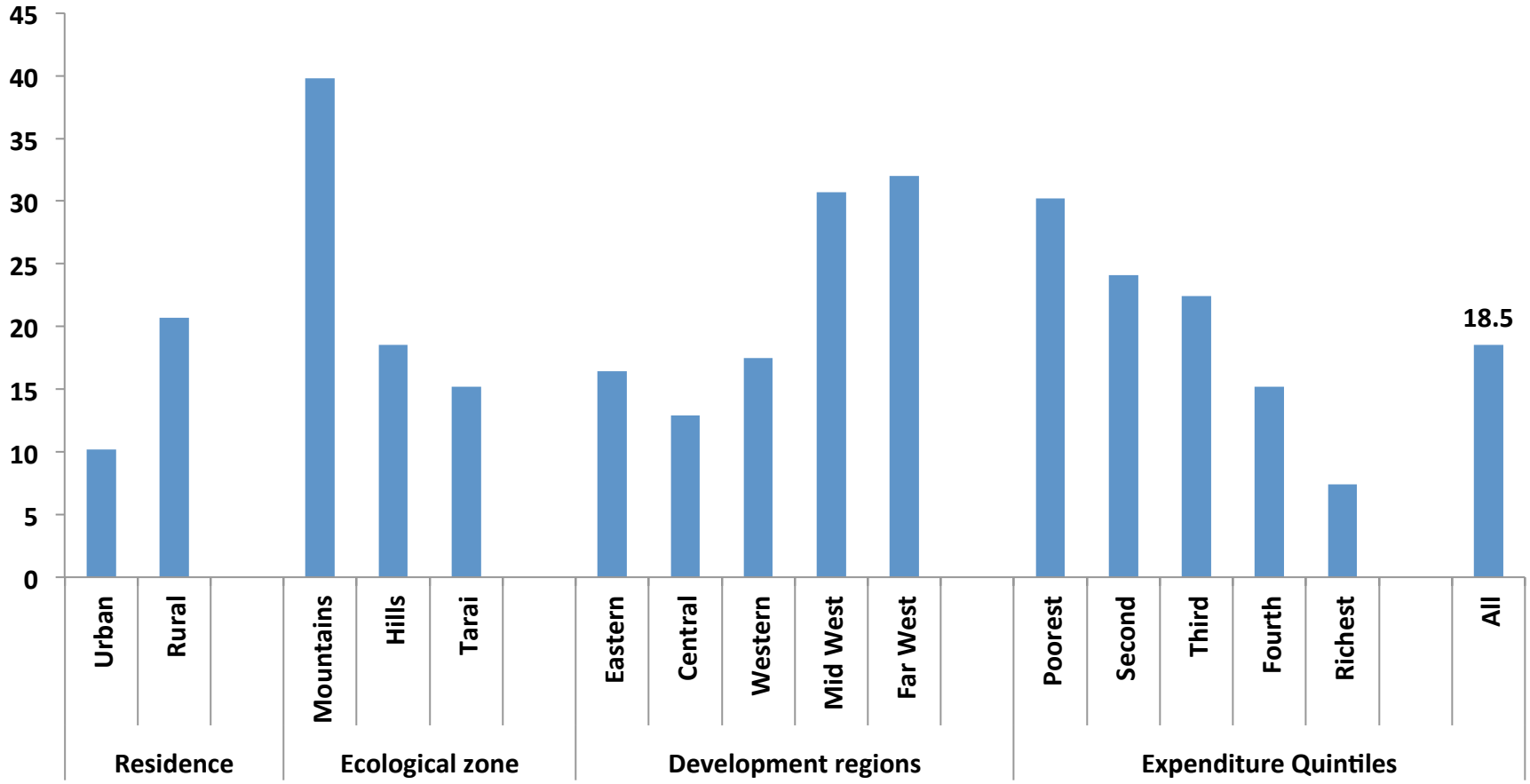
Source: Nepal Living Standard Survey, 2010-11

Inequity in Access/Utilisation – Time taken to reach nearest health post



Source: Nepal Living Standard Survey, 2010-11

Inequity in Access/Utilisation – Population (%) reporting less than adequate consumption of health care



Source: Nepal Living Standard Survey, 2010-11

Financing -- Data

- Nepal Living Standards Survey (NLSS) -- follow s the Living Standard Measurement Survey (LSMS) designed by the World Bank
- Covers rural and urban areas of the 75 districts of the country, grouped into three ecological belts and five development regions.
- Information on demography, housing, access to facilities, consumer expenditure, education and health
- Three rounds (1995-96, 2003-04 and 2010-11) of the NLSS so far -- reasonably comparable on information and schedule structure.

	NLSS-I	NLSS-III
Year	1995-96	2010-11
No of households surveyed	3373	5988

- The health section of the NLSS schedule comprises four parts: (1) chronic illnesses, (2) illnesses or injuries, (3) HIV/ AIDS knowledge and (4) immunizations.
- The first two parts contains information on, among others, the type of illness and the expenditure incurred on its treatment

Figure1: Ratio of Per Capita OOP Expenditure -- 2010-11 to 1995-96

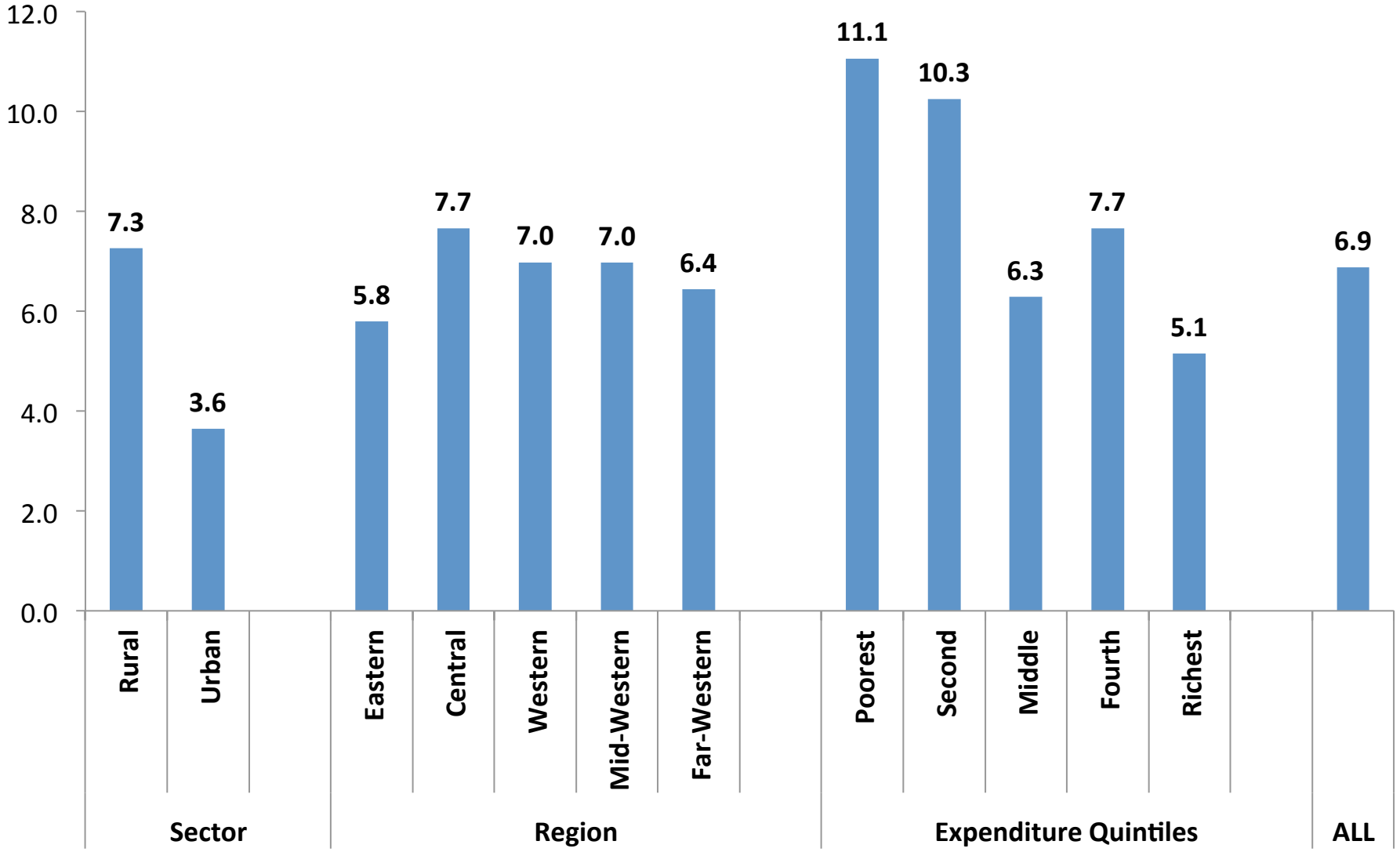


Figure 2: Share of OOP health expenditure in total consumption expenditure of households

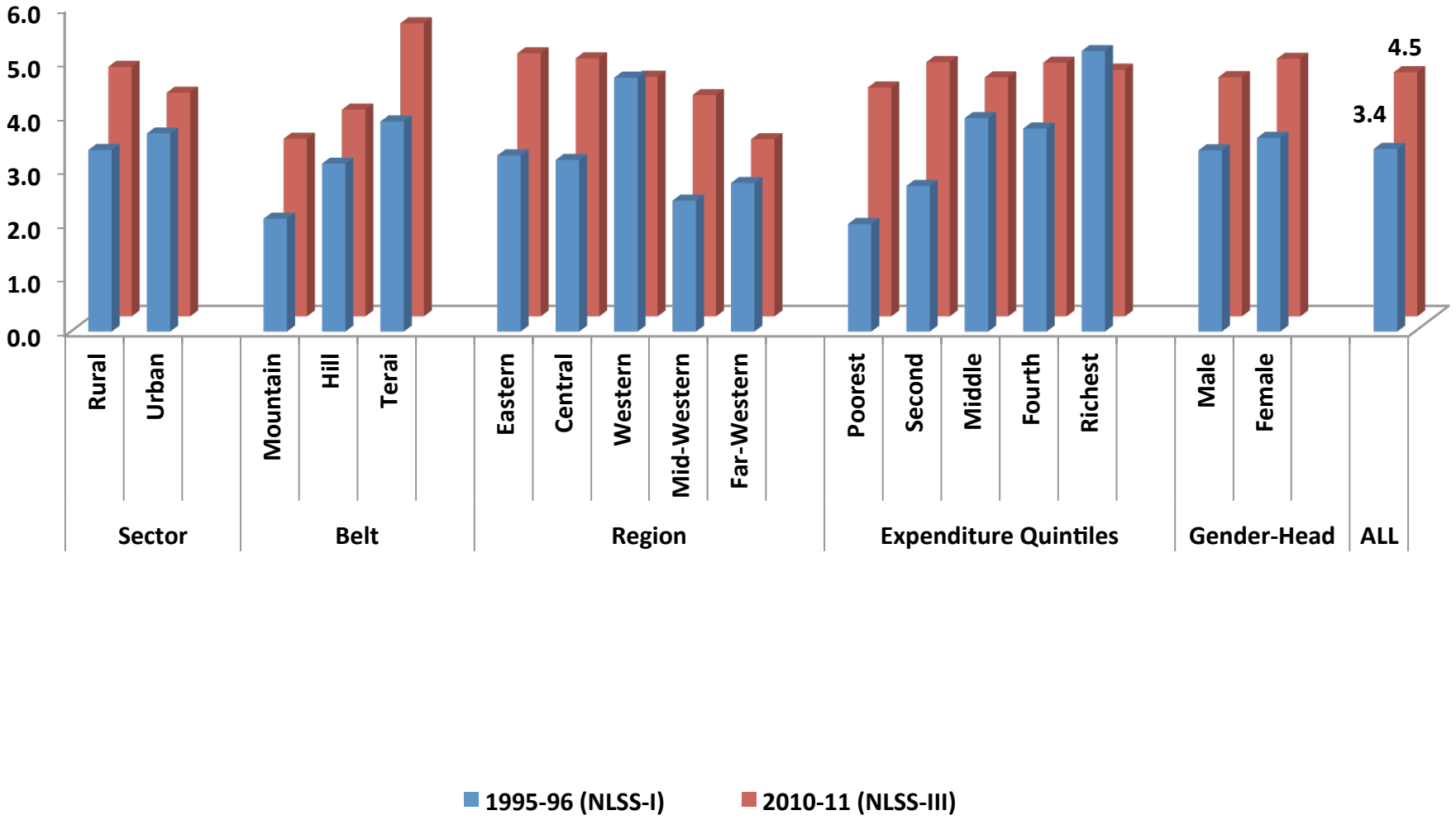
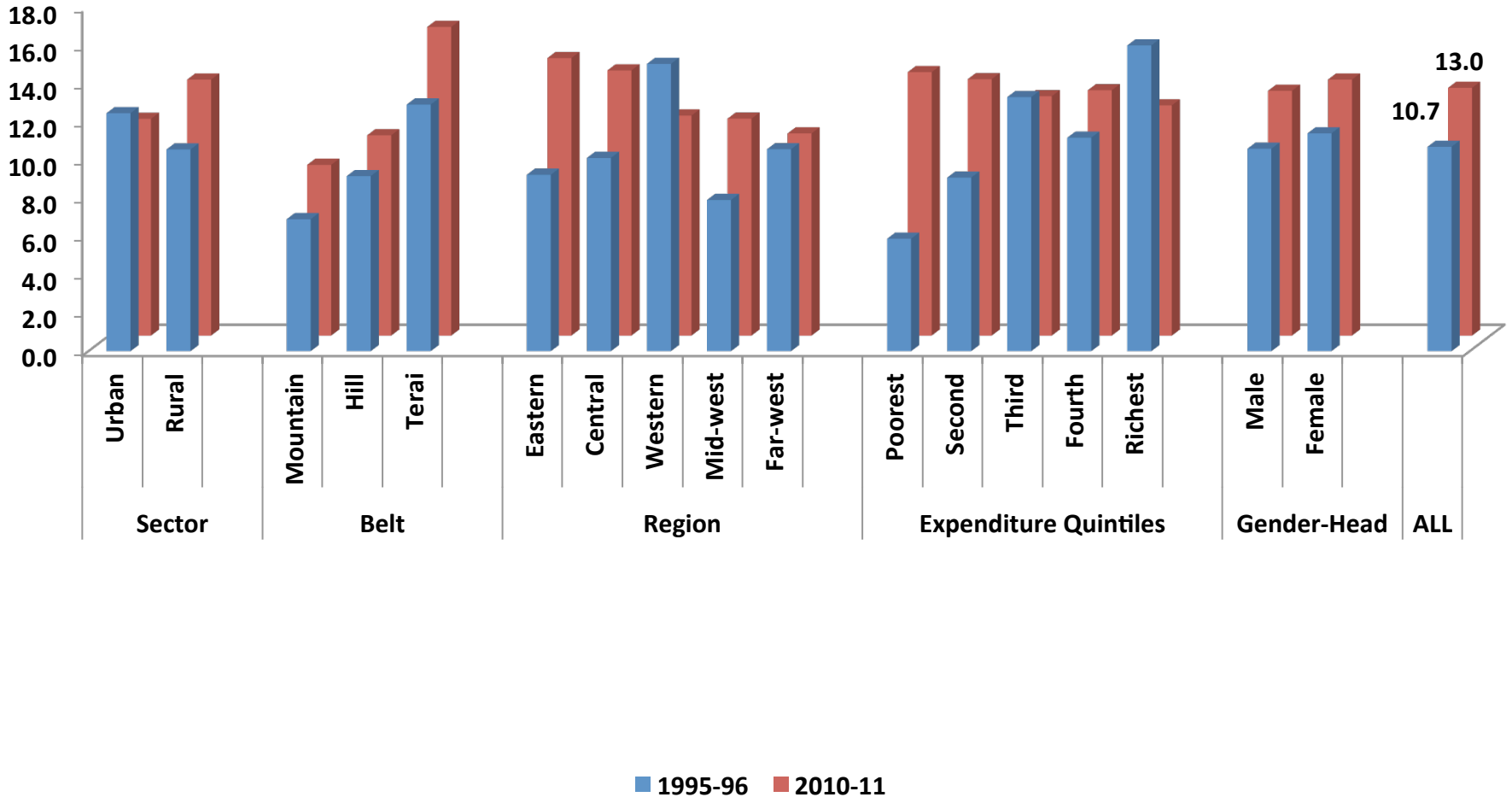
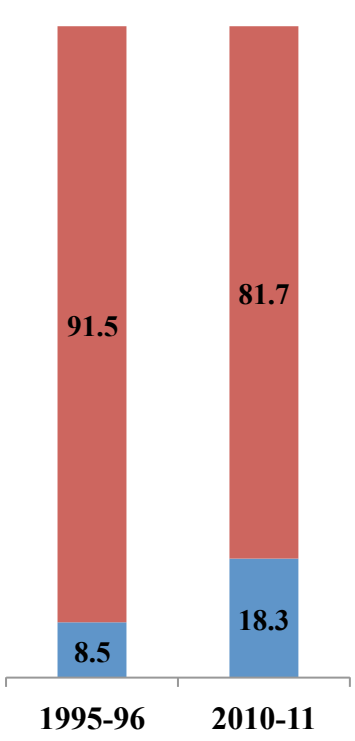
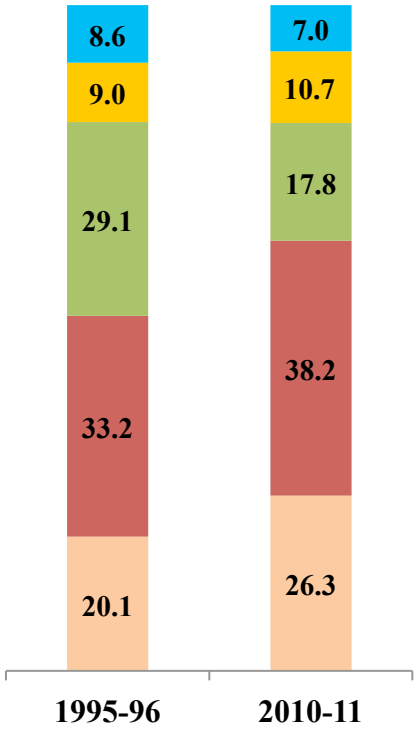


Figure 4: Households spending more than 10% of total consumption expenditure on health (%)



Distribution of households facing catastrophic expenses





To Summarize……

Dimensions	Residence		Ecological Zone		Development Region		Wealth/Expenditure Quintiles	
Indicators	Worst	Best	Worst	Best	Worst	Best	Worst	Best
Infant Mortality Rate	Rural	Urban	Mountain	Hill	Far-western	East	Poorest	Richest
Under 5 Mortality Rate	Rural	Urban	Mountain	Hill	Far-western	East	Poorest	Richest
Communicable Diseases			Mountain	Hill	Mid-western	Central		
Children not Immunized	Rural	Urban	Mountain	Terai	Far-western	Mid-west	Poorest	Richest
Institutional Deliveries	Rural	Urban	Mountain	Terai	Far-western	East	Poorest	Richest
Time taken to reach nearest Health Post	Rural	Urban	Mountain	Terai	Far-western	Central	Poorest	Richest
Adequacy in consumption of health care	Rural	Urban	Mountain	Terai	Far-western	Central	Poorest	Richest
Catastrophic Spending, 2010-11	Rural	Urban	Terai	Mountain	Eastern	Far-western	Poorest	Richest
Increase in Catastrophic spending between 1995-96 and 2010-11	Rural	Urban	Terai	Hill	Eastern	Western	Poorest	Richest

Policy Issues

- Inequality exists in access, utilization, financing and finally outcome

- Coverage -- Universal or targeted ?
  - -- Targeted – Mountain, Far-western, Rural, Poorest (RSBY)
  - -- Universal – Demand side issues, health infrastructure in hitherto uncovered areas

- Provider – public, private, both ?
  - -- Difference in the quantity and quality of private providers in say the Mountains and Terai
  - -- Private provider in the mountains and private provider in the terai……..are they of same quality ?

- Financial catastrophe more prevalent in Terai but the zone performs well in outcome (process) indicators

- Far-western region performs badly in all outome and access indicators but does well in financing

- So is there a wealth gradient or is it a reflection of quality of health services ?

Policy Issues

- Our ultimate objective should be to address inequity in outcomes
- That's because we are discussion "HEALTH"
- Access and utilization therefore becomes the next two important dimensions.
- Even after acknowledging the fact that financing can itself act as a barrier to access, financial hardships can also be addressed through other policy measures – income, employment, regional disparity, planning etc
- It can be about enhancing the denominator !!!!!

Policy Issues

- Any health insurance initiative must deliberate on these issues
- Important therefore is to have the coverage and quality aspect inbuilt from the very outset of an insurance programme (the case of quality in primary education in India-SSA-universal primary education)
- We should look at coverage also from the angle of availability of health services/infrastructure (e.g. health services in the mountains vis-à-vis the terai) and not only the population covered.
- Otherwise there is a danger of insurance remaining unutilized in certain pockets and overutilised in some !!!
- Inequities in outcme would therefore prevail……

Need of the immediate future

- Analysis of disease burden by ecological zones, development region, consumption expenditure quintiles
- Baseline survey to assess demand and supply side issues
- Monitoring mechanism