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A Critical Review of National Health Policy-1991

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FOREWORD

It's not every day you sit down to write a critical review though most of the leisure time conscientiously people often would be evaluating the way of things going-in; here, to be politically correct, they will be often revolving their discussions around policies. It is here that I have attempted to put most of the arguments from infantile to senescence; a plausible and more satisfying sanctities experiences with germane evidences.

Despite the popular trends in the academia in relation to critical review, I have rather chosen a self made way for reviewing the national Health Policy-1991 as HOW, WHEN WHAT.

I expect this report to prove a more valuable addition to the archival knowledge of the readers, due to the scarce nature of publication of this kind in the field.

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CHAPTER I

1. Introduction

1.1. Background

The harsh truth is that if the policy isn't hurting, it isn't working.
John Major (1943 -)

British prime minister.
Referring to his government's determination to counter inflation with high interest rates. Speech, Northampton

A statement of a decision regarding a goal in health care and a plan for achieving that goal; for example, to prevent an epidemic, a program for inoculating a population is developed and implemented. n 2. a field of study and practice in which the priorities and values underlying health resource allocation are determined (*Answers.com*).

Policies are typically promulgated through official written documents. Such documents have standard formats that are particular to the organization issuing the policy. While such formats differ in terms of their form, policy documents usually contain certain standard components including:

- A **purpose statement**, outlining why the organization is issuing the policy and what is desired effect.
- **Applicability and Scope** statement, describing who the policy affects and which actions are impacted by the policy.
- And **effective date** which indicates when the policy comes into force.
- A **responsibilities** section, including which parties and organizations are responsible for carrying out individual policy statements.
- **Policy statements** indicating the specific regulations, requirements or modifications to organizational behavior that the policy is creating.

This paper here attempts to critically evaluate the health policy of 1991 in relation to answering the basic questions like How, When, What of National Health Policy.

1.2. Statement of problem

Policy guideline and policy statement are in conflict which is to follow, as policy guideline is such stated that NHP-1991 shall be overridden.

Targets set forth by NHP by the year 2000 have already been met and it provides no ground for further use of policy.

Health-care facilities, hygiene, nutrition, and sanitation generally are poor and beyond the means of most, particularly in rural areas. Provision of health services is constrained by low government spending, rugged terrain, and lack of health education (which lowers the demand for health services). Most hospitals are located in urban areas, and rural health facilities often lack adequate funding, trained staff, and medicines. Thus, health clinics and hospitals generally are used only for persistent and serious illnesses. The government has tried decentralizing health services to villages, but the program has not provided notable public health improvements. In 2003 Nepal had 10 health centers, 83 hospitals, 700 health posts, and 3,158 "sub-health posts," which serve villages. In addition, there were 1,259 physicians, or one physician for every 18,400 persons. In 2000 government funding for health matters was approximately US$2.30 per person, and approximately 70 percent of health expenditures came from out-of-pocket contributions. Government allocations for health were around 5.1 percent of the budget for fiscal year 2004, and foreign donors provided around 30 percent of the total budget for health expenditures. (*Policy Project, 2006*)

1.3. Purpose of the study

1.3.1. General Objective

To critically review the National Health Policy-1991 of Nepal providing plausible arguments, evidence.

1.3.2. Specific Objective

- ✓ To determine "Hows" of Nation Health Policy-1991.
- ✓ To determine "Whens" of National Health Policy-1991.
- ✓ To determine "Whats" of National Health Policy-1991.
- ✓ To conduct Critical analysis of the National Health Policy-1991.

1.4. Literature review

Targets of the Three Year Interim Health Plan

S.N	Health Indicators	Situation up to 2006	Target till 2010
1	Access to Essential Health Care Service (%)	78.83**	90.0
2	Availability of Essential drugs in Health Institution (%)	93.3**	95.0
3	Women making 4 antenatal care visit (%)	29.4*	40.0
4	15-49 age group women receiving TT injection	63.0*	75.0
5	Delivery from health worker (%)	19.0*	35.0
6	Current user of Contraceptive (%)	44.2*	53.0
7	Use of Condom (14-35 years) (%)	77.0*	85.0
8	Total Fertility Rate (15-49 year women) (%)	3.1*	3.0
9	Neonatal Mortality Rate(Per 1000 live birth)	33.0**	31.0
10	Infant Mortality Rate(Per 1000 live birth)	48.0*	44.0
11	Maternal Mortality Rate (per 100000 live birth)	281.0*	270.0
12	Child Mortality Rate (Under-five) (per 1,000 live birth)	61.0*	55.0
12	Knowledge of Women (15-49) on ways to avoid AIDS (%)	65.0*	75.0

*** DHS/MoHP*
** NDHS. 2006*

Source: IHP+, 2008

NHSP Targets and Achievements

Indicators	Targets 2006	Targets 2009	Achievements (Demographic and Health Survey, 2006)
Maternal mortality ratio	325	300	280/100,000 live births
Child mortality rate	70	65	61/1000 live births
Infant mortality rate	50	45	48/live births
Total fertility rate	3.8	3.5	3.1/women
Contraceptive prevalence rate	43%	50%	44% modern method 48% any method
Skilled birth attendance	22%	35%	22.45 -HMIS
Child Immunization-DPT3	78%	85%	85%
HIV knowledge		75% women 85% men	58% women 82% men

Source: IHP+, 2008

Funding gap

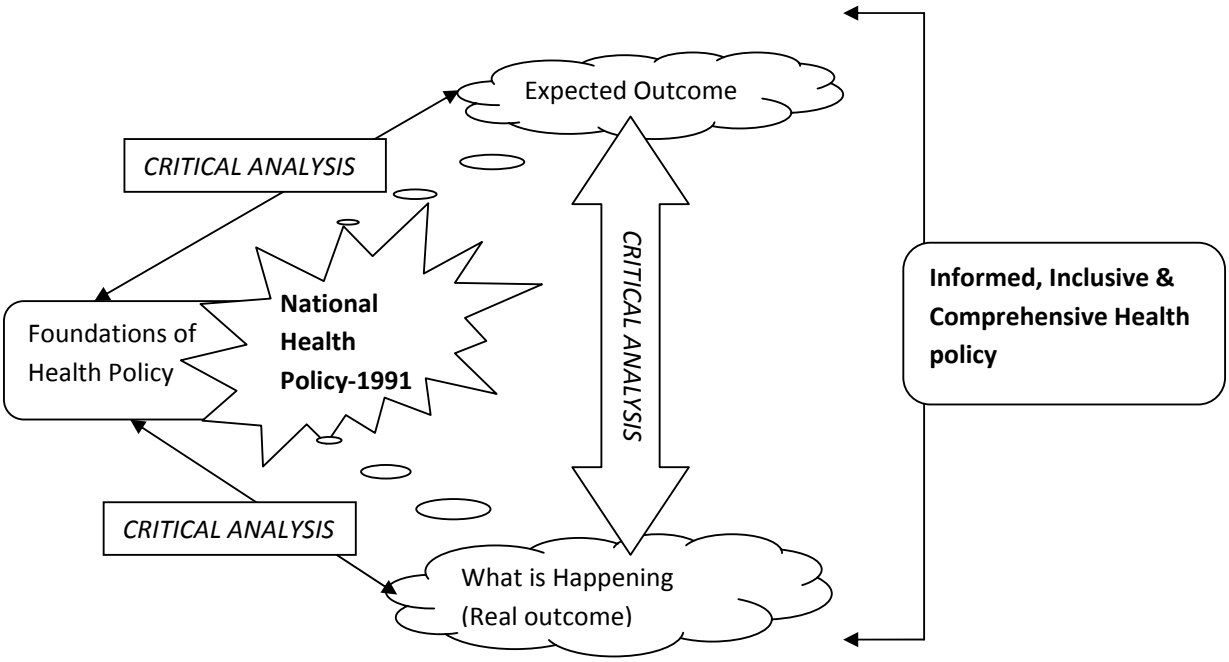
	2007/08	2008/09	2009/10
Total budget requirement	**12102420.2**	**18510985.0**	**21650967.7**
USD	189100.3	289234.1	338296.4
Total commitment	**10283795.6**	**14253458.2**	**16238225.8**
USD	160684.3	222710.3	253722.3
Gap	**1818624.6**	**4257526.8**	**5412741.9**
USD	28416.0	66523.9	84574.1
Gap %	***15.0***	***23.0***	***25.0***

Source: IHP+, 2008

CHAPTER II

2. Methodology

2.1. Conceptual framework



2.2. Study area

National Health Policy-1991 and limited supplementary policies including policy guidelines.

2.3. Study design

The study was Analytical in design.

2.4. Data collection techniques

Review of Various published critique on health policy of Nepal, lecture notes of Mr. Pradeep Pyakurel, discussion with HOD Mr. Ram Chandra Sinha.

2.5. Data collection process

Analytical evaluation of the published article in reference to National health policy of Nepal.

2.6. Data processing and analysis

Data were critically analyzed and evaluated in words.

2.7. Ethical consideration

The authors of this paper have tried to maintain a level of aptitude in healthy criticism, whereas in sections, sentences may appear too critical or too harsh for the reader on such case we request you not to take it personally or feel offended by the words so used.

2.9. Limitations

The main limitation of the study is: lack of adequate critical article concerning National Health Policy, might have affected content of the paper.

CHAPTER III

3. Result & Discussions

What a Great news, Nepal is one of the countries in the world to met MDGs in time or perhaps even before time (2015)! Take a look at the NDHS 2006, IMR and U5MR, from 64 and 91 per 1000 live births in 2001 to 48 and 61 per thousand live births respectively in 2006. The Maternal Mortality Rate has also come down to 281 per 10000 live births from 539 per 100000 live births in 1996.

People live longer than they did 15 years ago; now people have options in health care. Technologies are increasingly becoming precise & simple. Private sector especially in health has shown remarkable endeavour in years. Government services are more people oriented, than they were.

A chain of Universities and affiliate colleges are offering health related courses to the students leading to production of adequate human resources for health. Proactive Public health systems are now scrutinized even in large scale to get more promising progress.

The public health work force consists of about 28,000 persons distributed across the country, though problems in adequately staffing remote posts persist. A unique feature of Nepal's public health system is that at the community level, in addition to the health workers, there is a strong force of about 50,000 Female Volunteer Health Workers who are providing a number of basic services, and are particularly active in preventive health services. Their role expanding access to basic maternal and child health is considered especially vital.

Health budget is increasing every fiscal year. Donors are happy and thus are keeping the flow of money seamless and share of donations and numbers of donors are increasing every year. Political commitments are reflected in the Interim constitution of Nepal, free essential health care services have been put as fundamental right. Long term health plans, human resource strategic plans and of all the astonishing LSGA which builds on theory of decentralization simply makes any development partner go envy, what a beauty!

And, of course not to mention “The free obstetrics service” to the people of Republic Nepal, Nepalese women couldn’t ask for more. Not to mention the free EHCS. With PHC approach to health sector, a ravishingly new District Health System all the thanks & Glory goes to the National Health Policy-1991.

More people attend health facilities than they did before 15 years back. Lately but largely government is positive towards recognizing health of the people as fundamental right to be ensured by the state.

But that is not all the purpose of this paper, we are here not only to deal with gains in health sector but critically analyze the health policy-1991. Though afore mentioned gains are crucial and may appear impractical for any resource constraint and conflict afflicted country but that is not the point; the point here is how the health policy of 1991 has short comings which lead to inequity and imbalance in health sector.

HOWs of Health Policy

Health Policy-1991 was possible after the successful people's movement of 1990. Formation of democratic constitution with the aegis of Nepali Congress Party (the ruling party with majority seats at the time) provided fertile ground for the conception of National Health Policy-1991. Dr. Ram Baran Yadav (*Present President of Republic of Nepal*) was health state minister (*Swasthya Rajya Mantree*) at the time. Health policy-1991 was enunciated with spirit of "Health is Life".

Admonished Panchayat system was to be rationally blamed for the inefficiency and low gain in health sector. Because Panchayat system's foundation was so narrow to support the PHC which pre-requisite was to give power in people's hand, thus, as undoubtedly it failed. Not to forget, National Health Policy-1991 builds on the explanation: failure of Panchayat health policy.

New health policy builds in the criticism of Panchayat health policy; it begins with very gracious objective of "providing rural people health services" Panchayat health policy's objective was even comprehensive in this written aspect at least it stressed for "Health problems of People living under absolute poverty". It came forward with "Basic Need Program"; the failure of this program has another story let's not go there at least here.

It is not about Panchayat health policy was best; it is just that the policy objective of health policy-1991 was not comprehensive enough and more ever it was just biased towards urban people as it overlooked the health of urban population, floating population, refugees.

A remarkable difference from Panchayat health system was the introduction of District health System, each VDC would get a SHP though sounded ambitious, and each electoral

constituency would be entitled a PHC which was construed as gaining political ballot during elections.

National health policy-1991 aims to address these deficiencies of previous health policies as well Weakness in implementation of plan and program, centralization of resources, posts sanctioned for district level health were not filled.

Health policy was more politically fuelled; it reflects in the single party political commitment that comes attached with the health policy. It also creates an environment which indicates that Nepalese health policy is committed only by Nepali Congress and not other parties; if it had been it would be a common political commitment manifesto of all the then existing parties rather than single party commitment communiqué.

WHENs of Health Policy

At 1991 Nepal's census reveals Nepal's population to be 18491097 which is 18.67 % increase in regards to population of 22736934 of 2001. Though there may be huge chain of factor for this population change proportion maintenance, the credit is to the Health sector even more to the Health Policy.

The health of Nepal was challenged by: Falling life expectancy and Increasing CMR. Poverty was high as ever, 71 % of national population below the poverty line; though National Planning commission puts it around 40%, World Bank, 1990 and UNICEF, 1992 finds it at 71%.

Human Development Index (HDI) of any given country reveals the state of nation, to be precise of a country's development. Let's have look at the trends of HDI of Nepal since 1975-2005.

Table 1: Trend of HDI

HDI rank	**Country**	**1975**	**1980**	**1985**	**1990**	**1995**	**2000**	**2005**
142	Nepal	0.301	0.338	0.380	0.427	0.469	0.502	0.534

We can observe that HDI of Nepal is in an increasing rate, that should be happy news for all Nepalese but the rate of progress we are making is decreasing, curtails of factors like armed conflict, political instability etc may be the reasons. What's important is Nepal's HDI was 0.427 at time of formation of Health Policy, health has been pivotal to development, so what contribution did health policy made to HDI. 8.9 % progress rate (1990-1995) which is painstakingly slowest than 1975-1990 progress rate.

Nepal is one of three countries in the world where the life expectancy for women is lower than for men, which is an indication that health care for men has a higher priority than for women (Karki, 2003).

For a clear picture of National Health Policy's WHEN question it is imperative to observe the indicators at the time of 1991. The main indicators of 1991 are as follows:

- The crude death rate was 16 per thousand.
- The crude birth rate was 41 per thousand.
- The infant Mortality rate was 107 per thousand.
- The under five mortality of children below 5 years was 197 per thousand.
- The total fertility rate was 5.8.
- The maternal mortality rate was 8.5 per thousand.
- The average life expectancy was 53 years.
- One hospital for 168 thousand persons.
- One doctor for 92 thousand persons.
- One hospital bed available for nearly 4 thousand persons.
- One health post for 24 thousand rural people.

Source: National Health Policy, 1991.

WHATs of Health Policy

National health policy is to extend the primary health care system to the rural population so that they benefit from modern medical facilities and the services from trained health care providers.

It addresses 15 areas

- Preventive health services
- Promotive health services
- Curative health services

- Basic primary health services
- Community participation in health services
- Organization and management
- Development and management of Health Manpower
- Private, non-governmental health services and inter-sectoral co-ordination
- Ayurvedic and other traditional health services
- Drug supply
- Resource mobilization in health services
- Health Research
- Regionalization and Decentralization
- Blood transfusion services
- Miscellaneous
- Human resources for health development (HRH) [*according to Annual Report 06/07,DoHS in place of Miscellaneous*]

National health policy attempts to address the organizational and administrative areas with focus on rural health of Nepalese.

A Target vs. Achievement table proves more comprehensive in attempt to understand the WHATs of Nepal Health Policy-1991.

Table 2: Target vs. Achievement of National Health Policy.

Indicators	**Targets** *(to be achieved by year 2000A.D.)*	**Achievements** *(as per NDHS, 2001)*	**Achievements** *(as per NDHS, 2006)*
Infant Mortality Rate	50 per 1000	64 per 1000	48 per 1000
Under 5 Mortality Rate	70 per 1000	91 per 1000	61 per 1000
Total Fertility Rate	4	4.1	3.1
Maternal Mortality Rate	4 per 1000	...	…
Average Life Expectancy	65 years	...	…

None of the target was met by the year 2000, as per the survey of NDHS 2001. Though, significant gains have appeared in year 2006, just in 5 five years! This should put a

question mark on Reliability of data or survey or the health conditions have improved significantly just over five years; which means what we have now is just the gain of these five years.

According to 1996 Nepal Living Standard Survey, only 41% of households have access to a health facility within walking distance of 30 minutes or less (Wagner, 2003).

Nutritious Food, healthy air, water and sanitation are considered as pillars of public health, in this aspect National Health Policy does little to address than classifying it under Promotive health services.

Extra remarks

Nepali Congress's socialism coupled economic directive policy allowed plenty of room to for Private sector to call their cards and caused havoc in health sector. Capitalism, competition for Profit, individualism and interferences in various fields; these were some of the nature introduced by Nepali congress to the health sector of Nepal.

The health policy in one aspect is very clear, that it is valid till 2000 A.D. only because it clearly states for vision till 2000 A.D. and not even provides room for roadmap for scaling up of progress so far made. In this aspect the authors are happy to learn that the need for revision of National Health Policy-1991 by the year 2000 could be felt by the people *perhaps not by the stakeholders*.

In context of financing of Public Health, devolution of financing and management has been very weak as district is tied up with central level financing providing very less or little other financing options. The relative shortages in public and private spending on disease control. Disconnection between investment in health programs, services and the health problems affecting rural poor are some of the areas where policy and its subsequent plans fail to fill. Health policy is further dumb regarding Public Health and developing its infrastructures. Not to mention the ever-increasing national health target expenditure vs the microscopic increasing national health expenditure all leading to increasing funding gap every year. So, now the time has come for health professionals to look not for the amount of budget to health instead the percentage of funding gap we narrowed.

Multi-sectoral nature of health problems has been totally undermined. Health during emergency periods like war, armed conflict and natural disasters have been totally neglected; the state's responsibility of health in these times must be even more sensitive and pronounced.

It is dumb regarding suspension and enforcement of conflicting and necessary laws, bylaws and acts concerning health issues. In totality it lacks the legal part of policy which is necessary to make policy enduring. It has further limited the scope of behaviour Change for health output.

Issues regarding buying and selling of Blood has been prohibited and in turn Human organs vast business of buying and selling which is allegedly have been seen as international source market has not been addressed.

There are new onslaughts on health system now are increasing urban population, crisis in economic sector globally, questions of equitability, and greater access to health services, inclusive Human Resource for Health and more ever a need of Health System that really works for full strata of people.

Now, Republic Nepal is ushering into new era of inclusiveness, pronounced Devolution and various Health Sector Reform works.

Drug policy is inadequate now because Free EHCS is being practised and Nepal Drug Limited is paralysed in this golden opportunity, as a result government is buying drugs at high rate from the private sector.

Ministry of Health expenditure on secondary and tertiary hospitals increased from 14.6 percent of the health budget in 1991/92 to 37.5 percent in 1997/98, while the share of spending on primary care decreased from 76.8 percent to 57.25 percent over the same period though Out Of Pocket Expenditure (OOP) is 70 percent. *(Health Sector Strategy: An agenda for Reform, 2004)*.

There was a debate during 70s among health professionals of Nepal: whether to expand PHC or to choose Control of Diarrhoeal diseases, Tuberculosis, immunisation and keeping fighting with disease? The later won as a result is SHP, HP, PHC are in this state.

Focusing on inequality can have significant improvement in Health Services an example is Japan where till 1950s Japanese health was poorer than American Health but in 28 years it emerged as world's healthiest city. There are many reasons to it including cutting

the size of army and more important is Democracy and decentralisation particularly land reform(farmers were given interest free loans for 30 years to buy land from land owners which single handed changed the land ownership by 90%.

We still can take pride in our health policy as our health status is better than South Africa who boasted of 1st Heart Transplant in 1968. [Gautam & Bhattarai (eds.), 2065 B.S.]

CHAPTER IV

4. Conclusion

It’s not about who wins or loses from the national health policy, the only answer to that would be nobody is a winner or loser; they/we are all sufferers, sufferers of inexplicable diminutive health policy.

The National Health Policy-1991 needs to amend its short comings outlined in this paper including views from experienced health professionals, legal advocates, Citizen and private institutions in order to meet and create a Informed, Inclusive & Comprehensive Health policy.

National Health Policy-1991 addresses some modalities of delivery of health care services as well as information and administrative issues. But, not to the overarching health needs and future demands of citizen across Nepal.

CHAPTER V

5. Recommendations

The whole prose of paper may appear to be condemning rather than applauding for the gains in health so far and now, but that's the way it is meant to be.

The author has had much recommendation but all could be summed in one part which is:

- Create a new health policy with rigorous discussions involving stakeholders, retired and working health staffs including FCHVs, users of health services, students and private institution; it may take a while but the output must be justified.

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