An Analysis of National Health Policy 1991

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Policies are the summary statement of what is to be delivered to the target population. In true sense, National Health Policy of Nepal is the extension of international policies. International policies in Health have been fitted into the Nepalese context. Since its inception, the policy aimed at extending the health services to the rural population through the Primary Health Care (PHC) approach.

The National Health Policy was formulated in the year 1991 to bring improvement in the health of the Nepalese people. After the restoration of multiparty democracy system, the congress government formulated the National Health Policy with a framework to guide the health sector development to upgrade the health standard of the people by strengthening the PHC system making health care services readily available at local level. ***A good policy can make it easier for people to improve their livelihoods. A bad policy can hinder them.***

There are two major aspects when formulating a health policy:

i. **Time Dimension**: The time period when the policy was formulated is an important aspect that needs to be considered while reviewing a policy because health is in a dynamic equilibrium and priorities in health changes with time factor. Hence the policy that worked during the time of formulation may not be that important in the future. Hence it should be futuristic or should have a long term vision to address the forthcoming issues in health.

ii. **Cost dimension**: In the terms of Health Economics, health care is in market and health is a purchasable commodity. Nothing in this world is free and somewhere somebody has to pay for the services. But if we look at the Health Policy 1991, the financing mechanism was the much ignored part, which was only realized during the second Long term Health Plan (1997-2017).Actually, Nepalese Health System is much more dependent on the international agencies which accounted for 92 percent of National health budget and the sustained financing mechanism was not sought to meet the targeted programs.

These are some of the benefits of National Health Policy 1991:

§ Before 1990, there were health services mainly concentrated in the urban areas hence large effort was need to meet the health need of the rural people.

§ The policy statement has focused on the justice and equity. It has clearly addressed the sentiment and right of the majority of the rural people who were in the need of the health service.

§ The National Health Policy provides a framework to guide the health sector development in Nepal. Various short term and long health plans in Nepal are framed being guided by the National Health Policy.

§ The policy statement has promised to provide the primary health service basically incorporating at least 8 elements recommended by the Alma Ata conference.

§ It has clearly incorporated the ground reality of the country that it consists of many villages and country cannot develop without developing the village.

§ Reduction of Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR). Increase rate of Contraceptive Prevalence Rate (CPR) and Expansion of Essential health care services.

However, there are some shortcomings while formulating the policy and setting the objective. Nepal is facing currently which have been highlighted below:

- **Issue of Floating Population:** The people who are forced to come to the urban areas are termed as floating population. Though originally from the rural areas these people have been residing in the urban areas for the purpose of employment, education, legal procedures, etc. Today the population of Kathmandu alone have reached around 11 lakhs in the year 2001(Population monograph of Nepal, CBS, 2003) and till 2008, it must have reached much higher so the growth of these floating populations was not visualized during that period and the health services need and demand of these type of population were not taken into considered during the period when the policy was endorsed.
- **Issue of urban health services:** When the policy was formulated, it was assumed that urban population had adequate health services and the health system in the urban areas was perceived as if everything was perfect, but this is not true. The people residing in urban slums a still suffer poor health and urban areas also do have a set of health problems such as sanitation, poor health of slum dwellers, quality assurance among the mushrooming health facilities, life style related diseases and so on that seems to be over looked during the design of the Policy.
- **Growth of the private sector:** During the 1991, it was not envisioned that the private sector would rise at such speedy pace and hence the role and responsibility of the private sector was not well

defined and thus leading to duplication of resources.

- **Implementation Phase:** Policy makers are have extended the international policy to our context, however the extension of heath services to the rural areas seem poor in implementation phase because the disparity in the health services still persist .Still 48 percent of budget is centered in the urban area and only 52 percent of total budget is allocated for the rural areas where around 84 percent of the population reside. Private sectors are densely located in the urban areas only.
- **Widening inequality in Health:** Despite the government effort still there is a wide variation among the health status of the rural and urban population. If we compare the life expectancy of the people living in Kathmandu and the people living in Mugu, it is 74.4 years and 37 years respectively. Similarly TFR of woman in urban areas is 2.1 whereas it is 3.3 per woman in the rural areas. Similarly IMR in urban areas is 37 per 1000 live births whereas it is 64 per 1000 live births in the rural areas.

So we can conclude that

- The word rural is not enough to meet the needs of the rural population.
- More concerned with the rural population than urban.
- Failed to focus on some specific groups such as the marginalized people, indigenous people, dalits and people under poverty.
- The programme was oriented toward the horizontal equity. The socio-economic and a demographic setting of the society have created the unequal need which needs unequal treat. Thus the vertical equity was lacking.
- The concept of the 'Primary Health Care' was misinterpreted. The volume of the programme and the quality were minimized in the name of the primary health care. Thus instead of extending the primary health service, the whole health system was to be based on the philosophy and principle of primary health care.
- Lacks the concept of the people's participation
- Health is the issue of the multisectoral response such as agriculture, economy. The policy failed to ensure issue of the multisectoral response, which is one of the major principles of the primary health care.

As we know that the rural population is about 80 percent of total population. It is impossible to improve the health status of the population without developing the health service of the rural people. It has been decade long story that we have been trying to improve the health status of rural people, but as our target we are not achieving that. The more challenging is that the inequalities gap between the rural and urban is increasing. The gap is more widening between the different groups, ethnic people within the rural people. So we have to consider on these things:

- Expansion of the health services and must be equipped with the modern facilities.
- Intra and Inter sectoral co-ordination will help to get the better health of the rural as well as urban so multidimensional approach should be achieved.
- Special financial provision and schemes should be made available.
- More focused on the Human Resource Development.
- Decentralization of the health services.
- Public Private Partnership should not be neglected.
- **Targeted program for the Rural , Poor, Marginalized and the vulnerable groups**

Blanket policy cannot address this particular group, so targeted programs that is pro-poor, pro- marginalized focusing on rural areas should be developed such as the community health insurance, micro - credit projects, mothers group and special package of health services for the targeted group. Targeted programs can promote utilization of the health services by this group of the population.

- **Strengthening the Referral services**

  The referral system is poorly functioning in Nepal. Referral services can benefit the rural population by providing opportunity to utilize modern specialized services**.** We have only the Sub health Post and the health post with very limited technical and human resource capacity hence referral mechanism should be kept prompt and well functioning for managing complicated cases.

- **Strengthening the health system capacity**

  The capacity of health system both in terms of human resource and quality assurance needs to be enhanced through sustained financing, better organization of health care and effective purchasing of the resources. This requires government improving the role of government as steward and a regulator, together with service provider**.** All the sanctioned post must be filled and health workers working at remote rural areas should be motivated through better incentives

- **Intersectoral coordination** for maximum utilization of the resources and avoid the duplication is equally important. Services at the rural areas can be consistently delivered if the inter sect oral coordination is inadequate.

- **Creating demand and utilization of health services among the rural people**

People should be made aware about the utilization of the health services through awareness raising programs through mass media, posters, pamphlets, Behavior Change Communications., etc. Similarly the attitudes of the health worker also determine the service utilization hence health workers also need to be oriented before placement.