Original article

J Nepal Health Res Counc 2018 Oct-Dec;16(41): 372-7

DOI https://doi.org/10.33314/jnhrc.1584

Evaluation of Nepal's Free Health Care Scheme from Health System Perspective: A Qualitative Analysis

Shiva Raj Adhikari,[1] Diksha Sapkota,[2] Arjun Thapa,[3] Achyut Raj Pandey[4]

[1]Deparment of Economics, Patan Multiple Campus, Tribhuvan University, Nepal, [2]Kathmandu University, School of Medical Sciences, Dhulikhel, Kavre, Nepal, [3]Faculty of Humanities and Social Sciences, Pokhara University, Nepal, [4]Nepal Health Research Council, Ramshahpath, Kathmandu, Nepal.

ABSTRACT

Background: Access to high quality medicines is often considered as one of the main obstacle in achieving health for all. With the objective of increasing access to health services of poor segment of population, government of Nepal has implemented free health care program. However, there is strong need for evaluating the performance and coverage of free health Care scheme. In this context, this study aims to provide better understanding on the implementation status of free health care scheme in context of Nepal.

Methods: It is a qualitative study conducted in 7 districts of Nepal. Total of 14 focused group discussion were conducted among service providers and service users. All the discussions were carried in neutral and natural setting making sure that each of participants feels free to express their opinion. Focused group discussions were transcribed, translated into English, coded and analyzed manually.

Results: Participants shared that free health care has contributed positively in making essential health services reachable, affordable and accessible to all specially benefiting poor segment of population. However, multitude of factors like geographical access, perception of community people towards health services, availability of medicines, laboratory services and human resources come into play determining the utilization of health services. Service providers recommended that there need to be improvements in procurement and supply system for uninterrupted supply of services.

Conclusions: Despite having some problems in availability of medicines, human resource and diagnostic services, free health care has improved access to health services specially for poor population. Decentralizing the procurement process can be one promising option to overcome the inappropriate supply of medicines.

Keywords: Access to medicine; financial risk; free health care; Nepal; poor.

INTRODUCTION

With political turmoil and social transition, there was overarching problem of inequities and poor delivery of health services in Nepal. Realizing of utmost need of comprehensive provision of quality health care services which is accessible and affordable to all and reduction of health inequalities, free health care scheme (FHCS) was initiated by Government of Nepal in 2006.[1-3]

Studies carried out in South Asia show that medicines represent a large portion of Out of Pocket (OOP) expenditures.[4,5] Access to high quality medicines is especially difficult for the poor and thus access to medicines is one of the major impediments to health for all.[6] There is strong need for evaluating the performance and coverage of FHCS. This study aims to provide better understanding on the implementation situation and consequences of FHCS and understand the system wide effects and consequences among the building blocks of health system.

METHODS

Qualitative study was used to gain the broader and in-depth understanding of free health care scheme in Nepal. Seven districts namely Morang, Ramechhap, Parsa, Lamjung, Arghakhanchi, Jumla and Baitadi were selected randomly to represent all three ecological belts and five development regions of Nepal. Two FGDs were conducted on each district at the place accessible and feasible to the participants making total of 14 FGDs. FGDs were conducted in natural and neutral settings, separately among service providers and service users. Field researchers were given orientation training to familiarize them with study protocol, tools and

Correspondence: Achyut Raj Pandey, Nepal Health Research Council, Ramshahpath, Kathmandu, Nepal. Email: achyutrajpandey2014@gmail.com, Phone: +9779849215398.

techniques of data collection. All the participants were allowed and encouraged to express their opinions and there was room for interactions among the participants. Discussion was initiated with grand tour of broad questions asking participants about facilities they visit when family member get sick, changes noticed by participants after introduction of FHCS and type of people visiting public and private health facilities to reduce interviewer bias.

Discussions were audio recorded and field notes were also taken including every minute details of discussion, to complement the transcribed notes. Discussions were transcribed in Nepali language from the notes and audio record and then were further translated into English. The coded key word approach was applied which involves reading the focus group notes and transcriptions thoroughly and assigning a code/ key word to each comment in order to identify themes or categories within the text. [8] Inter coder agreement was checked to assess the consistency of code generation. Memos were prepared independently by 2 separate researchers and iteration was done at many levels to ensure validity and credibility of collected data. Data were reduced and narrowed to certain themes based on inductive approach which were finalized with rigorous discussion among study teams.

RESULTS

Findings from the FGDs are presented under six thematic areas

Information on FHCS

Though information about free medicines is within the reach of large segment of population via various types of media, many people still don't know explicitly which medicines are provided for free and which aren't. This seems to have caused confusion among the service users leading to anger and dissatisfaction when they fail to get medicines after visiting health facility. Furthermore, service providers shared that people have doubt about the efficacy of medicines provided free of cost.

"There is a need to make people aware that free drugs are also good and they work properly because many people think that free drugs do not work properly." [Service provider, FGD, Lamjung]

Private pharmacists were found to refer people when they realize that they cant afford to pay for medicines. Unlike what is generally assumed, lack of information was not found to be contributing non-utilization of free health services.

Service Delivery

Perception towards health care, service seeking behavior, utilization of health care and drug prescription practices were the common issues that participants shared about in the study while dealing about service delivery.

Participants shared their perception that free health care has a big role in primary health care. Many of them opined that it's quite a great relief for rural people who can't pay for large heft of money being taken by private facilities.

"*In rural areas, it's very difficult to go to private clinic, It is not possible to have cash income in hand, so FHCS has provided a great relief.*" [Service user, FGD, Thada]

Most of the participants expressed their preference to government health facility as it provided free health services. However, it was constrained by factors like long waiting time in government health facilities, long travelling distance, unavailability of health workers and lack of trust on quality of medicines in government health facilities. Although the first choice is public health facility, one of the other reasons for visiting private health facility was flexibility of time as they open for 24 hours and seven.

"*Had the PHC been to the place where private hospital is located currently, the no. of service users will definitely increase.*" [Service user, FGD, Manthali]

"*People get ill any time but the health facility is open from 10 to 2 pm only. Do people only get ill between 10-2?*" [Service user, FGD Bagahi]

In some place it was found that due to limited availability of medicines, complete doses of medicines aren't prescribed from providers' side. For those who go to private for checkup, they don't have enough money to pay for the higher prices of medicines and thus service users were also found to bargain at the doses leading to irrational use of drugs.

"*Office assistant is involved in distributing medicine. He may give 6 when 10 is prescribed considering unavailability.*" [Service provider, FGD Patan]

Health care providers shared that FHCS had also increased the misuse of free medicines in some cases. They shared that patients are more likely to complete the dose when they have purchased the medicine and discontinue it when they get the medicines for free which could be risky especially in case of antimicrobials.

"When bought from private money has to be paid so complete the dose and when it is free then they don't complete the dose." [Service provider, FGD, Mangalbare]

Leadership and Governance

Management committee was found to be actively involved in hiring the human resources, deciding the user fees, range of services available and active involvement of health committee were linked with better functioning of health facilities. Respondents verbalized that weak procurement and distribution system has invited several negative consequences like poor quality of medicines, irregular supply, and inadequate coverage of changing health needs. Service providers expressed their dissatisfaction on persistence of push mechanism of medicines from district health office despite the current provision of pull system in logistics management. Medicines are demanded on the basis of need and due to inconsistent supply of medicines; there is substantial increase in number of dissatisfied patients.

"*When patients come to take medicines, if there is stock out, patient usually get angry saying that previously it was available but why not now?*" [Service providers, FGD, Thada]

They suggested that procurement of medicines should be decentralized below district level also.

Private facilities were found to be complementing the public facilities ensuring the highest level of care and services to the public. Some participants recommended that community drug programme could be appropriate option to ensure round the year availability of medicines in health facilities.

"*Out of five medicines prescribed; only around three are dispensed, we get only 1 or 2 (medicines) and rest has to be bought from private*." [Service user, FGD, Okhreni]

"*But what we have thought is if we are able to implement it (CDP) then it will be beneficial for both us and health facility and remaining all will also be benefitted*." [Service provider, FGD, Rajghat]

Human Resources

Availability of human resources at health facilities is as equally important as availability of medicines and lack of any one can have serious impact of health system performance. Service users complained that service utilization has been hampered due to absence of doctor due to frequent organization and participation training and frequent leave and keeping the position vacant most of the times.

"*If doctor is present in public health facility, they come to check up otherwise they go to private health facility.*" [Service providers, FGD Lamjung]

Moreover, lack of counseling from HR stood as a major challenge in delivering effective health care and they mentioned that free medicine is not worthy unless the health workers stay regularly at health facility. However, especially private service providers shared that they counsel the patients appropriately as that also directly relate to their business.

"*Majority do not take care of dose as they are not counseled properly. They throw away Vitamin B complex tablet because of its odd smell.*" [Service provider, FGD Lamjung]

"*……..We tell the patient clearly about the medicines, how to take it and always smile while people complain that health workers at public health facility are rude and do not say anything….*" [Service provider (Private pharmacist, Lamjung]

Health financing

With the implementation of FHCS health care cost has been decreased but as all the medicines are not provided for free, large number of users have to buy it from private setting also. Eventually, the total health care cost has been increased. The registration fee that HFMC have been charging considering it as minimal was often found to restrict patients from visiting health facility.

"*They hide diseases when registration fee is charged. They even say that as in Rs. 5, we can purchase 2 match stick, why to go?* [Service Providers, FGD, Patan]

Private sector market has also been flourished and pharmacies are open near the public facilities only suggesting that private operate only in the presence of public. Considering Government budget as not enough for smooth running of the health facility round the year, health facilities were found to have registration fee independently with some additional services.

Linking quality to the factors like dedicated staff, operation of services beyond office hours, availability of medicines, participants attempted to further justify charging of registration as it had improved the quality of service.

Although community health insurance could be one of the alternative financing mechanism, participants expressed that they did not like it and discontinued it after enrolling in the first year. They complained that the health workers did not provide services properly if they found that they are insured and health workers blamed them of coming to health facility just to use up their premium money rather than due to real illness.

"*Other insured people have also complained about insurance scheme because they complained that they did not receive proper treatment from the health workers.*" [FCHV, FGD, Rajghat]

Medicines and Technology

Free medicines are often taken with disregard by general public who expressed their view that medicines are not of good quality and are of near expiry date, so they don't work properly. Public providers accused higher authority for sending near expiry medicines which needs to be dumped later. Medicines like $MgSO_4$, oxytocins are not needed in all health facilities, but they are still being provided leading to non-use, over stock and ultimately expiry and wastage of medicines.

"People have feeling that medicines which have crossed their date, rotten are provided (in public facilities) but these days publics are being aware so such things don't happen." [Service providers, FGD, Manthali]

"Sometimes, people come to us, tear the outpatient slip outside our facility, discard the medicine and purchase the same composition of medicine" [Service provider, FGD, Patan]

There were also some malpractices regarding the use of health services. Service providers shared that people have tendency to keep stock of common medicines like paracetamol, vitamins, digene etc in their home for future use. There were some interesting examples of increase in demand of medicines in a seasonal pattern especially people from the district and outside district come for harvesting Yarsagumba (a medicinal herb of high monetary value). The health workers mentioned that demand for medicines like antipyretics and analgesic increased because people came asking for medicine in health facility in large number to take as first aid on their trip to harvesting yarsagumba which often resulted in stock out of medicines in those health facilities.

"Since all the family members go for harvesting Yarsagumba, they come asking for brufen and paracetamol to keep in first aid kit. We have to give medicine without prescription."[Service provider, FGD Jumla]

Service providers also pointed out the lack of diagnostic service as one of the factor responsible for non use of public health services.

"There is no good quality medicine here. Does anybody get cured only by seeing doctors face? (Doctor sahibko cheherale birami niko hunchha ra?) there is no lab facility here, only attending to patient doesn't help "[Service provider , FGD, Bagahi]

DISCUSSIONS

Introduction of the policy on free health service could be considered as a great milestone by government in ensuring health for all by addressing the issues of accessibility and affordability. As in line with some previous studies, it has benefitted all but particularly this is of benefit to the poor who can now afford to seek assistance as soon as they feel sick.[9,10]

Health care providers strongly shared that community people now don't wait for their health problems to deteriorate before they seek health care which ultimately had accentuated the service utilization pattern. Private facilities have complemented public health facilities by making the wide range of medicines available. Free health care was often not perceived to have good quality simply because people have not paid for it. The understanding that was lacking was that the medicines are not exactly free but the cost of medicines has been paid for their benefit by government of Nepal. Hence, public need to be made aware in this aspect to improve compliance and adherence to essential medicines given from government facilities. In one of the previous article, Thapa et al had recommended to incorporate the issues about free health care in curricula of the academic institutions, which could be useful to clear some of the prevailing misunderstandings relating to free health care.[11]

Failure to include new drugs to meet changing health needs has forced public to buy medicines from private sector. Such out of pocket spending indicates the failure by the government to allocate sufficient financial resources for medicine supplies essential for treating prevailing diseases for the majority of population. This compulsion can led to increased catastrophic payment and making health services inaccessible to people belonging to lower socio-economic class. Despite having free health care program in place, previous studies also have revealed that out-of-pocket expenditure as percentage of total expenditure on health was almost 50% while the cumulative incidence of catastrophic health expenditure was 10.3% per month in case of Nepal which can be one of major challenge in achieving UHC.[12,13] High out of pocket payment also serve as a barrier in overcoming equity gap in health sector.[14] Previous literatures suggest that even poor people get ready to pay high amount for private services when public services are underutilized due to lack of trust.[15] The problem of occasional drug shortages due to delayed procurement and distributions by central and district levels is still persistent consistent to the study done by Sato and Gilson.[3] Similar study conducted in Pakistan had also identified procurement as one of the problem in availability of medicine and had recommended improve the procurement system making it more transparent and competitive.[16] Simple and cost effective methods to monitor the use of drug use could

be used to identify inefficiencies in drug procurement, supply and availability.[17] Shortage of drugs was also noted to be related to procurement and distribution system in one of the previous study done in Nepal.[18]

Mostly waiting time discourage users from seeking services from public facilities as they relate the time lost to the opportunity cost and as this cost exceeds the cost of medicines, they are prompted to use private health facilities which was also evident in some of previous studies.[19-22] Long waiting time is also closely related to absence of health providers in sufficient numbers. Similar previous study had also found that insufficient human resource can be one of the major barrier in implementation of free health care in Nepal.[3] Research findings highlight the fact that along with availability of medicines and human resources, government also need to make efforts in shortening the waiting line as there can be increased use of health services after implementation of free health care programs.

Though FHCS is supposed to provide every service for free, people are paying some money as user fees and most of them don't complain as they relate price to quality. The utilization of health services at the public health facilities is clearly linked with the availability of quality human resources. If the human resources are available, the FHCS is utilized; otherwise the people go for private facilities even if they have to pay the price. With the implementation of FHCS, government's expenditure on health has increased, but at the same time individuals' and household expenditure on health has also increased. It further highlights that medical cost or health care related cost is increasing. Consistent to the various studies, it was found that public expressed dissatisfaction in specific areas like waiting time, availability of essential drugs, ease of getting treatment in emergency situation, attitude of health workers etc. Provider behavior is also equally important in determining user's satisfaction.[23, 24] As highlighted in one of the previous study by Sato and Gilson[3], this study also highlights that it is important to anticipate and address people factors like (their views, motivations, attitude etc) planning health services.

Moreover, medicines were sent to health facilities by DHO without assessing the demand of local health facility following a push system while the existing policy recommends a pull system for sending medicines to health facilities. Mismanagement of drug in Nepal was also highlighted one of the previous article.[25] This situation has created imbalance in distribution and wastage of medicines due to expiry. Limited options of medicines in essential list, clients' mistrust in the quality of the FHCS free medicines were found to be affecting provider-client relationships leading to dissatisfaction among users. It highlights the need of strong monitoring, evaluation and appropriate distribution of free drugs on scientific basis relating to need of specific regions and setting.[25]

Government of Nepal has expressed its commitment to expand health services, reduce financial barrier and increase the population coverage.[14] In context when country is striving to achieving UHC by 2030[14], findings from this qualitative study could be useful for policy makers to get in-depth look into free health care program of government of Nepal.

CONCLUSIONS

FHCS has contributed significantly in making essential health services reachable, affordable and accessible to all the segment of population. Multitudes of factors were found to interplay and affect the access of drugs. FHCS had mostly benefited poorer segment of population.

Major barriers to access to medicines identified in this study are failure to provide uninterrupted quality health services to public due to limited options of medicines, lack of diagnostic facilities, less number of competent technical manpower. Improving medicine procurement and supply system with consideration of pull system will substantially contribute in uninterrupted services from public facilities. For ensuring this, decentralizing the procurement process can be one promising option.

ACKNOWLEDGEMENTS

We would like to acknowledge WHO Headquarter, Geneva for providing financial support in this study. We would also like to thank Dr Maryam Bigdeli for providing valuable comments on an earlier draft, with the errors being the sole responsibility of the authors.

REFERENCES

1. Ministry of Health and Population. Guideline for free essential health care services for poor and destitute people. Kathmandu, 2006.
2. Ministry of Helath and Population. Operational Guidelines with Amendment: National Free Health Care Program. Government of Nepal. Kathmandu, 2008.
3. Sato M, Gilson L. Exploring health facilities' experiences in implementing the free health-care policy (FHCP) in Nepal: how did organizational factors influence the implementation of the user-fee abolition policy? Health Policy Plan. 2015;30(10):1272-88.[Full Text]
4. Adhikari SR, Maskay NM, Sharma BP. Paying for hospital-based care of Kala-azar in Nepal: assessing catastrophic,

impoverishment and economic consequences. Health Policy Plan. 2009;24(2):129-39.[Full Text]

5. Garg CC, Karan AK. Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India. Health Policy Plan. 2008;24(2):116-28.[Full Text]
6. Ratanawijitrasin S, Soumerai SB, Weerasuriya K. Do national medicinal drug policies and essential drug programs improve drug use?: a review of experiences in developing countries. Soc Sci Med. 2001;53(7):831-44. [Full Text]
7. McCaslin ML, Scott KW. The five-question method for framing a qualitative research study. The qualitative report. 2003;8(3):447-61.[Full Text]
8. Chronic Poverty Research Centre. CPRC Methods Toolbox. Available from: http://www.chronicpoverty.org/page/toolbox.
9. Karkee R, Kadariya J. Choice of health-care facility after introduction of free essential health services in Nepal. WHO South East Asia J Pub Health. 2013;2(2):96.[Full Text]
10. Devkota B. Effectiveness of essential health care services delivery in Nepal. J Nepal Health Res Counc. 2008;6(2):74-83.[Full Text]
11. Thapa B, Prasad R, Bhuju BSG, Rajbhandari V. Essential Drugs Concept: its application in Nepal. Journal of Institute of Medicine. 1998;20(1).[Full Text]
12. Adhikari SR. Universal Health Coverage Assessment Nepal. Ottawa, Canada: Global Network for Health Equity. 2015.[Full Text]
13. Ghimire M, Ayer R, Kondo M. Cumulative incidence, distribution, and determinants of catastrophic health expenditure in Nepal: results from the living standards survey. Int J Equity Health. 2018;17(1):23.[Full Text]
14. Ministry of Health and Population. Nepal health sector strategy 2015–2020. Kathmandu, 2015.[Full Text]
15. Mamdani B. Governance in healthcare. Indian J Med Ethics. 2007;4(4):186-8.[Full Text]
16. Zaidi S, Bigdeli M, Aleem N, Rashidian A. Access to essential medicines in Pakistan: policy and health systems research concerns. PloS ONE. 2013;8(5):e63515.[Full Text]
17. Laing R, Hogerzeil H, Ross-Degnan D. Ten recommendations to improve use of medicines in developing countries. Health Policy Plan. 2001;16(1):13-20.[Full Text]
18. Development Resource Center. Evaluation on : Essential Drug Procurement and Distribution Program Under Free Health Services Kathmandu, 2012.[Full Text]
19. Aljunid S, Zwi A. Differences in public and private health services in a rural district of Malaysia. Med J Malaysia. 1996;51(4):426-36.[Full Text]
20. Shaikh BT, Hatcher J. Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. J Pub Health. 2004;27(1):49-54.[Full Text]
21. Bhatia JC, Cleland J. Health-care seeking and expenditure by young Indian mothers in the public and private sectors. Health Policy Plan. 2001;16(1):55-61.[Full Text]
22. RTI International. Implications of the Government of Nepal's Free Health Care Policy 2007.[Full Text]
23. Ehiri JE, Oyo-Ita A, Anyanwu E, Meremikwu M, Ikpeme M. Quality of child health services in primary health care facilities in south-east Nigeria. Child Care Health Dev. 2005;31(2):181-91.[Full Text]
24. IGE OK, NWACHUKWU CC. Areas of dissatisfaction with primary health care services in government owned health facilities in a semi urban community in Nigeria. Age. 2010;30:3049.[Full Text]
25. Gurung G. Free Health Care Policy in Nepal: Recent Trend and Challenges. J Nep Health Res Counc. 2009;7(2):138-9.[Full Text]