EXPERIENCE EXCHANGE

Health care in Nepal: An observational perspective

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ABSTRACT

Nepal is one of the several poor developing countries in the world that faces significant challenges in providing universal health coverage and equitable medical care. By coordinating with the Nepal Critical Care Foundation, two weeks of observation was conducted in Kathmandu during March 2016. The aim was to obtain a comprehensive understanding of the basic living conditions of the population and identify major barriers that the healthcare system is currently facing in providing quality patient care. Some of the key barriers identified were lack of regulation of hospitals in terms of quality assurance and accreditation, poor demand and supply of services such as workforce and essential medications, poor access to health care facilities in rural areas, and lack of funding for the poor. One of the most important lessons learnt was that nationwide protocols, policies, and legislation needs to be established as well as properly enforced in order to create and drive any sort of meaningful change.

Key Words: Healthcare, Nepal, Equity, Public health, Barriers to quality care, Nursing

1. INTRODUCTION

When analyzing the population statistics of Nepal, it can be seen that poverty is one of the largest barriers to quality healthcare. The population of Nepal is approximately 27.8 million with an average life expectancy of 68 years, compared to the life expectancy of 82 years in Canada.[1] It falls in the low income group with a gross national income per capita of $2 as well as a total expenditure on healthcare per capita of $135 or 6% of GDP.[1] Urbanization is a recent phenomenon in Nepal with 18% of the population living in urban areas and 58.1% of the urban population living in slum areas.[2,3] The rich are largely living in urban areas and poverty is prevalent in rural areas with 96% of the poor living in rural areas with scant access to quality healthcare. Lastly, 44.8% of the population is living below poverty line.[4] Low earnings combined with the poor living in rural areas creates inequity which is a major challenge for the government to tackle.

According to the World Health Organization (WHO), equity is the absence of avoidable differences amongst groups of people. Health inequity therefore, is defined as failure to avoid or overcome inequalities that infringe on fairness and human rights norms. It also involves inequality with respect to health determinants and access to resources needed to maintain health outcomes.[5] The government of Nepal has been working for years to provide more equitable services to Nepal. In 2007, the constitution of Nepal declared that every citizen would have rights to basic health care services. This included initiation of the Essential Healthcare Services (EHS) program which included free primary care services, basic secondary care services, and limited amount of free essential medications for the poor. A total of twenty five free beds were also allotted for the needy.[4] However, the nation is far away from reaching that goal.[6] Health equity and universal coverage is lacking due to significant poverty, diminished government funding, pro-rich bias, poor demand

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and supply, lack of education, and poor access to the rural areas.[6]

2. METHODOLOGY

Nepal's Critical Care Development Foundation (NCCDF) was contacted to set up an observational period at two local hospitals. The field work was organized, implemented, and written independently here as a perspectives paper by the primary author. The work took place in the form of field notes from observation, literature search, and personal interviews which were used as material for the paper. No direct patient care was involved and hence verbal/written consent was given by NCCDF and the healthcare staff during the on-site days. The paper's aims and goals were discussed with the director and physician of the foundation during personal interviews where they were able to provide valuable information about the barriers they feel are present. A community emergency hospital in Kathmandu and a larger teaching hospital were observed, called Shankapur Hospital and Tribhuvan Teaching Hospital respectively. The work was spanned over two weeks. Direct patient interaction was not involved but observation and verbal communication with healthcare staff was carried out and written as field notes, which are outlined in the paper with previous literature to support the findings.

3. BARRIERS TO EQUITABLE HEALTHCARE

One of the several issues that Nepal faces is the separation of individuals into different socioeconomic groups and geographic areas. It requires 1-4 hours for the population in rural areas to travel to a local health post.[7] In rural districts in Nepal, only 28.1% of people accessed a medical facility.[8] Females had 2.6 times less access to health care than men and individuals living one hour or less had 3 times more access to health care.[8] Distance alone is a major hindrance for the individuals to seek prompt and timely care. Moreover, privatization of hospitals causes the rich to segregate care at urban hospitals while the poor are treated at government funded hospitals. Majority of the larger trauma and teaching hospitals are in urban cities. The rural villages consist of smaller healthcare clinics and community hospitals with limited treatment options.[4] There is no universal health coverage and Nepal works on user-fee system where hospital funding is mainly through government via taxes and out of pocket payments.[7] Private sector accounts for 70% of total health expenditure with 81% of it coming out of pocket.[8] Individuals who cannot afford treatment often don't seek care as they feel hopeless. Furthermore, Nepal has 0.3 doctors and nurses per 1000 patients compared to the 2.3 recommended by WHO, leading to unsafe and poor quality care.

In addition to having overcrowded hospitals, the staff is now faced with having to treat a combination of communicable and non-communicable diseases. Generally in third world countries, the burden of communicable diseases is heavy and prominent. However, due to the recent urbanization phenomenon, non-communicable diseases are now becoming a healthcare burden.[9] According to WHO statistics in 2012, COPD was associated with 17.2 thousand deaths per year which is concerning due to the significant pollution and tobacco use.[9] The major source of pollution in Nepal is from automobiles, soil, and water. The severity of motor vehicle pollution increases incidence of respiratory illnesses and morbidity. The population can be seen wearing face masks while carrying activities of daily living and this has become the norm. The severity of and health hazard risk of pollution is not documented. There are also poorly designated garbage disposal areas for houses or cities causing garbage to be often dumped on the streets. Unsafe drinking water is present in majority of rural areas with proper sanitation lacking in many areas.[7] According to WHO in 2013 and in the current state, there is no existence of evidence based national guidelines, protocols, or standards for the management of major non communicable diseases such as cardiovascular disease, respiratory illnesses, cancer, and obesity. Furthermore, it lacked several screening programs at the primary health care levels. There was no availability of breast cancer screening, cervical cytology, colon cancer screening, or peak flow measurement spirometry. In addition, there are poorly established databases to identify problem areas which makes it difficult to calculate the disease burden. For example, there is no national surveillance and monitoring system against the nine major non-communicable diseases or a population based cancer registry. It is also unknown whether there is an established NCD branch within the health care ministry. Furthermore, there is no government strategy or action plan to reduce national risk for cancer, diabetes, cardiovascular diseases, or alcohol use. The only strategies in place are against reducing respiratory illness and tobacco use.[9]

Another barrier to quality care involves the conduction of procedures and policies around patient care. During observation at the local and teaching hospital, it was noted that family members play a central role in the care of the patient. Upon arrival, the family is given a list of treatments, devices, and medications needed. The family rushes to the pharmacy to obtain the needed supplies and then delivers it to the nurses and physicians. This often leads to delay of treatment. Furthermore, blood samples are most commonly collected in a syringe and delivered by the family member to the lab. Results of blood work and Imaging such as CT or X-rays are often picked up by the family and delivered to the physician

for interpretation. These steps cause for a significant chance of infection and error. Hand hygiene is also suboptimal with majority of the smaller hospitals not following the proper procedure of gloves and hand washing. When a patient comes in with a specific problem such as Diabetic Ketoacidosis, often the management and protocol is not established and is at the discretion of the physician. Dieticians and other specialized professionals such as Respiratory Therapists are not present, causing nurses and physicians to provide a larger scope of care. Furthermore, majority of the work is paper based as technology is severely lacking. Documentation, consultation, laboratory and imaging work is completed on paper. This often leads to poor patient care as their past medical history, previous medications and current medications, previous admissions and results, as well as trends for various lab reports are not available. The physician is often caused to treat the patient with minimal and inaccurate past history. Often there is no established medical database. Misdiagnosis or inappropriate treatment can be common at some of the smaller community hospitals. Basic equipment such as IV pumps is also lacking in majority of urban settings. Some of the lifesavings medications that are available on hand in developed countries are scarcely available.

One of the last significant barriers identified was around medications and self-prescription. The most important reason for not accessing health care was insufficient drugs or poor quality medications (61%).[8] Many individuals were found to be utilizing local pharmacies to self prescribe medications for their symptoms instead of seeking a formal diagnosis. Due to distance and lack of finances, a large number of rural inhabitants resort to traditional healers. The fact that certain illnesses are caused by ghosts and supernatural beings is prevalent in certain parts of the rural villages.[8] The government of Nepal initiated the free essential healthcare services program but there is still significant lack in the demand and supply side. The Ministry of Health and Population currently decided to increase the current number of free essential medicines from 40-70.[4] Even then, quality use of essential medicines is lacking and there are no standard guidelines to assure medications are administered properly. For instance, medications are often misused and prescribed in inappropriate circumstances. The essential medicines are still not fully available year around and their availability ranges from 16%-57% depending on the geographic area. Furthermore, medications are often expired by the time they reach a hospital setting. Currently, providing and distributing NCDs medicines is a major long term issue.[8]

4. Conclusion

There were a few key barriers that were learnt from the field observation and possible suggestions for improvement are provided below. Creating nationwide change in developing countries is a multi-factorial and often long process. In order for any system to function smoothly, its foundation needs to be well rooted. Regulations, policies, and rules govern the way healthcare is carried out and are an important source of equality. If this is lacking, inequity begins to arise in the system. Longstanding change needs to come from the bottom up, beginning with accurate data collection and analysis of the health care burden. Once statistics are established, feasible policies and regulations need to be placed in order to target vulnerable areas and groups. Regular assessment of action plans and revisions need to take place. For instance, equality amongst services needs to be ensured to close the gap amongst the poor and rich. Coverage needs to be expanded to the rural areas where majority of the poverty lies. Furthermore, medication and workforce issues needs to be addressed from both the demand and supply side including adequate funding for medications as well as ensuring a well educated and competent workforce. Change needs to occur from a macro level which includes establishment of rules and regulations as well as micro level including adequate training of nurses and physicians. Lastly, equitable protection for the poor is also needed through fair identification methods so that they can reap the benefits of free health care.[6]

Conflicts of Interest Disclosure

The author declares that there is no conflict of interest.

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