

# Policy Gaps and Implementation Realities: Navigating the Disconnect in Nepal's Health Sector

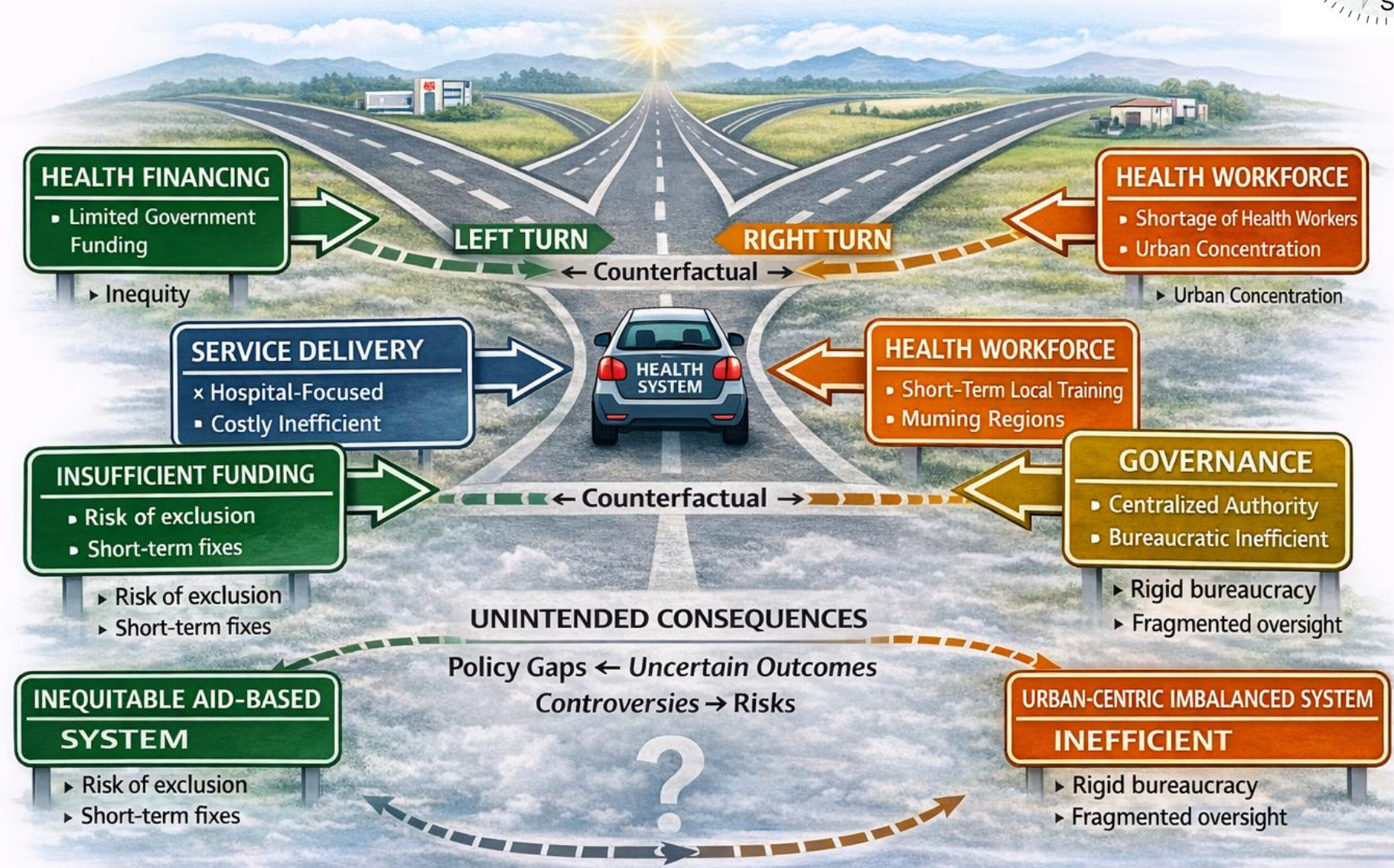
Shiva Adhikari

# Starting... ..

- Title: “Policy Gaps and Implementation Realities: Navigating the Disconnect in Nepal's Health Sector”
- Each and every words indicate “negative” but my interest is “ how to make it positive, but how to do it’s challenging”
- At first, ..... it might be healthcare ecosystem, but it is written health sector, again, how to do? It is challenging ....
- System is running ..... If we turn “left or right” “positive or negative way”, it matters but we don’t know which direction is right?
- Which turning produce what results and how?
- What is policy direction? Every directions determine counter factual

# Health System at a Crossroads: Every Path Generates Counterfactuals

## Policy Gaps and Implementation Realities: Navigating the Disconnect in Nepal's Health Sector

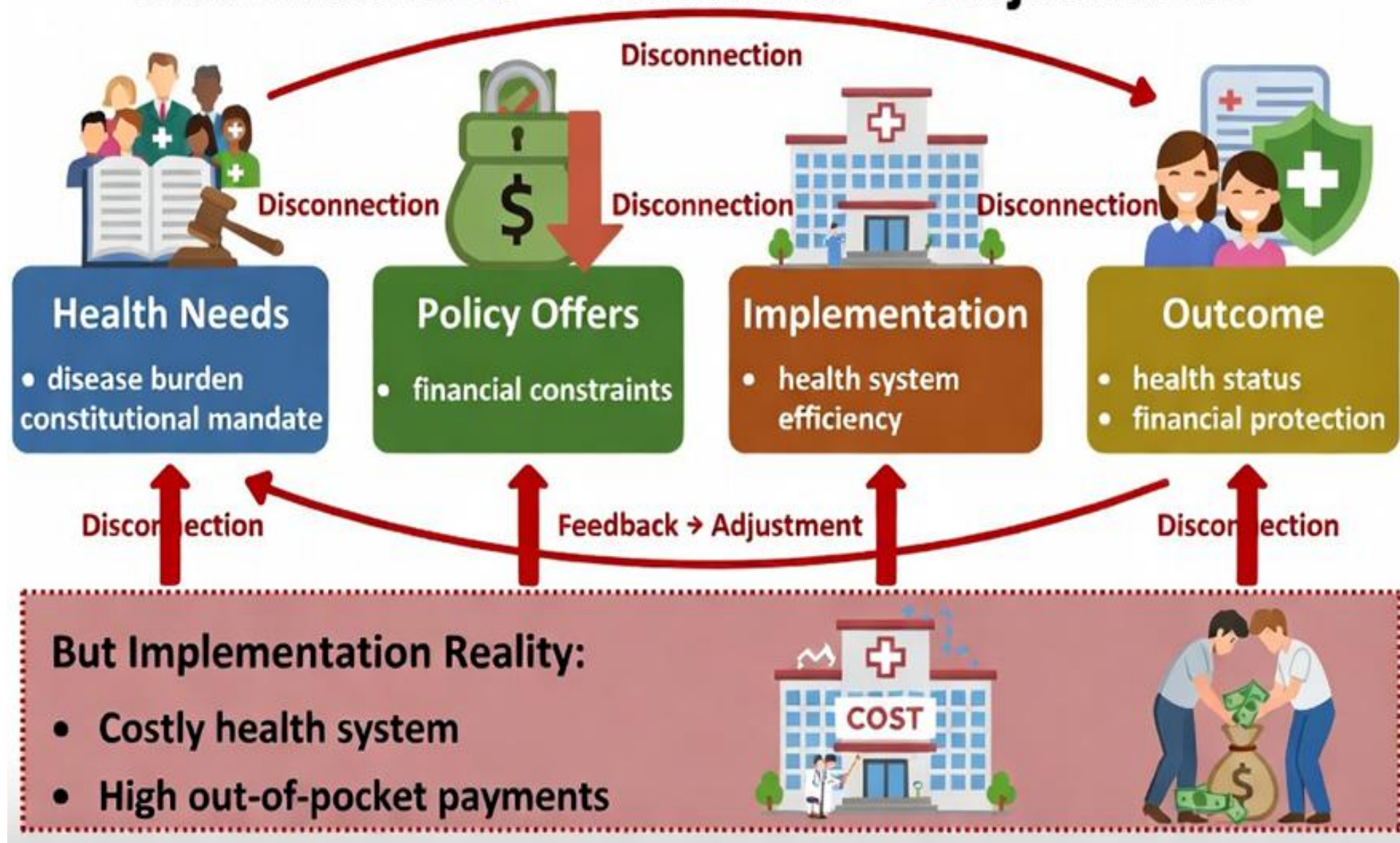


If, in the crossroad, ...  
methodology for the

analysis?

.....Ecosystem !!!

Health Needs → Policy Offers → Implementation →  
Disconnection → Feedback → Adjustment



# Health System: Need

**Pillar 1: Constitutional Provision (Normative Need):** Article 35 (Right to Health):

- Right to free basic health services; Right to emergency health care; Commitment to progressive realization of the highest attainable health standard

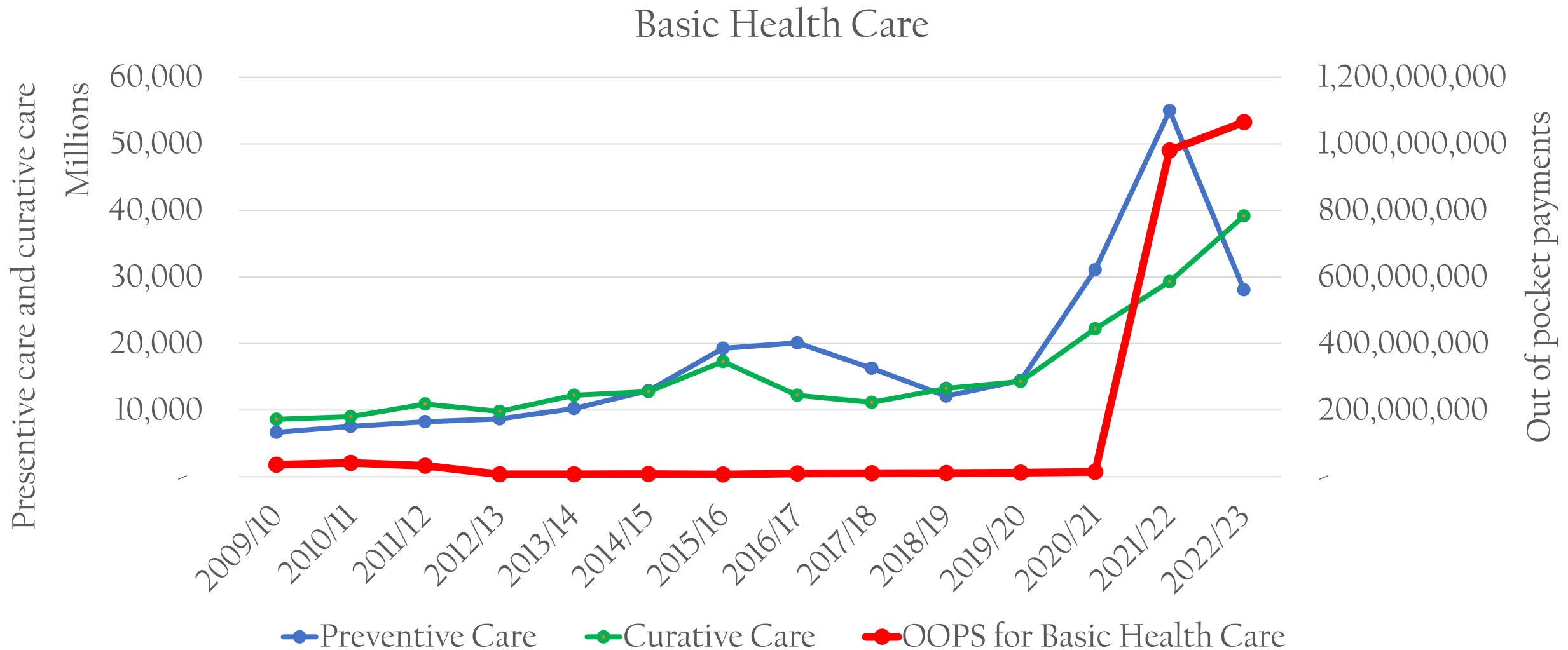
**Pillar 2: Disease Burden (Evidence-Based Need):** Disease burden reflects the actual health challenges faced by the population, measured through scientific indicators.

- DALYs (Disability-Adjusted Life Years) and Probability of premature death (PPD)

# Policy follows need, but implementation follows resources

- Policies, legal mandates, and delivery platforms are built to provide free health care.
- Free health care is delivered through public health system networks and financed by taxation.
- Policy offers institutionalize service delivery through legal mandates and health system networks to improve population health outcomes.
- Resources are allocated based on disease burden, financed through a mix of taxes, insurance, and out-of-pocket payments.

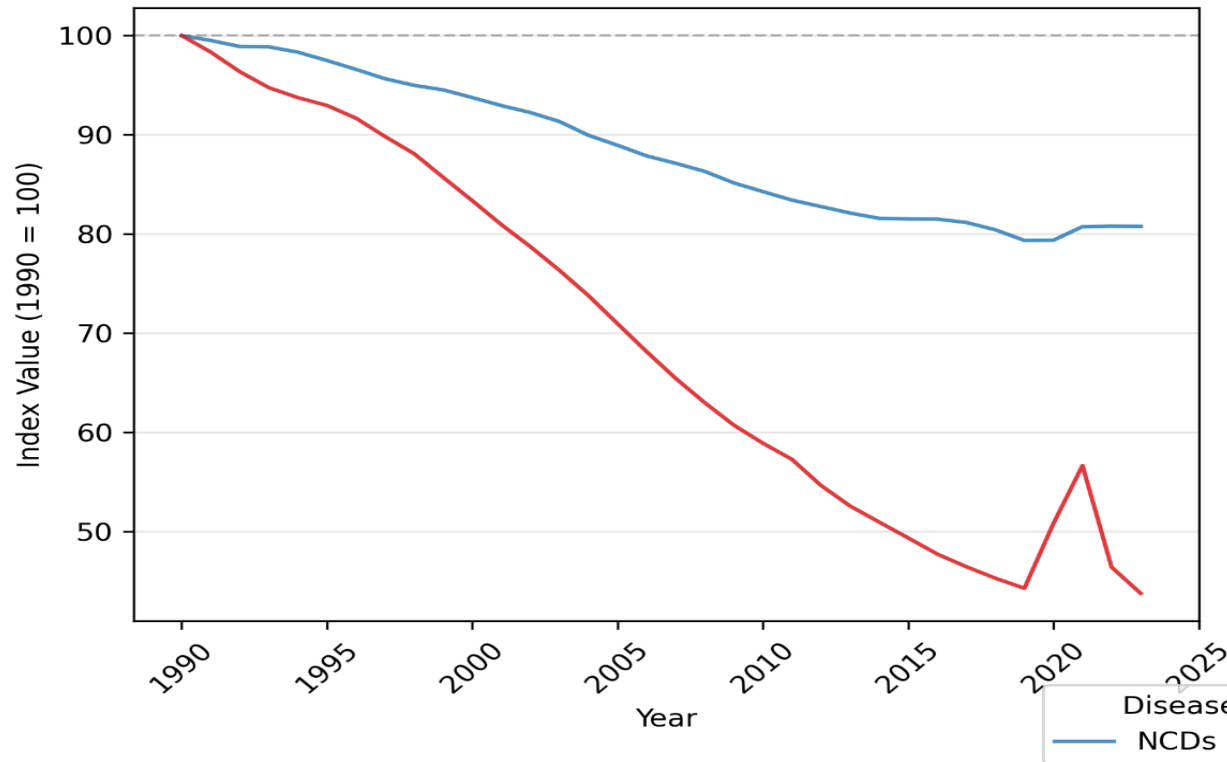
# Implementation realities: do people get basic health care services at free of cost



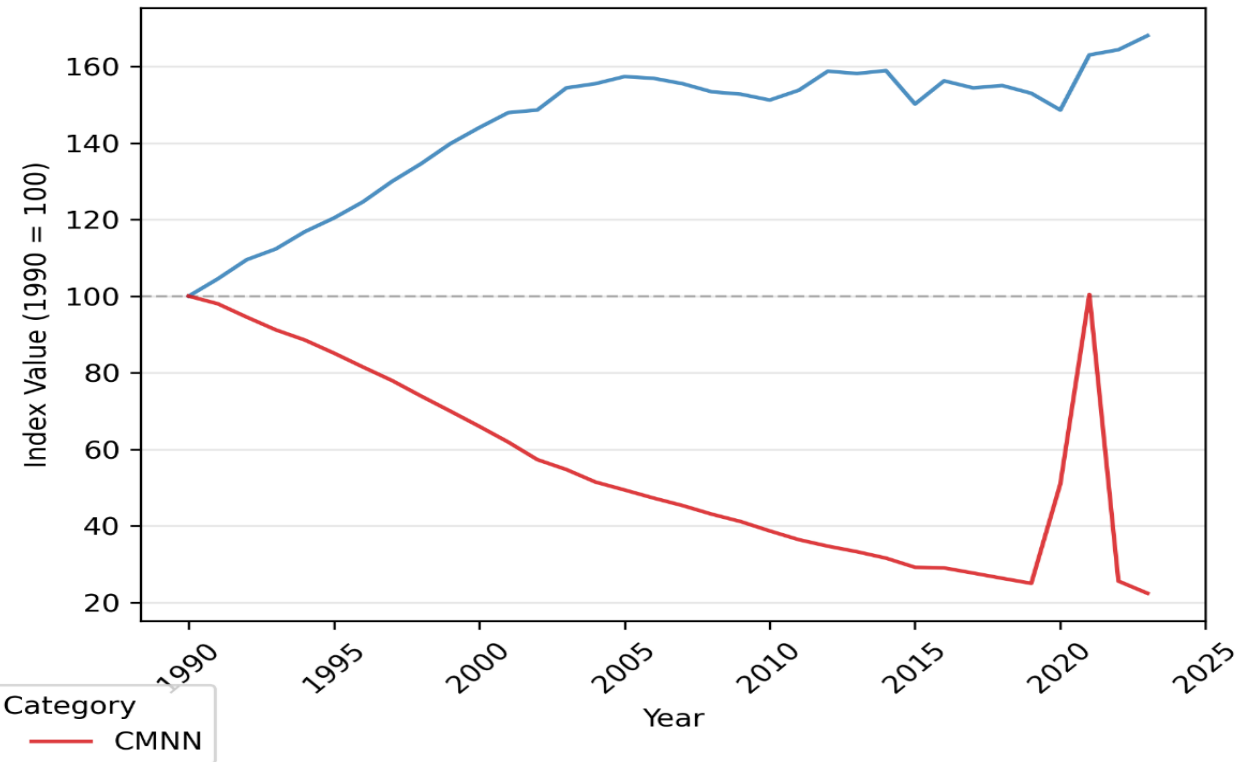
# Burden of disease: Communicable and non-communicable diseases

## Trajectories of Disease Burden and Premature Mortality Nepal (1990-2023)

A. DALY Rate Index (1990 = 100)

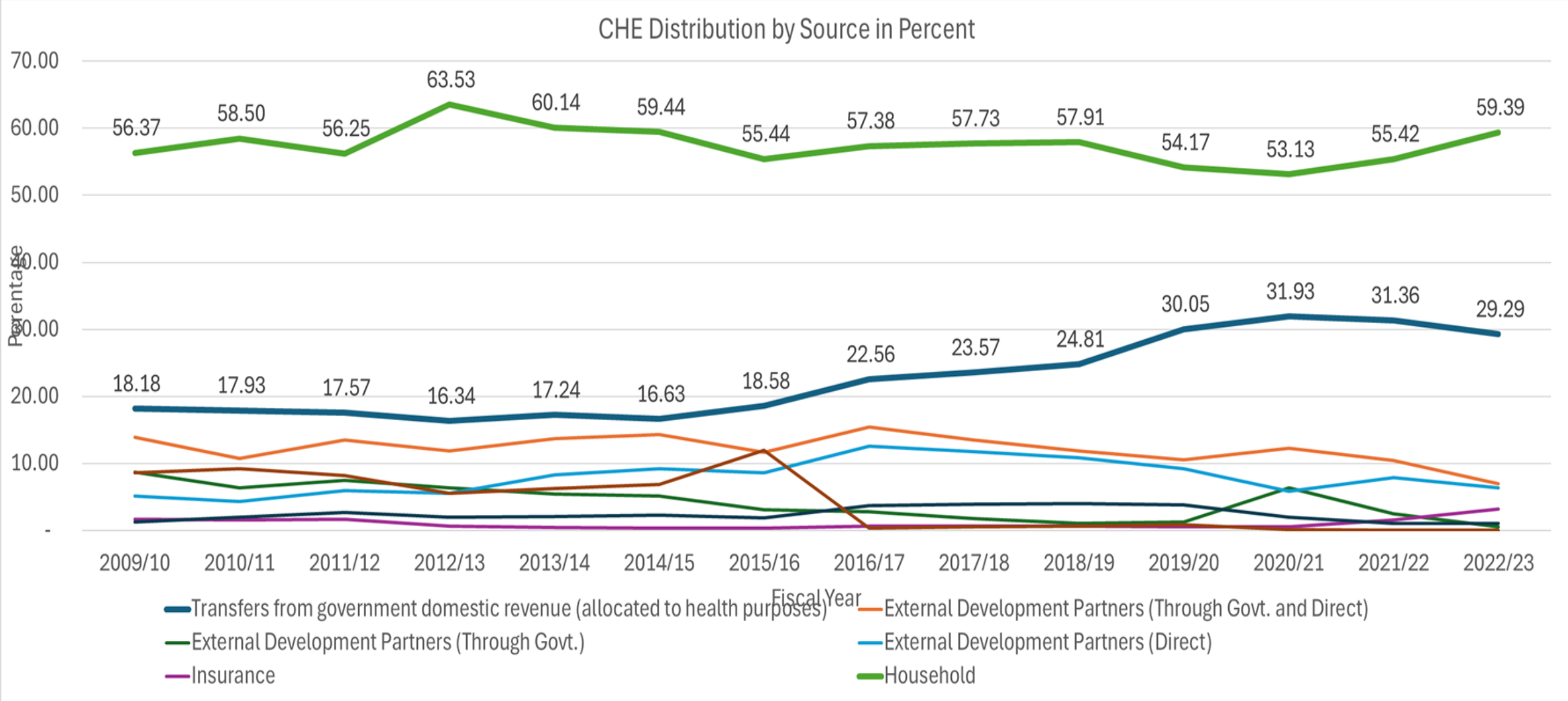


B. Probability of Premature Death Index (1990 = 100)



Note: Dashed horizontal line represents the 1990 baseline.

# Current health expenditure by sources

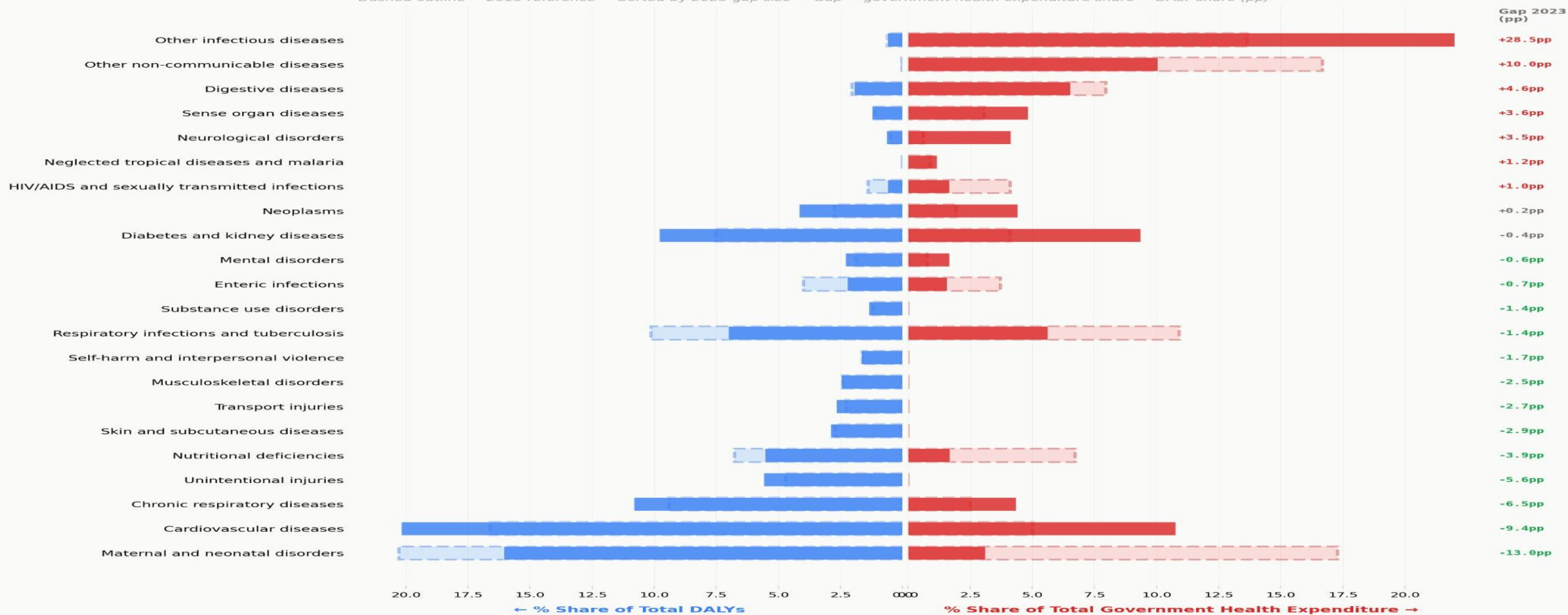


# Burden of disease & Health expenditure

## Disease Burden vs Government Health Expenditure: Share Comparison

% Share of Total DALYs vs % Share of Total Government Health Expenditure · Nepal 2023

Dashed outline = 2015 reference · Sorted by 2023 gap size · Gap = government health expenditure share – DALY share (pp)



Sources: GBD 2023 DALYs · Government Health Expenditure from PRD 2023 · Compiled Data · Nepal

# Policy gaps and Implementation Realities

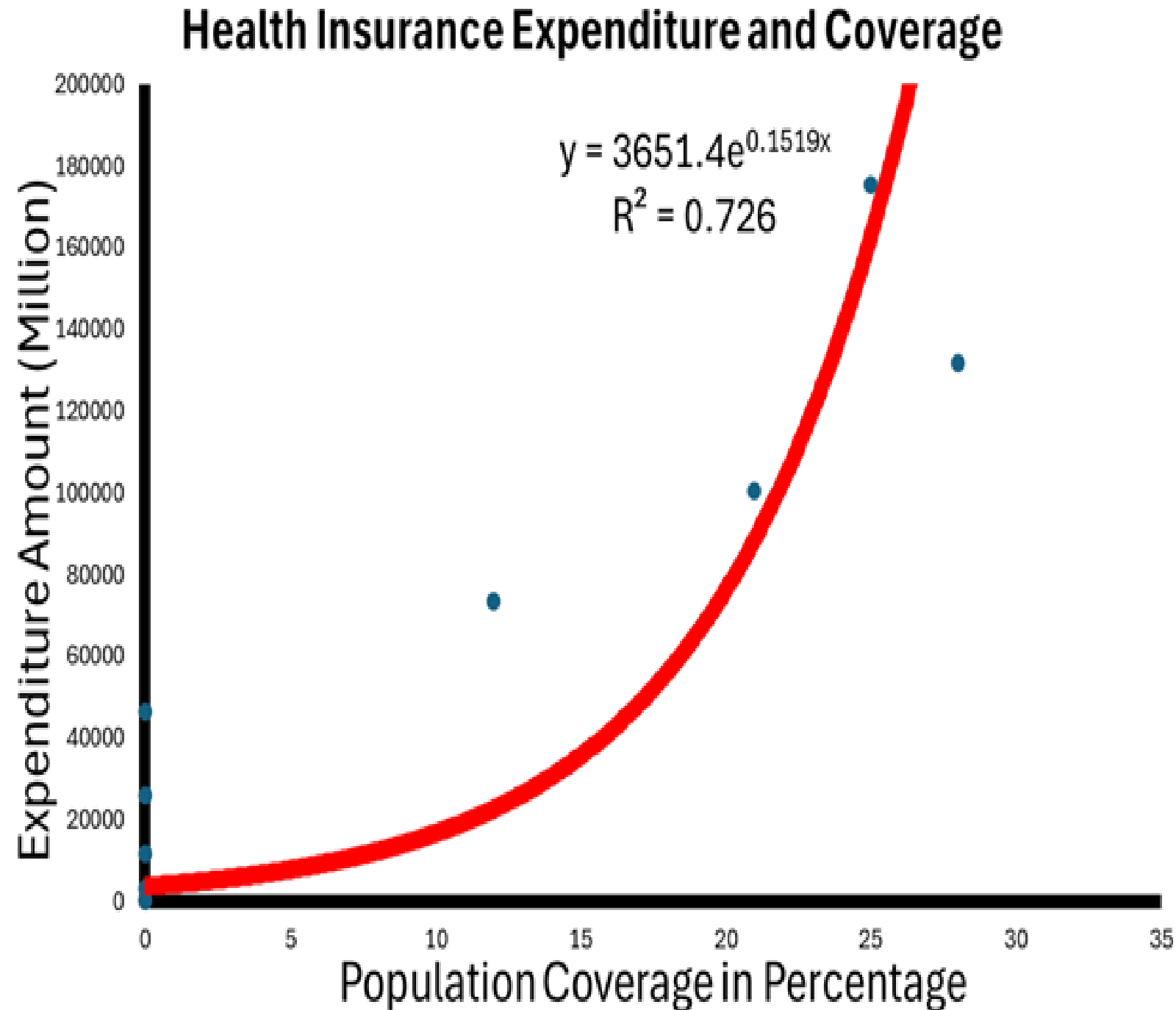
(Report of Auditor general 2082, page. 574)

- **Incomplete Implementation** – Policies like free medicines have not been fully implemented.
- **Human Resource Shortages** – There is an insufficient number of skilled health workers relative to population needs at federal, provincial, and local levels.
- **Integration of Alternative Medicine** – Plans to integrate Ayurveda, natural therapy, yoga, and homeopathy into the health system have not been effectively implemented.
- **Underutilization of Resources** – Available equipment and medical machinery are not fully used; maintenance and timely repairs are lacking.
- **Investment Gaps** – Health services have not received adequate investment or returns, affecting quality and access.
- **Persistent Health Challenges** – Communicable and non-communicable diseases, malnutrition, and disaster-related health issues remain prevalent.
- **Need for Effective Implementation** – Addressing these gaps is crucial for making the health policy truly effective.

# Navigating the Disconnect: The paradox of scarce budgets and unspent funds

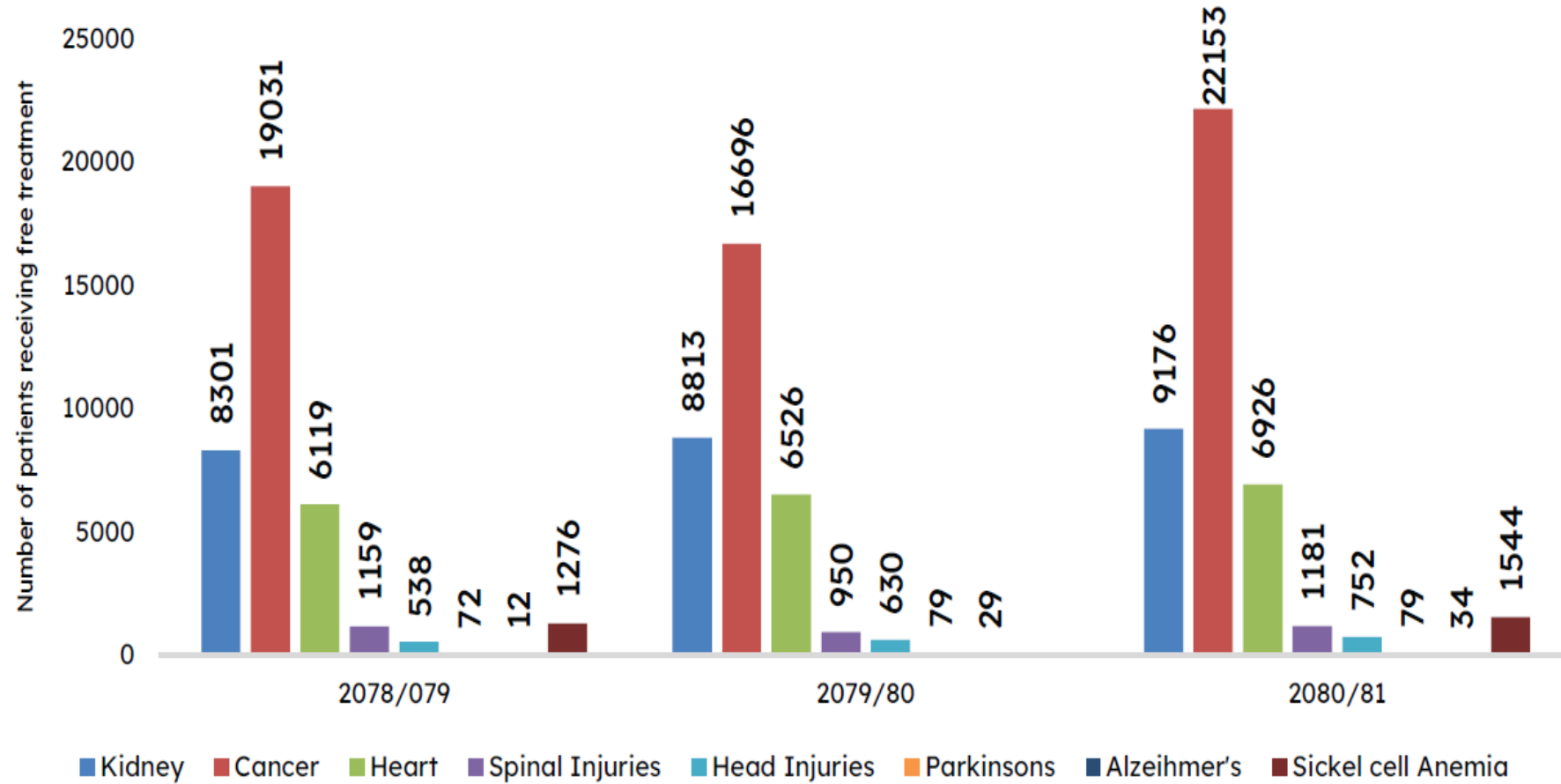
Budget Type	FY 2019/20		FY 2020/21		FY 2021/22		FY 2022/23		FY 2023/24		2024/25	
	Budget	Exp (%)	Budget	Exp (%)	Budget	Exp (%)	Budget	Exp (%)	Budget	Exp (%)	Budget	Exp (%)
<b>Capital</b>	9.3	77.5	16.10	49.28	20.06	100	19.89	76.40	15.42	63.09	13.71	67.86
<b>Recurrent</b>	29.9	80.5	43.35	72.09	71.24	55.47	44.62	54.91	35.07	77.04	37.55	87.23
<b>Total</b>	<b>39.2</b>	<b>79.8</b>	<b>59.45</b>	<b>69.80</b>	<b>91.30</b>	<b>68.34</b>	<b>64.51</b>	<b>61.54</b>	<b>50.49</b>	<b>72.78</b>	<b>51.26</b>	<b>82.04</b>

Health insurance:  
a double financial  
burden—a  
paradox of  
protection  
becoming cost.



# Scheme of Bipanna Nagarik Aushadi Upachar Program

A Paradox of Health Financing:  
Individual Resource Allocation  
Without System-Level  
Protection



- Intended protection for the vulnerable becomes uncertain when eligibility is unclear—a paradox of inclusion without definition.
- 2 arab 49 karid 30 lakh 78 hazaar expenditure for a total of 41,836 patients in 2080/81

# Some examples of Paradox

- Fiscal federalism–Resource Paradox: Responsibilities are devolved, but resources remain centralized.
- Governance–Structure Paradox: More layers of government, less clarity of responsibility.
- Conditional Grant Paradox: Stronger financial control leads to weaker service delivery.
- Policy–Implementation Paradox: Ambitious policies, minimal implementation capacity.
- Priority–Financing Paradox: High-burden diseases receive low financial priority.

# Final point: Fix the system, not just the programs

- Nepal's health system is not constrained only by lack of resources, but by misalignment between authority, incentives, and accountability.
- Health system reform!!!
- Reform is not about expanding programs; it is about fixing the delivery system—guided by evidence, not driven by political will alone.

Thank you ...all....and NHRC  
for giving “innovative title” too!