Decisions on the allocation of scarce resources for health are rarely made by governments - or their development partners - purely on the basis of technical criteria. Political and other factors also shape decision-makers’ choices. This is particularly apparent in Nepal, an economically undeveloped nation with a turbulent political history, and only recent transition to post-conflict democracy.

**Strategic context**

Nepal has made some dramatic and rapid progress in Reproductive Maternal Newborn and Child Health (RMNCH), despite being a low income country with high levels of poverty, difficult geography, and conflict. The Total Fertility Rate fell from 4.6 births per woman in 1996 to 2.6 in 2011. Nepal has already achieved the Millennium Development Goal (MDG) target of reducing maternal mortality by three quarters between 1990 and 2015, and the target under-5 mortality rate (U5MR) of 54 per 1,000 live births was achieved in 2011. As a result, new, more ambitious targets of 38/1000 for the U5MR, and 32/1000 for infant mortality, have been set by the Nepal government. Rates of stunting have also declined. These important RMNCH achievements are explained by a range of factors including the commitment of all political groups to RMNCH, even during the civil war; strong community participation to support evidence based interventions; transport subsidies and provision of free health care to users; vitamin A supplementation, and strong development partner support.

But Nepal still faces important challenges in terms of RMNCH and the health sector more broadly. Undernutrition and newborn deaths remain problematic. There are still large inequalities in access to services and RMNCH outcomes, including between rural and urban areas. The rapid rise in non-communicable diseases (NCDs) is taxing household and government budgets. Government expenditure on health needs to increase: public funding amounts to less than a quarter (23.7%) of total health spending, reflecting high levels of out of pocket expenditure and external financing. Universal health coverage (UHC) is needed to help reduce the high level of out of pocket expenditure and expand access to essential services. But achieving UHC involves significant
policy, managerial, regulatory and financial challenges. These challenges include the largely unregulated private sector, which is insufficiently accounted for in planning, priority setting, resource allocation, and quality control. Health worker promotions and placements are the subject of patronage and power in Kathmandu and need more regulation. Remittances totalled $4.9 billion in 2013, equivalent to over 25% of GDP—exceeding both foreign aid and foreign direct investment by a considerable margin. Remittances significantly help to increase consumption – including for expenditure on RMNCH and other health needs - and reduce poverty. But remittances carry some economic, social and health outcome risks as well, particularly when spent on an unregulated private sector.

**Key messages**

Given Nepal’s turbulent political history, and current complex environment, development partners should not view interventions through a purely technical lens. Nepal is emerging from a particularly tumultuous political history that includes feudalism, dynasties, royal assassinations, a ten year civil war, and the incorporation of Maoists into democratic post-conflict government. Key aspects of the functioning of the state, including the form of the Constitution and a likely transition to a federal structure remain unresolved. Development partners need to consider this troubled and complex situation in designing their support. Moreover, they should use their technical expertise and bureaucratic political capital to explain to their own stakeholders the risks of short-termism and ‘announcables’, and commit to the long term support that Nepal needs.

**Development partners have an important role in making UHC more effective, efficient, equitable, affordable and accountable by moving away from small, stand-alone “projects”.** All political parties in Nepal have committed to some form of health insurance: the challenge is to make UHC financially sustainable. An estimated 43% of the poorest in Nepal did not seek care for their last illness due to anticipated out-of-pocket expenses. Successful roll out of UHC may therefore be a ‘game changer’ affecting the entire health system, both public and private. But this will require more ‘upstream’ dialogue about its design, funding and implementation as it is progressively introduced.

**There are opportunities for development partners to engage with UHC**, for example through catalysing a stronger evidence-base that can then shape future related policies and actions. Strategic opportunities include the design of benefit packages to improve RMNCH and reduce inequity; reallocating resources to primary and secondary prevention to address the growing health and financial burden of NCDs, including advocacy for tobacco control, the key preventable risk factor for NCDs; impact evaluation about what works, for whom, at what cost and under what circumstances; and designing ways to increasingly engage the dominant – but largely unregulated and ignored – private health providers. There are also nascent attempts to introduce substantive planning and freedom to allocate resources at sub-national level, which partners such as the United Kingdom’s DFID and UNICEF have been supporting.

**But there are challenges as well.** Government needs to substantially increase the level – and effectiveness – of its own expenditure if it is to improve health outcomes and reduce financial risk. Total health expenditure is low at just $35.8 per person in 2012, compared to much higher figures recommended by global authorities. Planning and priority setting remains highly centralised in Kathmandu, despite early ‘bottom up’ local initiatives. Financial planning is complex, rigid, and centralised, with an estimated 166 fixed budget lines, but little opportunity for reallocation between line items to meet emerging priorities. Important health priorities appear with little advance notice or consultation, despite having major financial and resource implications. Important decisions about scaling up UHC have been made in the budget but to date have not involved detailed consultations with stakeholders, including development partners. Human resources remain weak at all levels, including in health planning, budgeting and management. There is need to determine the appropriate mix of public and private, clinical and preventive services to most equitably support Nepal’s widely divergent population. Finally, the regulatory, financial, structural and administrative characteristics required for the successful merging of public and private health services in the context of UHC must be introduced.

**References**

2. HEART. Nepal Health Sector Program II: Mid Term Review. Oxford Policy Management Limited, 2013