

Guest Editorial

Federalisation: Is It Facilitating Nepal in Achieving Universal Health Care

Ehsanullah Tarin

Federalisation on Nepal's progress towards UHC; and is conceived in the follow up to country signing up to UN 2030 Agenda for SDG. It includes, inter-alia a goal for achieving UHC, and alongside that in September, 2015 new constitution was promulgated, replacing the erstwhile unitary system of governance with a three tiered devolved federal state structure.

Eight key informants, selected purposively from the three tiers of health system hierarchy, were interviewed to collect primary data, substantiated with secondary data from published and grey literature.

At local level, elected Mayors and Councillors, responsible for health, often acted based on political expediency, and since were neither oriented nor was their capacity built, healthcare was not a priority. Thus, UHC targets were further pushed off. But, where Local Health Coordinator was strong, some tangible improvements were also noted. The federated structure is still evolving, as planning and implementation arrangements were not proper and robust. It was like "thinking and planning alongside the implementation" and with regard to interventions like establishing district health offices, it was a "hit and trial". On the other hand, provincial and local levels, which were relatively quick to organise, exercised the delegated authority in managing health sector. But, in the absence of uniform plans and guidelines, these bodies went in their own way, contributing to the "Americanisation of the health sector". The federal level, in the process, resisted the change, to maintain its organisation, faltering also in developing robust plan, guidelines and supporting the new federalised structures.

In September 2015, Nepal, together with 192 other

countries, signed on to the "UN 2030 Agenda for Sustainable Development"¹, which includes a goal for achieving Universal Health Coverage (UHC). Under UHC, countries engage to improve access to affordable quality health care. In line with these, Nepal has set country-specific targets related to the Sustainable Development Goals (SDGs) and UHC.

Also in September 2015, Nepal promulgated a new constitution, and in doing so it formally became a federal state. Since then, government structures and institutions, including in the health sector, are gradually being overhauled, to reflect a three-level state structure, comprising the federal level, seven provinces with a total of 77 districts, and 753 local bodies.² Each local body has a varying number of wards, which are the smallest administrative units. At federal level, a Ministry of Health and Population (MOH&P) replaced the hitherto Ministry of Health. At province level, there is a Ministry of Social Development, which in addition to health sector, looks after education, social welfare and women development. At local levels, local bodies, headed by elected Mayors, manage healthcare delivery within their own jurisdiction, and exercise authority over administrative, financial, human resources, planning and implementation issues. They are supported by a health coordinator.

We investigate in this paper, how federalisation, which aims at giving more authority to local levels, is influencing country's progress towards UHC. For that purpose, after defining the study methodology, the study findings are discussed. We conclude that the process of Nepal becoming a federalised state is affecting the country's advance towards UHC, and we advocate that a course of action be defined that allows for both federalisation and UHC to progress in

parallel.

Qualitative methods were used for collecting primary as well as secondary data. Eight key informants were interviewed. The participants, selected purposively, included health managers, at different levels of health system governance and stakeholders, barring the mayors and health services users, and represented urban as well as rural settings. Consent was taken from each interviewee and interviews were recorded using a recording device and participants were assured of confidentiality. A question guide was used to steer the interview process. Interviews conducted in Nepali language were transcribed and translated into English. Secondary data were collected by a review of documents including HMIS reports, referred to here and there in this paper. The authors, who have worked in the Nepal health system, also brought their insight and perspective, albeit exercising rigor for avoiding bias creeping into the study. The data, so collected, were analysed and the deduced findings together with quotes are interpreted and conclusions drawn as lessons learnt for defining the future course of action.

In Nepal, the concept of UHC is reflected in a number of national documents (see below), some of which date from before the UHC-era. However, Article 35(1) of the national constitution (2015) has been the real driver. This article states that “every citizen shall have right to free basic health services from the State, and no one shall be deprived of emergency health services”. In Nepal, the implementation of the UHC agenda has coincided with the process of establishing a federal state.

Limited knowledge and understanding of UHC at subnational levels

The ideas behind UHC, as indicated above, have in Nepal been reflected as the national policies and strategic agendas even prior to the UN’s proclamation of SDG, 2030. However, the actual implementation of UHC was seen by a former national-level government health manager as follows:

[UHC implementation] has been a discussion point at federal level, but has not been transcended to the lower levels of government”. It has been more of an intellectual debate among academicians and high level professionals, while politicians at local govern-

ment level know little about it.

Yet, in the opinion of a government provincial health officer, the lower levels have, unwittingly though, contributed to UHC:

There is a paradigm shift following federalisation. The service provision, which prior to federalism was steered by the federal level, has now become a local level responsibility. This has led to an increase of the available health workforce and supplies at local levels, but this has happened unknowingly, as the local level officials often lack knowledge and understanding of UHC.

Local level politicians are not well-prepared for implementing UHC

The above state of affairs is not uniform across in all local level units. Instead, although under the new constitution the local level, i.e. municipality has the responsibility of providing basic health care, there remains confusion about this role. A senior health official at provincial level, noting that despite the deployment of a “Health Coordinator” in each of the 753 municipalities, summarized the situation as:

Basic health services provision is within the authority of Mayors. But mayors often do not have a health background and often do not understand the urgency related to the provision of health services. So, health services in many cases do not get sufficient attention at local level, resulting in lower service coverage, making the UHC targets more difficult to reach. This is despite the deployment of a “Health Coordinator” in each of the 753 local municipalities.

In this context, as a Local Health Coordinator highlighted, there is a need to engage local politicians in health issues, i.e. in translating UHC concepts into implementation plans at local level. The elected Mayors and Councillors tend to take action based on what they perceive as being the politically important issues, which often are not health-related. A one-day workshop for Mayors about health issues at local level though held was insufficient and inadequate to properly orient and convince the Mayors to prioritize health issues.

Motivated local level officials can make a difference for UHC

The switch to a federal government system offers both opportunities and challenges, also for progress towards UHC. This was confirmed through our interviews. A local level health worker said that because the local government is now responsible for utilising the allocated budget as well as for generating additional resources, there could be an opportunity to align the provision of health services at local levels with the local health needs, which could contribute to Nepal's progress towards UHC. But in reality a mixed status has emerged. One respondent, who served in senior position at federal level said:

Federalization is certainly helping to make progress towards UHC... and despite no solid achievement yet, there will be improvements in health status. The monitoring and supervision of health facility and health workers by locally elected leaders will increase service availability, delivery and quality of care.

Other respondents also confirmed this view. The following quote illustrates an overall picture with regard to the progress made at some local levels:

Reducing staff absenteeism has in my area been reduced to almost zero, and availability of medicine has been improved, linking this to local epidemiology and demography. Ambulance services have now been made available, infrastructure like birthing centres hitherto unavailable in rural areas has been built and additional staff has been recruited.

The authors also observed that at least in one locality elected Councillors (empowered by federalization) visited health facilities to check the presence of health staff and the working conditions of the health facility. On the other hand, one senior government official voiced his concern that in his view:

“UHC was not yet up to standard rather still is at advocacy, resource management, designing process of UHC and planning to make population able to receive healthcare services; therefore we are at starting phase. So basically UHC financing and increasing reach of services”.

Changes in the administrative organization have an impact on UHC implementation.

In Nepal, as a consequence of the promulgation of

new constitution, the hitherto unitary system of governance is being gradually replaced with a three-tiered federal structure, comprising the federal level, seven provinces, and 753 local bodies (“municipalities”). Each local body has a varying number of wards, which are the smallest administrative units. But this administrative reorganization has not yet been matched by the institutionalization of sufficient capacity. One respondent said:

The provincial and local levels lack capacity in planning, budgeting and policymaking, besides limited technical capacity at the local level. Hence, in many cases there is low utilization of budget, which hampers proper delivery of services, affecting adversely progress towards UHC.

With regard to the above, one interviewee working at municipality level said that the local governments, which partially took over functions of the districts, had neither the capacity nor were trained for their new role. At the same time, the organisational structures are still evolving. For example, the 77 districts, which were the backbone of the health system in the pre-federal era, were abolished, and their staff reassigned, mostly to the local levels. Recently however, there were attempts to create “provincial health offices”, covering geographical areas similar to the ones covered earlier by the districts, but staffed with fewer and mostly new people.

This situation, as a respondent noted, has led to “a (at least partial) loss of institutional memory and functions hitherto performed by districts. Uncertainty prevails also as to the role of the districts or their equivalents in the devolved set up”. One example in this regard is that in the new set-up the reporting for HMIS from health facilities has been partially disrupted. And, the quality and completeness of the reported data can no longer be assured.

Better planning for transition of Human Resources is imperative

A transition to a federal set-up has implications for the human resources, which requires robust planning. Provincial Public Services Commissions have been established, as required under constitution, to coordinate reassignments and recruitment of staff at provincial and local levels. But other HR-related activities, such as updated rules and job descriptions

for civil servants, redefined career and incentive structures and induction courses to orient staff on their new roles and responsibilities, have largely been missed. A provincial health manager, in this regard, observed:

Preparations for transiting to federalization have been inadequate and no proper human resources planning have been done prior to introducing the new system. Particularly, since no service rules are defined and proper cadre rules are not in place, human resources management is often ad-hoc, especially with regard to the management positions in provinces.

In the devolved set up, when Federal Public Service Commission wanted to recruit civil servants for local levels, the move was vehemently resisted by lawmakers, because such an action flaunts the concepts related to the demarcation of powers of three tiers of government. A senior officer, who led the health sector in the transition phase of federalisation, was candid in admitting the gaps. He elaborated:

No policies were made, no guidelines were made to demarcate duties of each level of government... There was a lack of knowledge and experience in politicians and bureaucrats in implementation of federalization at three tiers of government so we depended on doing and learning principle.

Lack of planning has led to subnational levels overstepping their boundaries

The federal level is responsible to define political, fiscal and administrative details with regard to the federalisation of state structures. But, this has not always happened, as one official in the federal government observed:

Every line ministry should have developed a detailed work-plan to support the implementation of federalization at every level and in every sector, but that has not happened.

Thus, in the absence of implementation details, provincial and local governments made certain amendments to the existing systems as they saw fit, rather than letting the task to the federal government. The result is that, as a consultant noted, 753 local health systems (equivalent to the number of municipi-

palities) may be in the offing.

Federal level resisting the change

Federal level, according to schedule 5 (16) of the Nepal national constitution, is responsible for “health policies, health services, health standards, quality and monitoring, national or specialised service providing hospitals, traditional treatment services and communicable disease control”. That is, in conformity with this provisions, MOH at federal level should have devolved those functions not covered under schedule 5 (16) and appropriated staff to devolved units, for example, provincial and local levels. But, it has retained many functions and the related staff, almost maintaining with some adjustments the erstwhile organisation.

The federal level, a consultant advised, instead of focussing on the high level normative functions, and contributing to policymaking, setting standard, developing guidelines, remained short of defining rules and regulations, including updating civil services rules, supporting provincial and local levels, developing transition plan and managing change etc. It actually dropped the ball, and this situation connotes the rising concerns in other sectors also.

In Nepal, federalism is being implemented at the same time that the progress is also being made towards UHC. Although federalism affects all parts of government, its impact on the health sector also affects the work related to UHC.

So far, federalism in Nepal has been, as one can expect, a mix of opportunities and challenges for UHC. It was seen with optimism, as according to a senior manager, it is at the “initial stage” and federalised structures are still evolving. In a confirmatory note, a planning officer observed, “we were planning and thinking at each level, so as not to disrupt the in vogue healthcare delivery system”. Others we spoke to had a pessimistic view and felt that because federal level (responsible to define political, fiscal and administrative details), had “no proper plan that resulted in the expected progress not being achieved”.

It is clear that since the elections for all tiers of government in late 2017 major administrative and organizational changes have taken place at all three levels. At federal level, a Ministry of Health and

Population (MOH&P) replaced the hitherto Ministry of Health, while the health sector at province level has become the responsibility of the (provincial) Ministry of Social Development. At local levels, headed by the elected Mayors local bodies manage healthcare delivery. More contentiously, District Public Health Offices (DPHO), which had been the backbone of the healthcare system, became non-functional, in line with the view that the district level is not part of a federalised structure as defined by the constitution. Some interviewees had a different view and felt that not only there was a space for districts in the constitution, maintaining DPHOs would be key to ensure an integrated health care system for PHC. Interestingly, recently new “Provincial Health Offices” (PHO) have been created, which up to a limited extent could take over the functions that previously had been covered by the DPHOs. It is still to be seen to what extent these new Provincial Health Offices will contribute to UHC.

Subnational levels have authority for the oversight of health facilities, buying medicines (out of a predefined essential medicines list), paying for the operating cost, and recruitment of staff. Funding for the health sector is disbursed directly from federal level to provincial and local levels as “conditional (i.e. earmarked) grants” for mandatory services, while “equalization grants” and “substitution grants” are meant for other health services. For the latter two grants, the provincial and local bodies have flexibility on how to utilise these grants. In addition, while locally generated revenue can be used for health, it is up to local authorities to determine what their priorities are and whether these include health, and if so, what support to the health sector is most needed.

While funding is available at subnational levels, in the absence of clear plans and guidelines, this level went their own way of health sector management, as authorised under constitution. The result has so far been a wide variety of approaches taken by subnational levels for the health sector, with the risk of “mini- health systems” being formed in each locality. In addition, as each local body can purchase medicines, procurement is often no longer cost beneficial. The breakdown of a clear hierarchy and reporting lines has also led to gaps in regular reporting on progress towards UHC.

Against this backdrop of uncertainty on how federalism will play out, the federal level has focused on developing national acts, policies, guidelines, standards and documents. Once adopted and accepted by subnational levels, these directions should provide much-needed clarity in key health areas.

The government has also launched an insurance scheme in 42 of the 77 former districts, which should help protect people from health-induced financial hardship. Thus far, an estimated 12.8% of households or 5.6% of population are covered by the health insurance scheme. Anecdotally, the impact of federalism on the health insurance program has been minimal.

While no recent (post-federalism) data are available on UHC Coverage, the UHC Coverage Index for Nepal stood at 46% in 2015/16, compared to a regional average of 55%. This status reflects a relatively weak capacity of the health system in providing essential health services in the pre-federalised era, a claim substantiated by the findings of National Health Facility Survey 2015. Yet, aging population and rising burden of noncommunicable diseases (NCDs) have added to the demand. For the same period, health care remains expensive for many people, especially the poor: household’s out-of-pocket expenditure was 60.41% of CHE and the catastrophic health expenditure affected 10.7% of people, while 1.67% of population was pushed below the poverty line of PPP\$ 1.90 per capita per day.

In September 2015 alongside the proclamation of UN 2030 Agenda for SDG, which includes a goal for achieving UHC, Nepal promulgated its new constitution, which replaced the hitherto unitary system of governance with a three tiered devolved federal state structure. A qualitative study was conducted to investigate the influence of federalisation on country’s progress towards UHC. It revealed that, almost four years on, although progress is made, there were some serious shortcomings in how the state was federalised. As a result, the country’s advance towards UHC may have been compromised. In order to reverse the drift and accelerate the progress, it is imperative to define a roadmap for implementing UHC, but equally important is to develop a comprehensive plan of

action for the federalisation of state structure. Specifically, as the country has made a decision to become a federalized state, all efforts must be made to further decentralise and delegate powers to local bodies for hospitals and healthcare networks in a district or municipality. A wider stakeholder involvement across geographic and political spectrum and inclusive dialogue, under MoH&P leadership, is required to promote and implement the health system strengthening in a harmonised manner.

Shortcomings in how the unitary state was federalised affected and decelerated the country's advance towards UHC. It was, and is still imperative to define, with the consensus of wider stakeholders across geographic and political spectrum, a roadmap for implementing UHC as well as a comprehensive plan of action for the federalisation of state structures, as both should go hand-in-hand.

Reference

1. United nations in china. Sustainable Development Goals Officially Adopted by 193 Countries. [Online]. Available from: <http://www.un.org.cn / info/ 6/ 620. html> [Accessed 17 March 2020].
2. Nepal law commission. Constitution of Nepal. [Online]. Available from: <http://www.lawcommission.gov.np/en/archives/category/documents/prevailing-law/constitution/constitution-of-nepal> [Accessed 17 March 2020].
3. Thapa R, Bam K, Tiwari P, Sinha TK, Dahal S. Implementing federalism in the health system of Nepal: opportunities and challenges. *International journal of health policy and management*. 2019;8(4):195.
4. Pokharel R, Silwal PR. Social health insurance in Nepal: A health system departure toward the universal health coverage. *The International journal of health planning and management*. 2018; 33(3): 573-80.
5. Bhandari GP, Angdembe MR, Dhimal M, Neupane S, Bhusal C. State of non-communicable diseases in Nepal. *BMC public health*. 2014;14(1):23.