Health Service Decentralization in Nepal: Status and Reconsideration

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ABSTRACT

Keywords: Decentralization, Health service delivery, resources, impacts, planning, policies and strategies, and etc.

This paper analyze why the health indicators are not achieved as indicated in policy documents; discuss how GON has been transferring power and authority to local level in health sector; examining how health policies are being implemented and find out the impacts on the capacity of local level.

The research design of this study is analytical. Resources (human and economic); mode of planning and government commitment are as an independent variables whereas policy implementation of decentralization act as dependent variable for the study. To conduct this research, theory of decentralization was applied. This study adopted both quantitative and qualitative methods. For this, both primary and secondary data/ information were generated and utilized.

Finding of the study reveals that there are some pertinent issues related to health service delivery system to be addressed. The issues are tension between devolution and deconcentration, increasing disparity, increasing spatial hierarchy, centrally controlled top-down to bottom up mode of planning; poor service delivery; weak institutional capability of local organizations involved in health sectors; and lack of coordination of these health institutions and the like.

Introduction

Decentralization has been an incessant theme in Nepal over the last five decades. It has evolved according to the rationale of successive regimes (Gurung, 2003). It ranges from the Rana Rule (pre-1951), for cosmetic purposes, to the Panchayat period (1960-90), to sustain elite power and further, for good governance after the restoration of democracy (post 1990). Some legal initiations which include Local Administration Act (1965), District Development
Plan (1974), Decentralization Act (1982), Local Self-governance Act (1999) and etc. have been carried out. Besides, 13 high-level task force/commissions were constituted for decentralization in four decades (Gurung 1998, 47). However, there is centralized government structure as problem which loathes delegating authority (Micksell, 1999: 145). In Nepal, the existing centralized decision-making, planning and budgeting system as well as central control of resources has been considered major constraints in the good governance and decentralization reform process. In this context, the overall administrative system, staffing arrangements and accountability needs to be shifted from a central to local orientation. The resistance from line ministries to devolve resources both financial and staff to local governments has been a major constraint (Bista 2003). Weak capacity, structure, excess number and size of local governments are another serious constraint, which needs to be reviewed. The number of local governments in Nepal is unreasonable and too large for effective and efficient planning, administration, coordination, cost efficiency, resource allocation and service delivery (Bista 2003).

Keeping this situation in mind, this paper reviews the concept of decentralization, and analyzes legislation process and its impacts in health service delivery particularly in Nepal. Besides, this paper examine that how health service decentralized planning is executing in Nepal.

For this, the research design of this study is analytical. Legislation process, mode of planning and government commitment, and human resources are as independent variables whereas policy implementations of decentralization act as dependent variable for the study. To conduct this research, theory of decentralization was applied. This study adopted both quantitative and qualitative methods. For this, both primary and secondary data/information were generated and utilized. While doing this, the primary data/information was generated through interviews with key-informants. Secondary information was collected from sources such as Nepal's government's appropriate documents, office records of relevant offices, published and unpublished information by various individuals and the institutions.

**Concept of Decentralization**

Decentralization is widely believed that it increases possibilities for participation of all stakeholders; people would be empowered to manage their affairs; people shoulders
responsibilities and feel ownership; and there would be a more efficient provision of public
goods and services for the people in general and the poor in particular. Therefore,
Government of Nepal (GON) emphasizes on decentralization to devolve power in order to
provide health service at door steps of people.

Conceptually, decentralization within the state involves a transfer of authority to perform
some service to the public from an individual or an agency in central government to some
other individual or agency which is closer to the public to be served (Rondinelli and Cheema,
1983). The transfer of authority can be done two ways: territorial and functional. The basis
of transfer of territorial authority is placed at the lower level of territorial hierarchy where
service providers and clients are geographically closer. Similarly, the authority transfer can
also be made functionally. There are three types of such transfer of authority: i) within formal
political structure, ii) within public administrative or parastatal structure and iii) from an
institution of the state to a non-state agency(Turner and Humle, 1997:152). Expected benefits
of the decentralization are assumed as it would promote local democracy, debureaucratization
and mobilization of people’s participation politically (Shrestha, 2000: 55-56). From the
administrative view points, it improves administrative efficiency, make government quickly
respond to the needs and aspirations of the peoples’ and enhance the quantity and quality of
services, government provides to the people (ibid:56). Similarly, from development view
point, it lead better decision-making and greater efficiency and effectiveness on locally
specific plans, inter-organizational coordination, motivation of field level workers, and
etc(Humle and Turner, 1997:156-157).

However, these proposition of decentralization’ benefits seem from normative stance. It can
be argued that the possibilities of cost and risk of decentralization viz: loss of high scale of
economies and generation of duplication and unemployment of staff and equipment. It can
create coordination problem among inter- or intra- organizations within the state. Due to lack
of resource, there might be institutional constraints that can hardly cope with the need and
aspiration of the people. The possibility of disintegration of state also can be denied in
decentralization process. In practice too, the challenges of good governance through
decentralization are many. In most developing countries, there has been tendency for
independent governments to prefer delegating power within the public service
[deconcentration] rather than to locally elected authorities [devolution]. There has been much
rhetoric about participation and local autonomy, but central governments have jealously
guarded their power (Turner and Hulme 1997, 151-175). Under the banner of decentralization leaders have introduced policies that concentrate power and decision-making and weaken local areas. Serious devolutions have been rare, and deconcentration or the establishment of mixed authorities have been favoured modes for Third World Leaders (Turner and Humle, 1997: 174). Therefore, there seems a great tension between deconcentration and devolution of power for the service delivery in developing country at local level.

Legislation and Its effect

Case of Nepal, GON has introduced one of the world's most progressive legislation for decentralization in the world devolving primary responsibility for local development to elected local authorities (MOHP, 2006:9).

While the Local Self-governance Act (LSGA) mandates local government bodies to manage and supervise sub or Health Post (S/HP) and their functioning, local committees and Village Development Committee (VDC) and bodies like Health Management Committee (HMC) should control resources and management of S/HP. Another discrepancy is the allocation of responsibilities without any provision for the required resources. These differences in rules and regulations between LGSA, 10th Plan and Ministry of Health and Population (MOHP) guidelines and the role of local bodies (VDCs, and District Development Committees-DDCs) are a major concern for enhanced community ownerships of S/HPs.

Currently VDCs receive central government grant of which 25% are earmarked for social services including health. In addition, VDCs can generate additional resources to cover the services. No extra central government funds accompany the new arrangements under SHP handover. While the committees have the responsibilities to oversee and monitor the functioning of health staff, they have no responsibilities for their hiring and firing, which remains under the MOHP.

The chair of the SHP health committee is the VDC chairman when in post. In the current climate the chairman is the VDC secretary. The guidelines state that the committee must have four women as members and two candidates have to represent the dalit/Janajati community (with one being a woman). The SHP Management Guidelines outline the functions of the SHPMC but no role or responsibility to address gender and social inclusion concerns are
stated. The functions are state in a neutral manner, based on the assumption that services will reach all the members of the community. In an interview of both ex-chairman of the SHPMC, Wangsing and Chilaunebash, "the responsibility of the management is not transferred in true sense. People have no access to resources."

**Tension between devolution and deconcentration**

The Local Self-Governance Act 1999 develops a unique mixture of devolution and deconcentration. In one hand, Nepal has started decentralising health care delivery by transferring funds and responsibilities for managing health facilities to locally constituted Local Health Management Committees (LMHCs) in 2001. The logic behind this devolution is that by making health care providers accountable to a local committee, the local residents will have more say in how public resources for health are used and that consequently the quality of care will improve for the whole community. On the other hand, Nepal has been practicing the deconcentration since the mid of the 20th century in health and other sectors. A key issue is that the point of contact between devolution and deconcentration and the relations of authority established. While examining LGSA in Nepal, there are two problematic points of contact between deconcentration and devolution.

First, from functional backdrop of deconcentration, it is represented by the ministries with their lines of managerial authority stretching out to the districts. Shrestha (2000:42-3) points to the problematic relationship between the deconcentrated line agencies represented at the district level and devolved system of DDCs and VDCs: “Since the jurisdictions of the local body and line agencies overlap, the DDC itself wields little competence to influence the decision-making of the line agencies in the district. The line agencies function under the direct and exclusive administrative control of their respective ministries which provide them with their annual programmes including their targets and budgets.” Similarly, Adhikari (2001:9) sees the problem in terms of dual accountability of the line agencies which are, on one hand, accountable to parliament and the Auditor General and, on the other, are required by the LGSA to develop new forms of planning and accountability. LAFC (2000:41) (Commission 2000) also points out that “although local bodies have powers to monitor locally based government agencies and Non-government organizations(NGOs), they are not complete because their powers are not mandatory.”
The second form of deconcentration in Nepal is that integrated deconcentration. This represented by the Local Development Officer (LDO) in DDC or Secretary in VDC. This post came under some criticism, they are working at VDC or DDC but their work is evaluated by the Secretary of the Ministry of Local Development (Collins and et al, 2003:58-9). How they are accountable toward the elected leader at the local level.

**Spatial Hierarchy**

In Nepal, the territorial units within a country divided into fourteen zones, 75 districts and more 4000 village development committees and a number of municipalities for the political and administrative purpose in 1963(Thapa 1963). The zonal level was created basically for political purpose to filter political representation to the Rastriya Panchayat (National Assembly) and for security surveillance(Subba, 2004:775-788) (Subba 2004). The districts were assigned administrative and development functions, which later (1965-70) were considered the basis of decentralization (Gurung, 2006:22). In 1972, the country was divided into four development regions and later (1978) into five (Sharma, 2004:61-96).

Since the formation of development regions in 1972, various ministries established their regional offices/directorates at the designated regional centres with dismantling of department of the various sectoral ministries. There are five health regional directorates. These offices act as pool between the central and district health office. These offices collect the monthly report from districts and zonal offices and reports periodically to the Ministry. Later on, these regional directorates are kept under the Department of Health Service (DOHS) which was revived after the restoration of democracy. These regional health offices are not under the control of regional administrative offices but accountable to the respective central offices. It made regional level as superfluous hierarchy(Gurung, 2006:22).

After the restoration of democracy, zonal administration was abolished as a vestige of autocratic regime. But, there are ten zonal hospitals in the country. These zonal hospitals were established under the developmental act (2059 BS). These hospitals are directly accountable toward Ministry, not regional health directorate or regional administration. Zonal and regional administrators have been appointed recently due to security reasons not development concern. These regional and zonal offices have no right to monitor, supervise and giving feedback to regional service delivery offices e.g health offices. The underlined reason is that there was not
adequate delegation of authority whereby these regional offices became redundant hierarchy between central and district level. Besides, the applications of regional perspective in Nepalese development are the highly centralized system of governance and the primacy of sectoral approach (Gurung 2005).

**Decentralized Planning**

The decentralized planning process emphasizes to ensure active people’s participation in local development process aimed at enhancing the production of goods and services for the promotion of the welfare of the local people in general and rural poor in particular (Shrestha, 2000:85). It makes the people focal point for entire development activities and goods and services. Similarly, it mobilized the public, private, corporate bodies and social and NGOs sectors for accelerating development process at local level.

So far decentralized health planning is concerned; health service delivery is arranged along sectoral line agencies and local health organization. Ministry of Health and Population (MOHP) and its departments along with other private and NGOs cover health sector. Generally they follow directives and targets set by national development policy and plans. But the ministry and department have their own policy and programme. There is virtually a weak mechanism for feeding the concerns of the local communities into the planning process, because the planning levels are physically and institutionally far from local people. However, this necessarily does not mean that there no integration of planning efforts across different sectors, but integration often takes place at higher levels where the decisions are made on the allocation of resources. At the implementation level, there is little integration among the line agencies. Some integration appears where the extension services are multipurpose and cover wide range of areas, but planning and intervention of programme are generally carried out by each separate technical team recruited by Central government in accordance with what they consider to be priorities for their sector (Paudel:2002,194.)

However, integrated health service planning approach retains most of the core ideas of holistic planning, but is more focused on major key issues. It does not seek to analyze all components and linkages, to prevent the planning document from being a historical document rather than a strategic one. The interpretation is done with a limited focus for a number of reasons. First it accepts that we are unlikely to be able to understand all variation in a system,
and relatively small numbers of variables cause a large proportion of variation in health service delivery. Besides, this keeps more realistic expectations and allows plans to be completed in a more reasonable time frame (Michel 1996). Integrated planning approach tries to integrate planning activities across the various sectors at all levels. Generally, the process of integration commenced with a top down mode establishing national level planning mechanism and institution. However, the institutionalization of integrated planning frequently involves some degree of devolution of planning responsibilities and resources allocation on lower levels of administration. Coordination across sector is relatively better at these levels and planning mechanisms are closer to the communities.

In Nepal, the health service sector is based on a target oriented approach, where the target is passed down from the top, i.e from the National Planning Commission to Ministry level to the district level. However, often the target given to the local levels is unrealistically high and impossible to fulfill (UNFPA, 1989:171). Because of the wide chasm between the targeted policy goals and their implementation, most people feel dejected. The fact seems to be that irrespective of the commitment and resources of the agencies in charge of the implementation, some policies are impossible to implement from the outset (Hoppe, 1992: 327)

It is found that health policies very general without specified tasks and objectives for implementors at each level. It appears that figures and statistics received a disproportionate amount of importance. In others words, the targets themselves are more important than how to achieve them. According to UNFPA, the management at the MOHP suffers from overcentralized planning and budgeting, poor financial and information management, a personnel system too dependent on informal criteria, poor staff motivation and poor supervising practices. Furthermore, there is lack of "objective" evaluation. In case of health service, problems are underreported and achievements over reported (UNFPA: 1989). A lack of trained staff to do policy analysis is a further problem (Moharir, 1992:261). It appears that one problem reinforces the other problems, and that for example the absence of specification and appropriate planning is aggravayed by incorrect information.

**Increasing disparity**

In Nepal more than four thousands health institutions are constituted throughout the country. These health institutions are Hospitals (87), Health Center(6), Health Post(697), Ayurvedic
Hospital(287), Primary Health Centers(205) and Sub Health Post(3,129). Among them, 75 percent of the health institutions are distributed in the rural areas of the country. However, the number of health units does not realistically reflect the status of health service facility across rural and urban areas. There are two important aspects to be considered: distribution pattern of health institution and quality of service(Shrestha, 2006:125). In remote local area particularly in Mountain and Hilly areas, access to available health facility is constrained due to greater ‘friction of space’, measured in term of rugged topography and distance. Moreover, available health service in such areas is of low quality. On the other hand, access to available service is easy in Terai and urban areas due to low ‘friction of space’ resulting from transport facility and favourable terrain. Therefore, it shows the disparity between urban and rural areas.

**Human resources**

The availability of trained health workers is one the major problem of health policy implementation. The situation in the rural areas is relatively worst. Population per Doctor, Village Health Workers (VHW) and hospital bed is 16667, 4628 and 5130 respectively (MOH, 2001: Annex1). The district hospital is manned with 2-3 doctors, 4 nurses and other paramedical staff. A PHC center is staffed with a Medical Officer, two staff Nurses, Two Auxiliary Nurse Midwives (ANM), two Community Health Assistants (CMA) and other helping staff. The Sanctioned posts for a health post are, a Health Assistant or a Senior Auxiliary Health Worker, an Auxiliary Nurse Midwife, 3 Community Medical Assistants (CMA) and VHW for each area of village development committee(VDC). Similarly, in a sub-health post a CMA, a maternal and child health worker (MCHW) and a village health worker (VHW) are the official positions.

At the community level, there are Female Community Health volunteers (FCHVs) and Traditional Birth Attendants (TBAs). They act as linkage between community and grass-root level health institutions that is health post and sub-health post. There are around 4000 VDCs and each is divided into 9 wards. In each ward there is FCHV. There are more than 48000 FCHVs in Nepal. These volunteers are responsible to help village health workers to implement promotive and preventive health care. There are around 15,000 trained TBAs under the MOH (DoHS, 2005:24).
However, the quality of health service in Nepal is poor due to inadequately skilled personnel. Hospitals and health centres in rural areas often lack doctors and nurses and are managed by junior level personnel who have little medical competence. Many doctors and nurses are reluctant to work in rural areas (ESP, 2001:111 & Ali, 1991:8). Following barriers are observed in the health related human resources development.

- Human resource planning (HRP) is a centralized process, which does not accurately reflect need. It is not linked to the overall health planning framework and only addresses the public sector (excluding police and military). There is minimal input from lower levels and consequently limited sensitivity to local needs.
- The capacity for training midlevel health personnel is not sufficient. The quality of training is uncertain and the essential infrastructure necessary to impart adequate levels of skills often is lacking. This is a particular concern with regards to private sector training institutions.
- In-service and continuing education continues to employ a vertical program approach. They are not linked to carrier advancement opportunities.
- Deployment practices are weak in terms of placement, transfer and deputation of staff. Rules and regulations regarding placement, transfers, and deputation of staff are not strictly adhered to.
- Staff responsibilities and competencies are often mismatched.
- There is lack of incentives /carrier ladders for various categories of staff.
- Integrated supportive supervision at the central regional, district level and below is absent or inadequate.
- Paramedical staffs (e.g. ANMs, AHWs and HAs) often are engaged in private practice providing necessary services in under several areas. Such practice is illegal. There is no control over the quality of services provided in their private practices.

Conclusion

Decentralization was taken as a convenient tool to reinforce respective regime’s political power in spite of incessant theme in Nepal over last five decades. Some legal initiations for the decentralization were also made. At present, LGSA is in the operation. It mandates local government bodies to manage and supervise S/HP in order to deliver health service
effectively including other developmental activities. However, there is mismatch between the allocation of responsibilities and the provision of required resources. There are contradictory rules and regulations between LGSA, 10th plan and MOHP guidelines and the role of local bodies. As a result, the jurisdictions of the local bodies and the line agencies overlap. Local bodies can not influence the decision-making of line agencies.

GON has constituted regional development office to facilitate and support the local level so that people would not come to central level. In this line, five health regional directorates were established. Similarly, zonal offices also established with the aim to monitor, supervise and giving feedback to the local health offices. However, these zonal and regional health offices became redundant between central and district level. It is because that there was not adequate delegation of authority to regional and zonal office. These offices can not do anything except collecting monthly reports. The applications of regional perspective in Nepalese development are the highly centralized system of governance and the primacy of sectoral approach.

Decentralized health planning seems only in name but not in function because the planning levels are physically and institutionally far from the local people. Local people hardly know the information about the planning mechanism of health(Paudel 2007) (Paudel, 2007:10). The health service sector is target based where the target is passed down from the top i.e. from the National Planning commission to Ministry level to the local level. Generally, local health organization follows directives and target set by national development plans and policy. But the ministry and department have their own policy and programme. But, very often the target given to the local levels is unrealistically high and impossible to fulfil. It is due to the management at the MOHP suffers from over centralized planning and budgeting, poor financial and information management, a personnel system too dependent on informal criteria, poor staff motivation and poor supervising practices. As a result, there is disparity increasing between urban and rural areas even though more than 75 percent of health institution are distributed in the rural areas. This is due to rugged topography and distance and low quality of health service. The quality of health service in Nepal is poor due to inadequately skilled personnel. Hospitals and health centres in rural areas often lack doctors and nurses and are managed by junior level personnel who have little medical competence. Many doctors and nurses are reluctant to work in rural areas.

References


