JMMIHS Vol 7, issue 1, 2021, 3-14.

Original Article

AN INVESTIGATION INTO THE IMPACT OF DECENTRALIZATION ON THE HEALTH SYSTEM OF NEPAL

Rushton S[1-2]†, Panday S[1], van Teijlingen E[2,3], Subedi M[4], Balen J[1-2], Karki J[1,6], Simkhada P[6] for the Nepal Federal Health System Team

[1]The University of Sheffield, Sheffield, UK. [2]Manmohan Memorial Institute of Health Sciences, Kathmandu, Nepal.[3]CMMPH, Bournemouth University, Bournemouth, UK.

[4]School of Public Health, Patan Academy of Health Sciences, Nepal. [5]PHASE Nepal, Kathmandu, Nepal. [6]University of Huddersfield, Huddersfield, UK.

†Corresponding Author: Simon Rushton Email:simon.rushton@sheffield.ac.uk

DOI: https://doi.org/10.3126/jmmihs.v7i1.43146

ABSTRACT

This paper introduces our international research project 'the impact of federalisation on Nepal's health system: a longitudinal analysis', which is examining the effects of changing Nepal's constitution towards a federal republic on its health system. After a short overview of recent changes in the constitution of Nepal, which in turn affects the organisation of the nation's health system, we offer a short theoretical introduction on the decentralisation of health systems. We briefly outline the WHO (World Health Organization) Health System Building Blocks and some of the issues for policy and practice that have arisen in other countries where similar major system-wide reforms have been implemented. After this, we outline the key research questions and research methods of our study, which involves an international and interdisciplinary team of researchers from Nepal and the UK and will be conducted over a period of three years, from 2020 to 2023.

INTRODUCTION

Nepal is currently in the midst of a process of radical constitutional reform. The 2015 Constitution marked the beginning of a complete restructuring of the country's political system, creating a new Federal Republic with significant devolution of power and resources

from the central government to seven new provinces and 753 local governments. All provinces have their own legislature and all local governments have their own elected governing body[1]. While Article 35 of the 2015 Constitution states that every citizen shall have the right to seek basic health services from the state and no citizen shall be deprived of emergency health care[2], the wider reform process is already having, and will continue to have, significant impacts on the health sector. Traditionally, the Nepali health system has been highly centralised with a low proportion of around 4% of its GDP (Gross Domestic Product) spent on health, according to the Ministry of Finance[3]. Moreover, key decisions used to be made centrally by the Ministry of Health and Population in Kathmandu and cascaded down the pyramidal health system structure via Regional Health Directorates and District Health Officers. The new constitution places primary responsibility for the delivery of health services on the new provincial governments – in effect a shift towards a far more decentralised structure. Provincial governments are adopting their own health policies and have taken on responsibility for delivering health services – although significant confusion remains about mandates and lines of reporting[4].

Many other countries have previously decentralised their health systems, for a variety of reasons. In some cases, decentralisation was intended to make systems more agile or to bring decision-making closer to the people, allowing for greater responsiveness to local priorities. In other cases, it was intended to increase efficiency and allow resources to be better managed. International organisations and donor agencies, including bodies such as the World Bank, have often promoted and supported such decentralisation processes.

The process of decentralising the health system in Nepal deserves particular attention because the primary driver of change was not the intended benefits for the health sector itself. Instead, health sector decentralisation was a by-product of a much larger scale constitutional reform effort after the country's civil war (1996-2006). The move to a federal state, and the creation of new provincial governments, was a political decision to which the country's health system had to re-act and adapt, rather than being adopted in pursuit of health system gains. Some have argued that federalisation can be difficult in a resource-poor country with incompatible political values, weak institutions and poor governance[5].

To date, little empirical evidence exists of the impact that federalisation is having on the health system in Nepal (for an exception, see the 2018 paper by Regmi[6]) – and it is this gap that our project is seeking to fill. This overview article outlines our approach to generating evidence of the impacts (both positive and negative) that decentralisation is having on the functioning of the health system, in real time. This project is interdisciplinary (including not only experts in public health and health systems, but also in health economics, sociology, law, political science, and

more) and examines the health system holistically, covering not only service delivery but also the other WHO (World Health Organization) building blocks including financing, human resources, medicines and other vital medical products, health information, and leadership and governance (see Box 2)[9]. The ongoing roll-out of decentralisation is a unique opportunity to study such a large-scale reform in real time, as well as to feed the findings directly back in to policy and practice by helping stakeholders to identify problems and good practice, as well as routes to addressing them.

First, we provide a brief review of what is known about health system decentralisation – and some of the challenges and benefits that can arise - from other countries that have implemented similar reforms previously.

Health system decentralization: A brief review of lessons from elsewhere

Although definitions have been debated since the 1960s, health system decentralisation is generally seen as a process of the reallocation of power, authority, resources and responsibility in the health system from the centre to the periphery. Decentralisation may occur in different parts of the political system and in different formats. Thus, decentralisation may include political, economic, legal and administrative systems[8]. Decentralisation of low-income countries' health systems has, at various times, been promoted by a variety of donors and international organisations. In doing so, a variety of benefits have been claimed for health system decentralisation including creating greater efficiency, strengthening accountability, encouraging public participation in decision making, and promoting good governance[9-10]. In practice, the realisation of these benefits has been mixed across the many countries that have implemented decentralisation processes.

A systematic review of decentralization of health systems in low and middle-income countries over the last 40 years by Muñoz and colleagues reports that quantitative studies found that decentralisation had a positive effect on mortality rates, health financing and human resources[9]. Qualitative studies, meanwhile, suggested a more mixed picture of positive and negative effects on governance and service utilisation, and predominantly negative effects on medicine/equipment availability and human resources[9]. This highlights the need for a mixed-methods approach[11] to understanding decentralisation in Nepal that looks not only at the overall effects on macro-level health indicators, but also at the experiences of health system stakeholders.

This mixed picture has been similarly found in other studies. Some have argued that there is limited evidence of decentralization's claimed positive impact on health systems at the point of service delivery, or that at best such positive impacts seem to accrue only under certain conditions. For example, only the richest areas of Spain with full financial (fiscal) and political powers benefited from decentralization[12]. A systematic review found limited empirical knowledge of the impact of decentralization on health system performance[13]. A study of health system reforms in Turkey reported that decentralization improved certain health outcomes, but it did not solve existing problems of health inequality[14]. A similar study from The Philippines concluded that decentralisation "must not only transfer decision-making responsibility to local levels but also ensure that those granted with the decision space could perform decision-making with adequate capacities and could grasp the importance of health services" [15,page 2]. A study in Pakistan reported that decentralization of the health system had resulted disparities in health services among different provinces[16]. In short, across a variety of studies, decentralisation has both positive and negative consequences.

The reasons for the different outcomes in different countries are, of course, context-specific, but there may well be generalisable features that can guide help analysis. These include: a) that health system outcomes will be a product not only of policy and planning, but also of the implementation of reforms; b) that the resourcing of the health system (and whether those resources change throughout the decentralisation process) will be crucial; c) that wider issues of the quality of governance (beyond the health system, and including issues such as

corruption and clientelism) will have an impact; and d) that the pre-existing strengths and weaknesses of the health system, and the pre-existing burden of disease on the population, will have a significant impact.

From the existing literature examining the decentralisation of health systems elsewhere, we have drawn four key insights which inform the approach taken in the project that we describe in the following section. First, there is no single methodological or disciplinary approach that will be able to capture the complexity or the range of experiences of the process. Instead, a mixed-method approach is called for which tracks both health indicators and the day-to-day experiences of those working within the health system. In addition, no single discipline can provide all of the tools or approaches necessary to understand this process.

Secondly, it is necessary to take a holistic view of the health system. Munoz et al. found that studies of decentralisation most frequently focus on service delivery[9]. Whilst this is clearly a crucial area (and one that has direct implications for population health and wellbeing), it is also necessary to look at the other health system building blocks upon which service delivery rests, including governance, financing, human resources, health information, and the supply of medicines and equipment.

Thirdly, the various levels of the health system - from the federal government right down to the Female Community Health Volunteers (FCHVs) who are on the frontline of service delivery in many rural areas - will have varying experiences of the impact of reform, and all will have knowledge to contribute that can play a part in identifying and addressing problems being encountered, and identifying and promoting best practice. Communication between levels is vital, both to identify and address any negative impacts and to ensure that policy and planning translates into effective implementation.

Finally, decentralisation processes are dynamic. Reforms take time to implement (as is currently being seen in Nepal) and implementation processes are frequently characterised by ‘mid-course corrections’, adaptations in practice, and positive or negative feedback loops. Researchers need to consider that some parts of the health system might be at different stages of federalisation at the same time. It is, therefore, necessary to examine such sub-systems and

processes as they develop over time – indeed it is arguable that such processes are never entirely 'finished.' The next section builds on these four lessons.

Researching the 'federalization' of Nepal's health system

Generally, health systems analysis addresses underlying causes of poor health system performance and suggests how reform policies and strengthening strategies can improve performance in a system[17]. Our study 'The impact of federalisation on Nepal's health system: a longitudinal analysis' hopes to achieve this in Nepal. This study is funded for three years by the Health System Research Initiative,which is a collaboration between three UK-based funders: the MRC (Medical research Council), the Foreign, Commonwealth and Development Office, and the Wellcome Trust. The team includes researchers from two Nepali institutions (Manmohan Memorial Institute of Health Sciences and the NGO PHASE Nepal) and three UK institutions (the Universities of Sheffield, Bournemouth and Huddersfield).The study began on 1 April 2020 and will run for the next three years to answer the research questions listed in Box 1.

Box 1 Key research questions health and federalisation

1. How is the move to a federal system impacting upon Nepal's health system at all levels (from federal government down to local service provision)?
2. What do stakeholders perceive to be the implementation challenges in moving the health system to a more decentralized structure? Where do they see progress being made?
3. How is decentralization playing out across the six WHO health system building blocks (service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance)? Are obstacles and opportunities the same across the building blocks, or is there differentiation? What are the relationships between the issues affecting the different building blocks?
4. What changes to policy and practice might allow the opportunities of decentralization to be captured, and the problems mitigated?
5. What can be learnt from Nepal for other countries moving their health systems from a unitary to a federalised structure?
6. What can Nepal learn from countries that have tried this before?

As is clear from the research questions (Box 1), all four of the key insights identified in the previous section are central to the research design. Here we focus in particular on how one element of the project's methodological approach (*Participatory Policy Analysis)* responds to the first, third and fourth of those insights (considering interdisciplinary approaches to addressing decentralisation; considering various levels of the health system; and considering the dynamic nature of the system respectively); and how the framework for analysis (*WHO Health System Building Blocks)* responds to the second (importance of a holistic view of the health system).

Participatory Policy Analysis (PPA)

Central to the project's approach is the use of PPA. Critics of traditional 'expert-led' approaches to policy analysis have argued that such approaches undermine democracy, lead to poor advice, and have limited impact in terms of policy uptake[18]. Collaboration with stakeholders in co-producing policy analysis is one way of addressing these problems, founded on the notion that researchers are collaborators with policy setters and policy implementers in doing the best we can in a given situation[19]. PPA has previously been used through a variety of approaches, including simulation exercises and consensus meetings[20]. What unites these approaches as way of producing policy-relevant information is the starting point that 'insiders' within the system have important perceptions and insights, both into where problems lie and how they might be addressed, and that through facilitating processes of reflection and dialogue between stakeholders, policy analysis can be conducted collaboratively (co-producing knowledge) and recommendations produced. For this, we use PPA workshops, bringing together stakeholders from different levels with roles/expertise across a variety of building blocks.

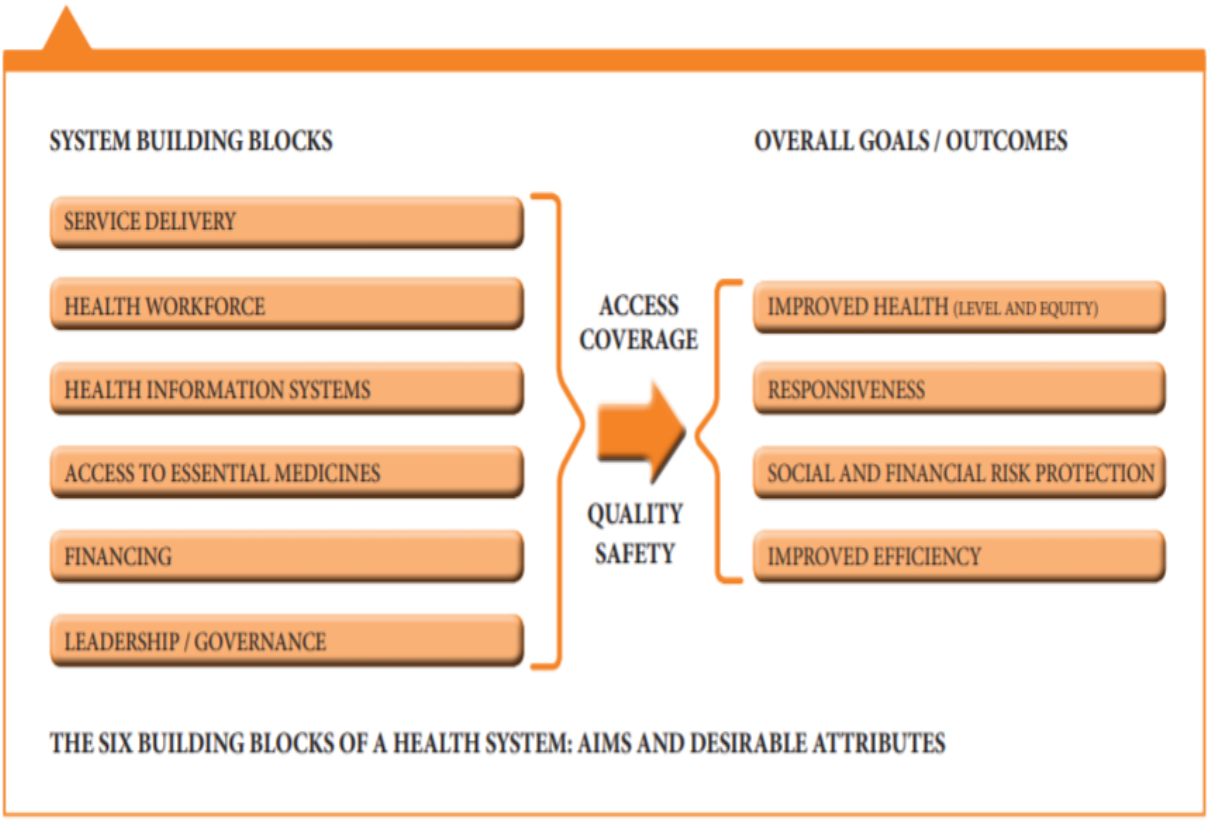
Over the duration of the project we are iteratively engaging with stakeholders, from federal government down to frontline service providers, not only to gather perceptions and understandings, but to collaboratively identify policy and practice options for addressing identified problems and to feed these back to the relevant stakeholders. This is important, given the central role of people and relationships in the health system[21].

WHO Health System Building Blocks

The WHO proposed a framework describing health systems consisting of six interdependent building blocks: (i) leadership/governance, (ii) financing, (iii) health information systems, (iv) health workforce, (v) supplies and technology, and (vi) service delivery (Box 2)[6]. These six building blocks, and their inter-relations, have been described extensively elsewhere, and the framework can be used to assess in-country healthcare performance, interactions between health reforms and country health systems, implications of health sector reforms, the status of health facilities, and specific health problems[22-26]. There are some limitations to the building blocks framework that have often been identified, perhaps most notably its alleged failure to capture complexity and the inter-linkages between systems components. Nevertheless, the framework provides a useful analytical device for our project for two key reasons: i) it is widely accepted within the health policy community in Nepal, and therefore provides a 'common language and approach' through which we can engage and converse with health system stakeholders; ii) it comes with a set of WHO indicators (for which data is available in Nepal) which can help us to contextualise stakeholder perceptions through quantitative analysis.Our projectemploys the framework as a tool for monitoring change over time, with a holistic view of the system including a mix of inputs, processes and management issues (Box 3). We will

use qualitative and quantitative data to monitor performance and evaluate progress as the federalization unfolds.

Box 2 WHO building blocks [8]



Box 3 Overview federal health system interlinking in Nepal

Service delivery	Health workforce	Health Information Systems	Access to essential medicines	Financing	Leadership/ governance
Federal government ⇓					
⇑ Provincial government ⇓					
⇑ Rural municipality					

Final thoughts

Health is multi-sectoral. Sustainable Development Goal (SDG) 3 'Good Health and Well-Being' focuses specifically on health, but health is of course connected to almost all other

goals, therefore requiring a multi-sectoral systems approach. In Nepal, social and health inequities, environmental pollution, large-scale labour migration, disaster planning, the gap between rural and urban populations, and many more societal problems require health systems thinking. We know that general policies and non-health interventions can have health implications at national and regional and local levels.

Our project had a rocky start as COVID-19 erupted a few months before our study started and the WHO declared it a pandemic six weeks before the project's launch[27].

We shall document as much as we can the influence of this pandemic on (1) the health system in Nepal; (2) health policies; and (3) our ability to conduct the research. We hope that other countries can learn from our analysis of federalisation and health in Nepal, by taking on board what worked well and by not making the same mistakes.

ACKNOWLEDGMENTS

The study described in this article is funded by the Health System Research Initiative (Round 6): grant reference: MR/T023554/1.The Nepal Federalisation of Health System Team comprises (in alphabetical order, at the time of writing): Shiva Raj Adhikari; Pratik Adhikary; Nirmal Aryal, Manish Baidya; Julie Balen; Surendra Bhandari; Sujan Gautam; Jiban Kumar Karki; Andrew Lee; SujanMarahatta; Sarita Panday; Simon Rushton; Sujata Sapkota; PadamSimkhada; Madhusudan Subedi; Edwin van Teijlingen, Sharada P. Wasti.

REFERENCES

1. Subedi, M. *State, Society and Health in Nepal*. New Delhi: Routledge, 2018.
2. Nepal: opportunities and challenges. *Int J Health Pol Man* 2019;8(4):195–98.
3. Rushton S, Ghimire S. Marahatta SB. Nepal's Bumpy Transition to Federalism: Implications for the Health System, *J Manmohan Memorial Inst Health Sci* 2019;5(1): 1-3.
4. Ministry of Finance. *Budget Speech of Fiscal Year 2018/19*. Ministry of Finance, Government of Nepal, Kathmandu, 2018. Retrieved from https://mof.gov.np/uploads/document/file/speech_english_20180715091610.pdf
5. Chetri TB. Federal Democracy Nepal: An Assessment of Two Years Democratic Practices. *J Pol Sci*, 2020;20: 142–163. https://doi.org/10.3126/jps.v20i0.31799

6. Regmi K. Methodological and practical viewpoints of qualitative-driven mixed method design: the case of decentralisation of primary healthcare services in Nepal. *Primary Health Care Res Develop*, 2018;19(1), 64-76.
7. World Health Organization. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. Geneva, Switzerland: WHO, 2010.
8. Brinkerhoff DW, Leighton C. *Decentralization and Health System Reform*, Insights for Implementers Series No. 1. Washington, DC: US Agency for International Development, Partners for Health Reformplus Project, 2002.
9. Muñoz DC, Amador PM, Llamas, LM, *et al.* Decentralization of health systems in low & middle income countries: a systematic review. *Int J Public Health* 2017;62(2), 219-29.
10. Cheema GS, Rondinelli DA. From Government Decentralization to Decentralized Governance. In: Cheema GS. &Rondinelli DA. (Eds.)*Decentralizing Governance:Emerging Concepts & Practices*. Washington: Brookings Institution Press, 2007: pp. 1-20.
11. MacKenzieBryersH,vanTeijlingen E, Pitchforth E.. Advocating mixed-methods approaches in health research, *Nepal J Epidemiol* 2014;**4**(5): 417-22.
12. Jiménez-Rubio D, García-Gómez P. Decentralization of health care systems and health outcomes: Evidence from a natural experiment. *Soc Sci Med*, 2017;188, 69-81.
13. Dwicaksono A, Fox AM. Does decentralization improve health system performance and outcomes in low- and middle-income countries? A systematic review of evidence from quantitative studies. *Milbank Q*. 2018;96(2):323–368.
14. Ali Jadoo SA, Aljunid SM, Sulku SN, Nur AM. Turkish health system reform from the people's perspective: a cross sectional study. *BMC Health Serv Res*. 2014; 22; 14:30 10.1186/1472-6963-14-30
15. Liwanag HJ, Wyss K. Who should decide for local health services? A mixed methods study of preferences for decision-making in the decentralized Philippine health system. *BMC Health Serv Res* 2020;20, 305. https://doi.org/10.1186/s12913-020-05174-w.
16. Khan SA. Situation Analysis of Health Care System of Pakistan: Post 18 Amendments. *Health Care Current Rev* 2019;7:244.
17. Berman P, Bitran B. *Health Systems Analysis for Better Health System Strengthening* Health, Nutrition, and Population (HNP) Discussion Paper, prepared for The World Bank, Washington DC, United States of America, 2011. https://documents1.worldbank.org/curated/en/472131468331150352/pdf/659270WP0Healt00Box365730B00PUBLIC0.pdf
18. Durning D. Participatory policy analysis in a social service agency: A case study. *J Pol Anal Man*, 1993;12(2), 297-322.
19. Guba EG. What can happen as a result of a policy? *Rev Pol Res*, 1985;5(1), 11-16.
20. Geurts JLA, Joldersma C. Methodology for participatory policy analysis *Eur J Operational Res* 2001;128: 300-310
21. Gilson L. Trust and the development of health care as a social institution. *Soc Sci Med* 2003;56(7), 1453-68.
22. Fisher JR, Cabral de Mello M. Using the World Health Organization's 4S-Framework to Strengthen National Strategies, Policies and Services to Address Mental Health

Problems in Adolescents in Resource-Constrained Settings. *Int J Ment Health Syst* 2011;5: 23. https://doi.org/10.1186/1752-4458-5-23.

23. Mounier-Jack S, Griffiths UK, Closser S, Burchett H, Marchall B. Measuring the health systems impact of disease control programmes: a critical reflection on the WHO building blocks framework. *BMC Public Health* 2014;14, 278 . https://doi.org/10.1186/1471-2458-14-278.
24. Mutale W, Bond V, Mwanamwenge MT, Mlewa S, Balabanova D, Spicer N, AylesH,Systems thinking in practice: the current status of the six WHO building blocks for health system strengthening in three BHOMA intervention districts of Zambia: a baseline qualitative study, *BMC Health Serv Res* 2013;13:291.
25. Obermann K, Chanturidze T, Richardson E, Tanirbergenov S, Shoranov M, Nurgozhaev A. Data for development in health: a case study and monitoring framework from Kazakhstan', *BMJ Glob Health* 2016;1(1):e000003.
26. Senkubuge F, Modisenyane M, Bishaw T. Strengthening health systems by health sector reforms, *Global Health Action* 2014;7:23568.
27. Adhikary P, Balen J, Gautam S et al. The COVID-19 pandemic in Nepal: Emerging evidence on the effectiveness of action by, and cooperation between, different levels of government in a federal system, *J KarnaliAcad Health Sci* 2020;3 (3): 1-11