Technical Brief

July 2022

Health Systems Analysis:

Findings and implications from a study on health systems functions from provincial and local level governments in Lumbini and Madhesh.

I. INTRODUCTION

The Government of Nepal introduced a new Constitution in 2015 with a federal system replacing the unitary government, governed by three levels: federal, seven newly create provincial governments and 753 local level governments (municipalities, or palikas), each with their own elected governing body. The district level is no longer a separate administrative division and former structures fall within the jurisdiction of provinces. A qualitative study, conducted by the Nepal Health Sector Support Programme (NHSSP), aimed to examine how the health system is performing at provincial and local levels of government under the devolved system, identify progress and challenges since decentralisation and understand implications for health system. This briefing presents the summary of the study and its findings.

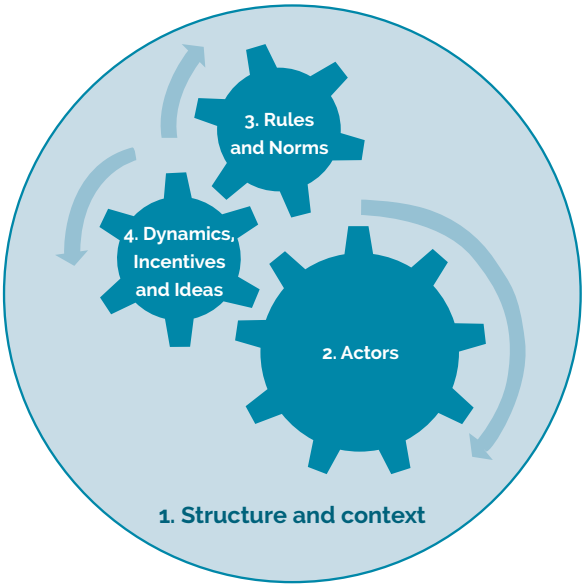

Figure 1 Conceptual framework

II. METHODS

Our conceptual framework included four analytic components to understand how the relationships and inter-linkages between health sector staff, civil servants and elected representatives (the 'actors'), contribute to the effectiveness, efficiency and challenges in health systems functions in 2 provinces, Lumbini and Madhesh (Figure 1). We conducted 74 key informant interviews with these actors in the health system at provincial and local levels of government, and 6 semi-structured discussions with federal level stakeholders. We developed and validated process maps (Figure 2) through 6 sub-national workshops as a tool to understand stakeholder relationships, identify bottlenecks and gaps that affect the performance of each health systems function.

III. FINDINGS

Nepal's move to federalism has created opportunities for the health sector in terms of the potential for more localised policies and accountability. Conversely, there have also been concerns that the technical efficiencies of a centralised system may be at risk through devolved authority to such a large number of diverse local governments. Our study highlights progress and some challenges as the health system strives to achieve the vision of federalism, that is, the expectation that devolution will lead to improved local accountability. We share highlights on six themes.

1. Actors, roles and dynamics

Sub-national governments, especially local levels, appreciate having the decision-making authority. Resource allocations are guided by the formal processes, but Mayors have the final formal authority in decisions, as well as significant informal influence on the decision-making processes. As such, health has been politicised with little separation between technical and political decision-making. This can be beneficial when political interests and technical advice coincide but may distract from evidence-informed prioritisation.

"If a visionary mayor is not elected in coming election, the palika health system will be collapse." Health provider, local level

Formerly the District Health Offices (DHOs) had provided technical health expertise and oversight for the health system to facilities for around 8-10 municipalities, though the number varies widely depending on geography and urban/rural settings. Now, under the federal system, many of the public health responsibilities have been devolved to municipal Health Section Units which typically comprise of a 2-3 person team, led by a Health Section Chief, who is from a clinical background and with limited public health management experience. Their current expertise is often not commensurate with the expectations of role, which include ability to interpret health data, understand its implications and be capable to operate in politically driven decision-making and planning forums. Health Offices, now part of the province structure, have retained some of the health expertise required but this is largely under-utilised,

Many permanent positions are vacant at subnational levels while the Civil Service Act is yet to be passed in the parliament. Without this, provincial governments are unable to undertake recruitment for permanent positions. Devolved mandates for recruitment and management of staff at local levels in temporary contracts has eased some human resource pressures in the health sector, but has led to complex power dynamics. Patronage enjoyed by some of the locally recruited temporary staff leads to their allegiance, but also conversely making it difficult for elected representatives to withdraw such patronage for fear of loss of political support from these local staff.

"The situation of Palika is very much manipulated (..). There is designated post of public health officer at health section at municipality level who must be qualified in public health either by education or by level upgrading but the filled posts is not fulfilled and made empty. It is being carried out by other personnel who are not qualified for the roles and responsibilities" Health Official, local level

2. Leadership and governance

Where functions and responsibilities are clearly written, respondents confirmed they were generally followed without contention at the local level. Federal level guidance is followed in all cases, and where there has been a need or possibility, these have been adapted for context and additional local level acts, policies and guidelines have been developed. However, our study confirmed that a lack of formal guidelines mandating communication and coordination between the three different levels of government persists, especially where there are concurrent functions assigned. When the rules of engagement are not clearly delineated, individuals including decision-makers act based on their own interpretation of roles and processes.

"We do not have any coordination mechanism with district, province, and federal and other stakeholders," Elected Official, local level

Lower levels of government perceive that the federal level retains control of authority that provincial and local levels of government feel constrains their decision-making ability and contributes to a sense of distrust.

Figure 2 Local level health staff validating process map on Coaching and Mentoring

"The federal government holds the more rights, power and the budget and allocates or distributes fewer rights to the province and the local levels" Elected Official, local level

Conversely, Federal government actors feel disempowered to ensure standardisation of national level guidance and feel it relies greatly on individuals wanting to 'do the right thing' rather than being mandated to do so.

3. Planning and budgeting

Local and provincial governments perceive federal level mandates such as the conditional grants being a way to retain central-level power, leading to tensions, and they felt this limited their authority and space to make decisions. These tensions in authority play out particularly in the management of conditional grants which flow to local levels from both federal and provincial level and are a major mechanism for health financing of subnational levels. This reduces the provincial level's influence and awareness of related health activities and contributes to duplication of funding i.e., where some activities are funded through the conditional grant and where subnational levels have also allocated additional budgets. The flows of conditions grants and gaps in coordination between the local and federal levels with the provincial level are evidenced in the process map (Fig 2).

"Palikas are better coordinated with federal government because they get budget from federal so federal has budget leverage, province can't do anything as we don't have budget leverage, so Palikas don't listen to us. We don't know what federal government is providing to Palikas which impedes our decision-making. … There is poor coordination with Palika Health Office.", Senior Government Official, provincial level

Other issues include late issuance of guidance and funds from federal to lower levels affecting planning and ability to fully utilise the budget, lack of alignment to local needs and limited local flexibility to adapt.

The involvement of health officials in planning and budget discussions relies on personal networks and is not systematic across local levels. Due to a lack of guidance and expertise in using health data and evidence for decision-making, resource allocation is often influenced by 'best judgement' rather than evidence. The degree to which health is prioritised relies on elected officials' understanding of health priorities and needs and balancing this with their other priorities. As a result, the level of budget allocated to health and is often not made based on evidence and therefore not commensurate with need.

"There is no formal mechanism in health sector for a coordinated or integrated planning." Government Official, provincial level

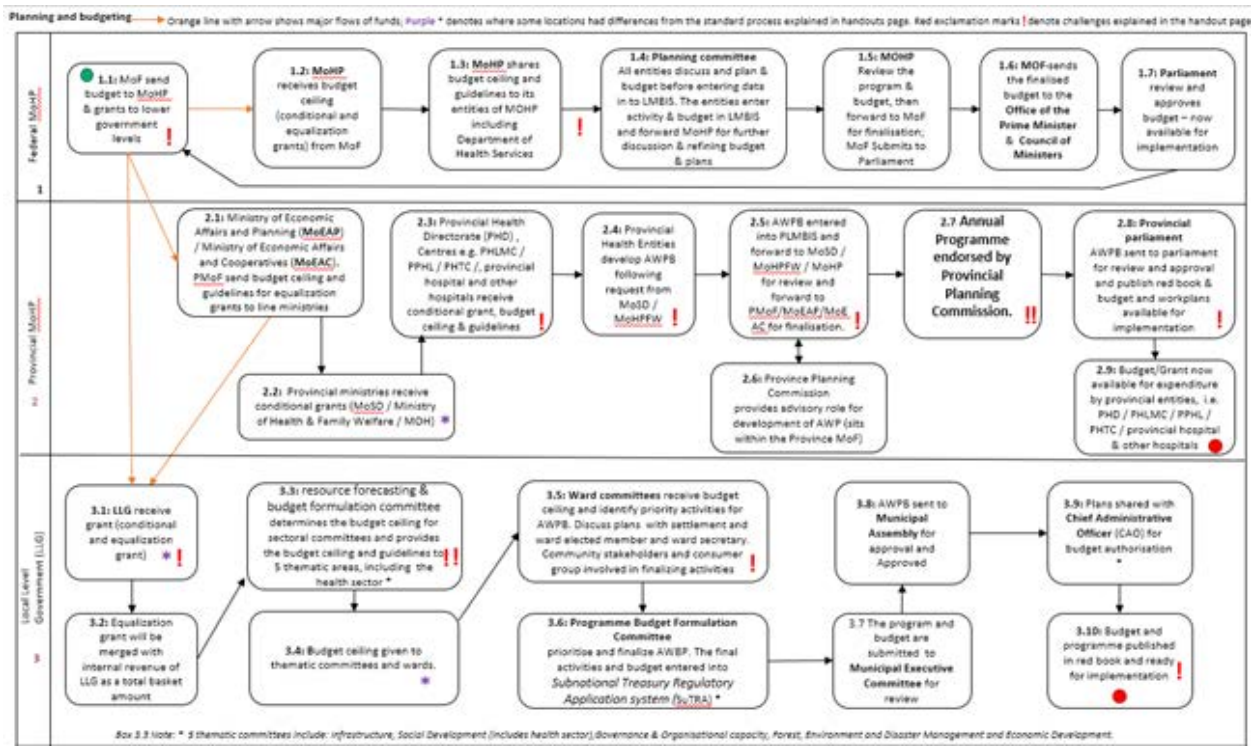

Figure 3 Process map for planning and budgeting in the health sector

4. Procurement and supply chains

Devolution of medical drug procurement to local levels of government has enabled municipalities to mitigate drug stock outs. Local levels are increasingly allocating their own resources allowing them to respond rapidly when there are supply issues.

"Some of the positive aspects of federalism are that we can purchase as per our need and availability throughout the year." Health official, local level.

On the other hand, periodic drug stock-outs and other inefficiencies such as over-supply of certain drugs are still being reported. This is due to limited communication, coordination and unclear procurement roles and responsibilities across the spheres of government leading to a lack of clarity on who is purchasing what and often results in concurrent purchases and duplication.

Local level purchasing has led to a reduction in quality of drugs as local level governments cannot benefit from economies of scale due to small order quantities and lack effective quality assurance systems. Concerns were also raised that decisions on local suppliers may be influenced by personal interests and financial gain.

"The supplies received from the Palika are in low quantity, but we get more from the Province as compared with our demands. The supplies are not available on time and that affects service delivery." Health provider, District Hospital

The Health Offices play a role in distributing medicines that are purchased from federal level (e.g. for HIV, tuberculosis, malaria; vaccines; nutrition products; family planning commodities and emergency supplies) and were commended for their flexibility and responsiveness to requests, particularly in the Covid-19 response. However, wide-spread lack of capacity in forecasting and quantification was reported, which is usually based on the previous year's purchase and use of supplies, rather than actual need. There is a lack of accurate and up-to-date data for proper needs assessment and planning is haphazard, despite the roll-out of the electronic logistical management information system (e-LMIS).

"eLMIS is not fully embedded at local level; not everyone is trained", Health Official, provincial level

"We provide based on quantification and forecasting but the Palikas demand haphazardly." Health official, district.

5. Health management information system (HMIS) and use of data

Reporting through digital HMIS is steadily increasing, and with the data available online, anyone at any level of government with the relevant administrative rights can access HMIS data. However, many facilities still lack the required infrastructure for online data entry, or health staff have not received the required training. Data monitoring and accountability is weak, and health data is rarely reviewed for quality and meaning at the monthly Health Section meetings. Health Offices lack a formal mandate to strengthen data quality and timeliness of data entry at local level.

"After the implementation of federalism, the local governments run the health facilities therefore information flow has decreased through the Health Office. At times, we feel that information is blocked when the Health Section does not timely convey messages of the Health Office and Provincial government. This has caused delays in reporting. There is no clarity on which information should go to which staff [at the] Health Section, District Health Office and Province." Health provider, local level

"We prepare eLMIS report but there is lack of feedback mechanism. In monthly meeting, the details of the HMIS forms are not verified so data quality cannot be ensured.", Health provider, local level.

Lumbini province hosts a functional data management team that regularly and systematically reviews data, from which lessons could be learnt.

6. Quality of Services

Access to services has improved, but accountability for assessing quality of health services and responding to gaps is weak. This was a role formerly held by District Health Offices and is yet to find a reliable home within the health system. Health Offices are not systematically involved in ensuring quality of services, and the previous practice of drawing on skilled expertise from Health Offices no longer happens, and the local levels also do not practice drawing on provincial, or federal level for support where needed.

"There is no quality improvement mechanism. So, no one is responsible to ensure quality health services.", Elected official, local level.

Existing quality improvement mechanisms are insufficient and inconsistent. For example, challenges with implementing the MSS include delayed funds and budget allocated for the assessments is often inadequate to cover regular assessments in all relevant facilities. Additionally, the tools have not yet been appropriately adapted for all types of facilities. Onsite coaching and mentorship for skilled birth attendants was a mechanism also facing inadequate or delayed budget, lacks adequate feedback mechanisms and there were insufficient clinical mentors to. enable coaching in all facilities regularly.

"In the health section of the metropolitan city, there is lack of health experts, so we have some problem in monitoring and onsite coaching." Health official, local level.

Figure 4 Health incharge providing services

Suggestions for short to medium term actions

- Incentives for **stronger coordination and communication** across all levels of government are need for all health system functions to tackle the lack of institutionalized vertical and horizontal planning, coordination, and coordination, and the lack of clarity on the roles of each level of government. The **Federal government** has to improve communication (including sharing of fund allocations and flows) at each level of government to allow visibility on which activities are funded across the levels, and avoid activities being missed out or duplicated. **Provincial levels** could undertake consultations to inform the short-term scope of work for technical experts at Health Offices to maximise the use of their skills and fast-track diffusion of expertise. **Local levels** could create platforms for focused evidence processing (e.g., sub-national 'knowledge café type events) that are organised through support from Health Offices.

- The current gaps in public health expertise at the local level could be filled by **incentivising better use and distribution of technical health expertise** for planning, budgeting and implementation processes. Draw-down technical expertise from Health Offices, at least in the short term, could be supported by putting the 'purchasing power' at the local levels (e.g., via conditional grants or earmarked funds) and fuelling demand rather than imposing technical support.

- Invest in **building the capacity of Health Section teams** to have a greater influence on local level planning decisions and budget allocation. Since the Health Section Chiefs are often clinicians with limited or no management or public health expertise, they need opportunities to develop the required skill-set to effectively fulfil the wide-ranging requirements of their role (combining strategic, operational, clinical, and networking skills).

- Prioritise and implement **quality improvement mechanisms for health services comprehensively.** Greater clarity needs to be communicated among local and provincial levels of government around where their responsibilities lie with respect to federal level quality improvement mechanisms and standards. For example, under the leadership of the federal government, all governance levels could develop and agree clear terms of reference and job descriptions for Health Section Chiefs, Health Offices and provincial levels for responsibilities around overseeing and implementing quality improvement standards and assessments.

Longer term implications and wider considerations

Wider considerations including those that may be beyond the remit of the Ministry of Health and Population include:

a. **The Government of Nepal needs to consider whether conditional funds flow through provincial governments to local levels or remain as a direct transfer from the Federal level.** This needs to be done in a way that is not perceived as reinforcing a hierarchy that does not sit easily with subnational governments.

b. **Conditional grants could have increased flexibility to better meet local needs.** This could be achieved by having more flexible grants linked to broad areas of technical priority and over time to performance and outcomes (e.g output based conditional grants).

c. **The role of the Health Office in the longer term needs to be discussed and whether there should be re-investment or phase-out needs to be resolved.** For Health Offices to be recognised as having a non-authoritative technical role, it will require their new place in the federal system to be defined through wide consultation and clearly laid out. Provincial governments can assess whether investing in Health Offices would help strengthen their reach to LLGs, as well as in terms of making technical expertise and co-ordination support accessible to LLGs.

d. **Government could revisit procurement of medical drugs to understand better whether devolved procurement should continue.** A possible alternative to the current system be a hybrid model which combines aspects of the federal framework contracts with actual local purchase (for example, a nation-wide list of pre-approved suppliers with pre-set prices, approved by federal level) ensuring that LLGs retain the 'authority to purchase' locally.

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www.nhssp.org.np
info@nhssp.org.np

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