Thinking through Healthcare in Nepal:

Decision Space, Accountability and Capacity

Forum of Federations
The Global Network on Federalism and Devolved Governance

UKaid
from the British people

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ABOUT THE AUTHOR

Gregory P. Marchildon, PhD, FCAHS

Gregory P. Marchildon is the director at North American Observatory on Health Systems and Policies. He is the Professor and Ontario Research Chair in Health Policy and System Design at Institute of Health Policy, Management and Evaluation at the University of Toronto. He is also the Professor at Dalla Lana School of Public Health / Munk School of Global Affairs and Public Policy, University of Toronto.

Previously, he was Canada Research Chair in Public Policy and Economic History at the Johnson-Shoyama Graduate School of Public Policy,

Prof. Marchildon received his PhD from the London School of Economics, and later served for five years at Johns Hopkins University's School of Advanced International Studies in Washington, DC. In the 1990s, he was Deputy Minister of Intergovernmental Affairs and subsequently Deputy Minister to the Premier and Cabinet Secretary in the Government of Saskatchewan. From 2001-2002, he was executive director of a federal Royal Commission on the Future of Health Care in Canada (the Romanow Commission). He is the author of numerous journal articles and books on Canadian history, comparative public policy, public administration and federalism, including Health Systems in Transition: Canada co-published by the World Health Organization's regional office for Europe on behalf of the European Observatory and the University of Toronto Press.

THINKING THROUGH HEALTHCARE IN NEPAL: DECISION SPACE, ACCOUNTABILITY AND CAPACITY

Nepal is undergoing a momentous transition from a unitary state to a federal state. The new constitution (2015) divides powers among three orders or "levels" of government: federal; provincial; and local. Article 35 of the Constitution of Nepal guarantees every citizen "the right to basic free health services from the State" (Constitution of Nepal, 2015). This is reinforced in the National Health Insurance Act of 2017 which repeats the country's aspiration for universal health coverage (Sharma et al. 2018; WHO, 2017).

The transition to a new system of federalism is a resource and time intensive process that will be ongoing for years (Thepa et al. 2019). During this transition, the disruption of historically centralized health system stewardship and management in the country has been responsible for the deterioration of some public services, including health services, to the citizens of Nepal (Adhikari, 2020). If the cost of transition becomes too great over time, then public and stakeholder confidence in the federalist project itself may be undermined. This would be unfortunate as there are many potential benefits to be gained through a more federalized and decentralized health system.

THE VIRTUES OF FEDERALISM

Numerous scholars and students of federalism have pointed out the benefits of federalism and decentralized decision-making in social programs such as healthcare in countries in various stages of development (Acharya and Zafarullah, 2020; Costa-Font and Greer, 2013; Fierlbeck and Palley, 2015; Guanais and Macinko, 2009; Liwanag and Wyss, 2018; Marchildon and Bossert, 2018a, 2018b;). These potential benefits include:

- better matching of health resources and services to local needs;
- more effectively responding to patient needs;
- reducing layers of bureaucracy;
- improving timeliness of service delivery;
- promoting innovations in service delivery;
- enhancing stakeholder participation in decision-making; and
- improving economies of scale particularly for primary care services

Although decentralized health system structures cannot guarantee that such benefits will be achieved, more highly centralized health systems are designed in ways that make them unlikely to ever achieve such benefits (Rondinelli, 2006). Despite this, national politicians and the bureaucracy of the central government may continue to try to exert influence and authority over subnational governments in key programs areas such as health particularly during a transitional phase in which subnational governments are taking over these responsibilities for the first time.

Not surprisingly inn Nepal, there has been some resistance to the new system of federalism by stakeholders and the bureaucracies within some ministries, "especially health and education", to the point that they have tried to reverse "the devolution of authority and resources" (Adhikari, 2020, 108). The reasons for this likely go well beyond a questions of position and power but may involve perceptions, whether accurate or not, of the ability of provincial and local levels of government to carry out their new responsibilities. Whatever the motives behind this resistance, the consequence of this has been to stall the implementation of a federalized system of healthcare. The purpose of this think piece is to propose a potential way to address the current deadlock.

INTERVENTIONS THAT CAN EXPEDITE THE TRANSITION TO FEDERALISM

1. Creating and implementing a healthcare transition plan

One of the ways to reduce the high cost in the health of this lengthy transition to federalism is to create and implement a sectoral transition plan for health services. However, for any health sector transition plan to have any purchase among stakeholders and government officials, it needs to be based on new evidence generated through a study based on determining the real gaps between the health sector decision space that the respective federal, provincial and local governments should be occupying and the decision space they are occupying in practice. This study should also include an examination of the accountabilities between and among governments and citizens, and the types of accountability mechanisms needed to improve the quality and timeliness of delivery of health services as well as patient responsiveness. Finally, such a study should also determine the current capacity of the provincial and local governments and the capacity actually required to exercise the authorities and responsibilities to which they have been assigned (Bossert and Mitchell, 2011; Liwanag and Wyss, 2019).

2. Reaching an intergovernmental agreement on precise responsibilities and authorities

This guarantee of universal coverage for basic health services must be implemented through the appropriate level of government as defined under the constitution. However, because the constitution does not assign health or health services as the exclusive jurisdiction of one of the three levels of government, this can create real problems in terms of determining which level of government is responsible for what and therefore the best ways in which authority can be transferred from the federal government to the provincial and local governments during the transition phase.

Health is actually listed in the areas of common competence and concurrent legislation in Articles 23 and 24 of the constitution. In this respect, it should be noted that "health services" is in the list of federal powers (Schedule 5, s. 16) and the list of state powers (Schedule 6, s. 9) while "basic health and sanitation" is listed in the local level powers (Schedule 8, s. 9). This is further complicated by the fact that "health" is assigned to the concurrent powers (Schedule 9, s.3) of the federation, state and local levels of government (Constitution of Nepal, 2015).

Without doubt, such a constitutional configuration creates challenges. However, it also presents an opportunity to decision makers in Nepal who are not constrained by the constitution in terms of allocating actual health system authorities and responsibilities. In practice, once decided, this allocation could be set out very precisely through federal legislation with supportive laws at the provincial and local levels with the details set out in accompanying regulations and – if helpful – through explicit intergovernmental agreements among the three orders of government. It is important that this allocation of authorities and responsibilities among the three orders of government is based on the best information available on decentralized health systems in other federations.

3. Recognizing and facilitating healthcare capacity of local governments

In the case of Nepal, it does appear that the original desire for a federalist system was motivated in part by a belief in the benefits of subsidiarity, in other words having public services delivered by the most local government consistent with fiscal and administrative realities. Subsidiarity was associated with both democratic reform through grassroots local governments and their potential ability to reap some public service economies of scale. In 2017, the local government sector was restructured and 700 local government units were established (Acharya and Zafarullah, 2020). Given the more extensive powers of taxation assigned to the local level relative to the provincial/state level, the local level of government may also have greater fiscal capacity – in terms of own-source taxation – to carry out its health system responsibilities (Constitution of Nepal, 2015; Adhikari, 2020).

WHY DECISION SPACE, ACCOUNTABILITY AND CAPACITY?

In this section, I will examine why assessing decision space, and the gap between conferred or expected authority and responsibility with that actual experienced by practitioners on the ground, is an essential first step. Associated with decision space are the concepts of accountability and its associated mechanisms as well as the capacity needed to carry out the mandated authorities and responsibilities. This will be followed by a proposed research design for a study that would provide the empirical results to make more evidence-based judgments concerning the future allocation of authorities and responsibilities, the accountability structures and mechanisms that need to be put in place, and the measures that need to be introduced in order for local and provincial governments to carry out their responsibilities in more effective and innovative ways.

Decision Space: Assessing the Choices actually available to Subnational Governments

Decision space refers to the range of choice actually available to decision makers during or following a process of decentralization. In the case of Nepal, this process has been triggered by federalism, the implementation of which is still very much in its infancy. The originator of decision space analysis, Thomas J. Bossert, initially applied it to the health sector in low and middle-income countries with unitary political structures (Bossert, 1998; Bossert and Beauvais, 2002; Bossert et al., 2003). At the request of the Forum

of Federations, Bossert's decision space framework was adapted to federal countries including federations across the high, medium and low income spectrum (Marchildon and Bossert, 2018a and 2018b).

The purpose of decision space analysis is to determine the decision-making choice actually being exercised by a level of government as narrow, moderate or wide in any given health sector function and associated indicators. These health sector functions can be defined based on the health system being examined but invariably include (Roman et al., 2017; Bossert, 1998; Marchildon and Bossert, 2018a):

- financing and budget allocation in terms of the sources of revenue, both the level of government's own-source revenues and the transfer revenues it may receive from another level of government and the conditions that may attach to those transfers, as well the extent of discretion exercised by that government in health sector expenditure allocations;
- service and program planning, implementation, organization and delivery in terms of the services or programs that are required (generally through legislation) to be delivered, the ways in which providers are paid, the degree of autonomy in how hospitals and other facilities are governed, organized, and managed;
- health workforce management in terms of extent to which staff, including clinicians, can be autonomously hired, fired, and managed by the level of government in question; and
- access rules in terms of the extent to which the level of government is subjected to, or can control, patient access to services for the basic universal health coverage package and for services outside this package.

Depending on the health system being assessed and the focus of the research, other functions can be added. In a decision space assessment of the Philippines, for example, the management of facilities, equipment and supplies as well as the monitoring and utilization of data were added to these functions while health system planning was treated as a separate function (Liwanag and Wyss, 2019). In a study of health system decision space in the state of Karnataka, India, contract management and performance monitoring were added as functions (Seshadri et al., 2016).

However, for any federation, one further function should be added. This function should focus on the federation's governance rules including what is required by the level of government in question in terms of collaboration or agreement with other levels of government, especially where health is determined by the constitution to be a shared jurisdiction among three orders of governments, as it is in the case of Nepal – a configuration similar to that inn Brazil (Arretche & Da Fonseca, 2018) These rules can also be cultural norms such as the practice of negotiating intergovernmental accords before decisions in the health sector are finalized.

Decision space in each of these health functions is assessed through a series of qualitative and quantitative indicators which provide the evidence base upon which a judgment as

to whether the decision space is narrow, moderate or wide in that particular function. Considerable knowledge of the local context is required in order to formulate the indicators. In reality, the quality of the judgment is dependent on the availability and quality of financial and other data in the system as well as the quality and consistency of questions posed to key informants to get the evidence required for the qualitative indicators.

Synergies among decision space, accountability and capacity

Beyond decision space, it is essential to understand both accountability and capacity. Indeed, there is a synergy between a level of government having the appropriate decision space (de jure and de facto), effective accountability and sufficient fiscal and managerial capacity to actually carry out its health system mandate in a manner that delivers high quality health services to its population in a timely and responsive manner (Bossert and Mitchell, 2011).

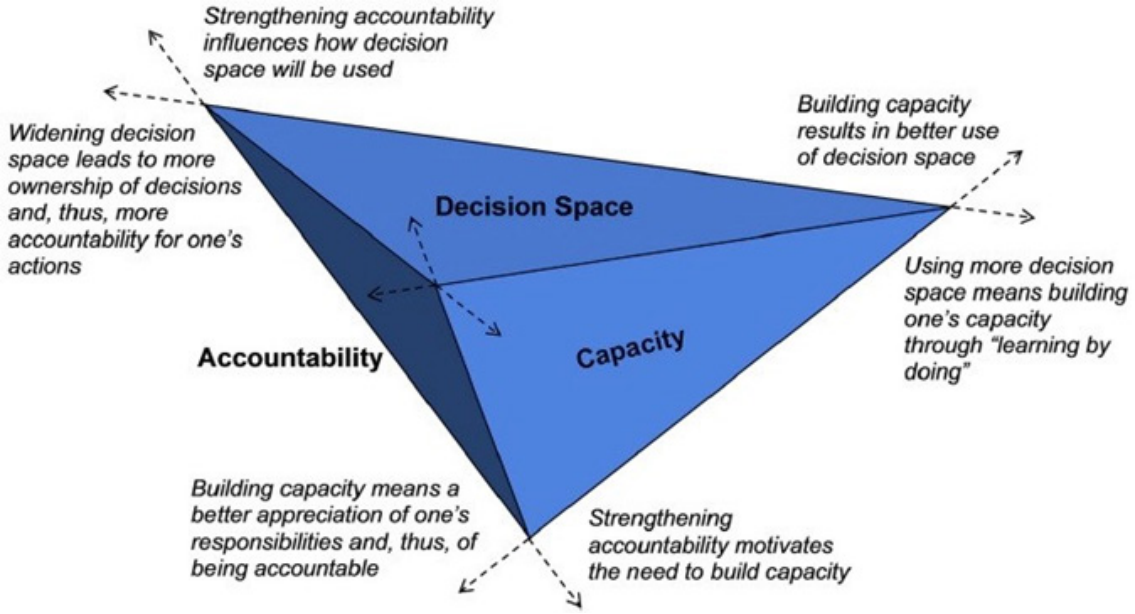
Liwanag and Wyss (2019) illustrate these synergies in the three dimensional pyramid shown in Figure 1.

Figure 1: Synergies among decision space, accountability and capacity

Source: Liwanag and Wyss (2019), p. 3

Accountability of Governments: Key Aspects and Mechanisms

While determining the degree of decision space is extremely important, it is also useful to



know the precise ways in which the decisions taken by a particular level of government are accountable. This should include examining accountability mechanisms within a level of government, government-to-government accountability but, perhaps most significantly, government-citizen accountability in terms of health programs and services.

There are three key aspects to any accountability relationship (Tuohy, 2003). The first is the specific responsibility assigned to the level of government. As mentioned above,

The second aspect is the information that level of government must provide to the individuals or institutions. While this likely includes information that should be provided to other levels of government, the most important requirements stipulates the information which much be provided to citizens themselves so that they have access to the necessary information to hold their respective governments to account.

The third aspect is the sanction imposed in the event the level of government does not comply with its responsibilities. Usually, this means examining the formal, institutional arrangements for accountability, including identifying the exact responsibility of the level of government in question, the information it must provide to the public it serves, or to an oversight agency within its own government or another level of government, and the sanctions in the case of non-performance or shoddy performance. In the case of the general public accountability, it is essential that the information required be provided in a highly transparent and disgestible manner. In the case of intergovernmental accountability, it is extremely important in any federation to develop appropriate measures and mechanisms, many of which are non- legislative in nature and operate through intergovernmental negotiation and consensus agreement (Graefe et al., 2012; Fafard, 2012; Cameron, 2012).

These intergovernmental mechanisms as well as the functioning of other accountability mechanisms generally requires much more than a review of the structures. To obtain evidence on the strengths and weaknesses of these accountability structures and mechanisms, it is necessary to dig deeper through key informant interviews. Only this qualitative information will provide the raw material on which to make judgments on what it is required in order to improve or extend existing accountability mechanisms or whether new institutions or mechanisms are required.

Capacity of Provincial and Local Governments

It is well known and stubborn fact that central governments generally have greater capacity in terms of personnel and institutions than lower levels of government. This is a product of a number of factors including the higher remuneration (relative to lower level governments) and therefore ability to recruit candidates with more education, training and experience, the higher status associated with working for the national government compared to provincial or local governments, and the preference of public servants to live in urban areas, especially well- endowed national capitals.

Any well-functioning federation must work against this natural gravity by establishing reducing these differences through incentives, reducing differences in remuneration, and, over time, changing a political culture that emphasizes the value of working for the federal government relative to provincial and local governments. Moreover, the federal government could even use the public's growing discontent with the inability of the central government to deliver health services in an effective manner to make the case for more decentralized delivery by provincial and local governments even more compelling for stakeholders and members of the general public (Rondinelli, 2006).

In the case of Nepal, it is important to understand the gap between the capacity needed at the provincial and local levels of government to carry out its health system responsibilities and the capacity that actually exists. This is made more complicated by the fact that administrative and fiscal capacity will vary across states although there is likely to be a close correlation between the level of income and wealth in any given province or local government unit (relative to other provinces or local government units), the population upon which this capacity can be drawn and the level of human development in the jurisdiction relative to others (Sheshadri et al., 2016).

Fortunately for Nepal's provinces, the population and land area differences are minimal compared to other federations. Even the least populated province (Karnali Province) has a population of 1.6 million while the most populous province (Bagmatic Province) has a population of 5.5 million. These are minor differences relative to most other federations. Moreover, the human development index for the provinces varies from 0.567 to 0.469, not an enormous difference in the state of development. This allows for a targeted strategy focusing on the hiring, development and training of public sector managers and employees (and perhaps even clinicians on contract) at the provincial and local levels in an effort to address human resource supply shortages and reduce the gap between current capacities and those needed to fulfill their respective governments' health system mandates.

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ABOUT THE FORUM OF FEDERATIONS

The Forum of Federations is a 'one-of-a-kind' international organization focused on federalism and decentralization – systems of governance which uniquely provides for the accommodation of diversity within a nation. Federalism provides a platform for all voices to be heard.

The Forum's mandate is a straight-forward and practical one, sharing the experiences, challenges and lessons learnt of its partners - federal countries and their sub-national units. The importance of this is significant as it offers peer exchange and understanding to reform efforts to improve the values, policies and polity each nation provides its citizens. Whilst it is true that there is no one-size-fits-all approach to federal design, there are commonalities within federations which offer opportunities to learn from one another."

The Forum is supported by the following partner countries – Australia, Brazil, Canada, Ethiopia, Germany, India, Mexico, Nigeria, Pakistan and Switzerland.

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Forum of Federations
75 Albert Street, Suite 411
Ottawa, ON K1P 5E7
Canada
www.forumfed.org