

Building Health Care Systems In Post-Earthquake, Post-Constitution Nepal

[Duncan Maru](#), [SP Kalaunee](#), and [Shanta Bahadur Shrestha](#)

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Nepal finds itself at a critical juncture in its history. On September 20, 2015 a [new Constitution](#) was brought into full force, crystallizing the coming of age of the world’s youngest democratic republic. Today, challenges abound in Nepal — recovery from the worst natural disaster in 80 years, a brutal border conflict with India, and entrenched poverty. And as a landlocked nation with limited options for exporting goods, Nepal continues to face economic stagnation.

Yet the new Constitution brings us great hope. It is among the world’s most progressive, particularly when it comes to the provision of Universal Health Coverage, stating overtly, “Every citizen shall have right to get basic health care free of cost from the state.” As the World Health Organization and others in the global community ramp up efforts at Universal Health Coverage, Nepal has the opportunity to be a crucible of action and innovation.

The new Constitution also created a federal structure with [seven provinces](#). Such an approach will have profound implications for the health care system in Nepal and the goal of Universal Health Coverage. In particular, federalism poses an opportunity to catalyze the process of decentralization of health care delivery systems. This offers exciting new avenues for creating accountable care systems that meet the

Triple Aim of patient-centered care, population health, and affordability, and that are capable of adapting to Nepal's evolving health care needs.

Federalism's Core Tension: Autonomy Versus Equity

Federalism will decentralize health care services, which in turn may foster greater local accountability, autonomy, and flexibility. On the other hand, it may put equity, a goal enshrined in the constitution, at risk. For example, if left overly autonomous, poorer provinces with less financing and less human resources may be less capable of delivering core social protections to the poor. In some instances, minorities within provinces may need greater protection of their human and cultural rights. The federal government has a role to play in addressing these risks.

Financial And Regulatory Challenges

To meet its equity goals, the federal government will need to continue financing much of the public health care system. In parallel, the federal government will also have a strong role in advancing policies around quality, reform, and affordability. To enforce these policies, the federal government will have to link financing to the ability of provincial governments and other local non-state providers to meet basic standards of care.

So, while the federal government may leave actual health care delivery to the provinces, there will be a strong regulatory and financing role to play. This indeed is consistent with the Ministry of Health's third five-year plan, the Nepal Health System Strategy (NHSS) 2015-2020, which provides a roadmap towards universal coverage of basic health care services. In particular, the NHSS identifies the notion of the State as regulator and financier, with a role in both reigning in the excesses of unregulated, fee-for-service for-profit providers and providing more opportunities for private providers to deliver public sector health care.

Health Care Delivery System Challenges

The Nepal Health System Strategy (NHSS) attempts to move the current allocation of health care facilities away from the long-standing practice of placing one facility in each Village Development Committee (VDC). The VDC system is based on old administrative boundaries, rather than population numbers or transportation networks. Instead the NHSS moves towards de-centralized, population-based considerations, calling for at least one health center for every 10,000 citizens, smaller 15-25 bed hospitals for every 50,000 citizens, and 25-50 bed hospitals for every 100,000 citizens.

These goals are forward-thinking yet achievable within the means of the government. The new constitutional framework provides an opportunity to realize this vision. Population-based allocation of services must go hand-in-hand with a greater focus on community-based health care delivery, namely via professionalized community or "extension" health care workers. Unlike purely facilities-based care which is more expensive and less effective, using community health care workers can keep health care affordable. Yet a shift toward this approach leaves a series of challenging questions:

- How should poorly located health posts that see very few patients be closed?
- How can sparsely populated, remote communities maintain access to basic health care?
- How many community health care workers should there be for a given population? How should they be trained and paid? What is their scope of practice?

The shift toward federalism also raises questions about how the health care workforce should be supported and managed. Notably, it remains to be determined which aspects of workforce benefits, recruitment, testing, transfers, and promotion should be managed at the provincial level and which should be managed at the federal level.

Decentralization And Federalism

The transition to federalism will go hand in hand with the decentralization of health care services. There are three main concepts that can be used to try to understand the issues that will arise with decentralization:

- **Decision space** refers to which roles and responsibilities will remain with the central government and which will be transferred to the provincial governments. For example, the central government will likely remain the source of funds and the final regulator of all health care in Nepal, but the provincial governments will become responsible for health care delivery.
- **Institutional capacity** refers provincial governments' ability to deliver health care. Health care delivery is an increasingly complex and technical field and Nepal's central government needs to ensure that all provincial governments have the ability to deliver high-quality health care to their populations.
- **Accountability** applies to two distinct challenges. First, the central government and the provincial government must hold each other accountable. Provinces with increased need—for example, the mid-Western province—must be able to communicate this need to the central government and receive more funding. Conversely, as the ultimate regulator, the central government, must hold provinces accountable if they do not deliver high-quality health care.

Second, the population within a province needs to be able to communicate its unique health needs to its leadership and its leadership needs to be able to deliver health care that is responsive to these needs. Clear mechanisms must be established for the population to hold its government accountable if it does not respond to its citizens' needs.

A Test Case In Dolakha

In this context, the Ministry of Health of Nepal and the nonprofit health care company [Possible](#) have negotiated, over the last four months, a Public Private Partnership (PPP) to explore innovative financial, operational, and regulatory mechanisms to realize the right to health care. We have done this in Dolakha, a district which was among the most devastated by the 2015 earthquakes. The approach we are taking in Dolakha has been developed over the last seven years through our work in the remote far western district of Achham. We have [previously written](#) in *Health Affairs* Blog about Possible's approach to PPPs in Achham.



Patient performs a blessing on the first day of the PPP, together with Possible's Medical Director, Governance and Partnerships Director, and a government official.

Our work started in the district's Charikot Hospital, an institution featuring well-built government infrastructure that survived the earthquake but which under the existing centralized system, struggled to meet the community's substantial need with current staffing levels. On January 19, 2016, the Ministry of Health and Possible (a non-governmental organization in Nepal with a sister nonprofit in the US) signed a 10-year contract establishing an innovative public private partnership based on the following basic tenets:

- **Management Is Decentralized:** Possible independently manages a 25-bed government-owned hospital. This hub of Possible's engagement in the district is set to be doubled in capacity.
- **Government Supply Chain:** The government provides access to the same centralized supply chain on which all government hospitals rely.
- **Government Regulation:** The government provides co-financing to Possible based on a performance-based grant agreement partially tied to [performance metrics](#).
- **Mixed Staffing Model:** Staff come from both the government's civil service and from Possible's independent recruitment and hiring process.
- **Community Care:** Possible will expand its footprint via community health workers and at the health clinics over time, in keeping with its hub-and-spoke approach.

On January 24, five days after the agreement was signed, services began. Today, the partnership provides outpatient care (200-250 patients per day), emergency care, surgical services (over 33 major operations have been performed since January), inpatient care, and maternity care (over 130 deliveries

have occurred since January). An electronic health record (EHR), first deployed in Achham, is now operational across these services, including laboratory, pharmacy, and supply chain. What we learn from government decentralization and regulation will be relevant both to other public-private partnerships and to newly empowered government managers at the province level.

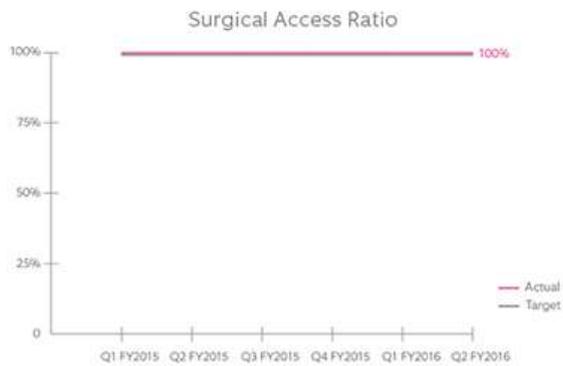
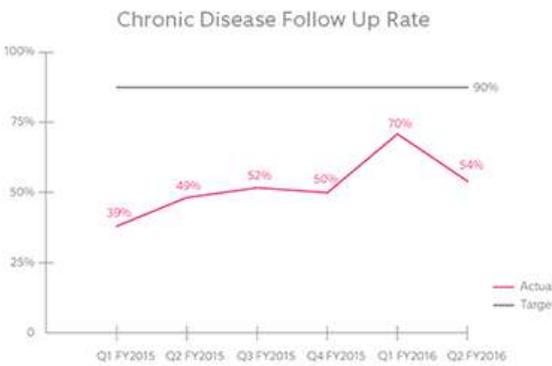
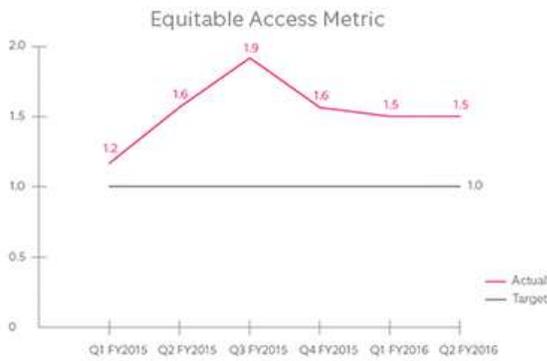
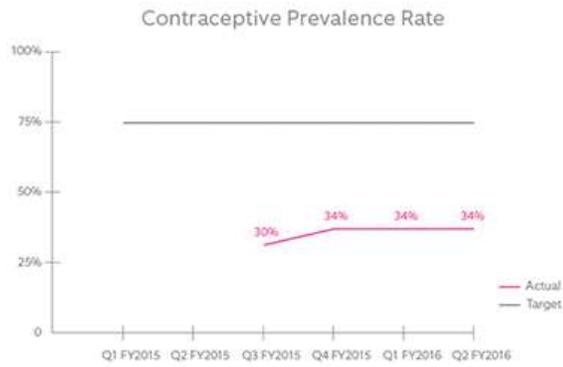
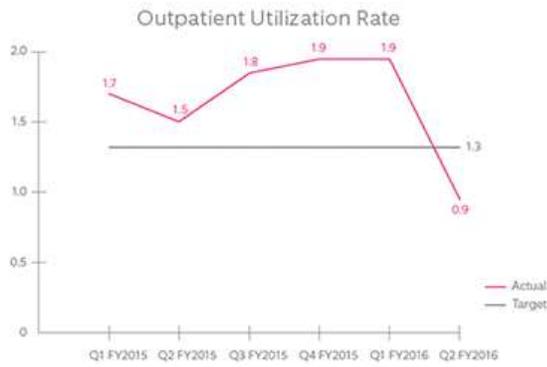
An Opportunity To Define Decentralized Metrics, Regulation, And Financing Structures

When it comes to health care delivery, Nepal's government funding and regulatory system remains ill equipped to provide capitated payments for population outcomes. Even after funds are allocated, transferring those funds is a slow and inconsistent process, driven primarily by paper-based communication.

Possible has heavily invested in its government affairs team to navigate this process, which has been a core part of the government partnership. This process will have to be streamlined in order for decentralization to succeed, and to encourage more private nonprofit providers to partner with the public sector. We will continue to monitor just how quickly the central government can deliver funds committed to the Dolakha health care system.

The government lacks resources for a strong regulatory team, having a small staff dedicated to monitoring and evaluation. This is a missed opportunity for the central government to better hold health care delivery organizations—be they government or non-government actors—to account for population-based outcomes. By working with government bureaucracy to better understand and respond to population-based metrics will we be able to achieve our larger goal of health sector reform. This is a challenge we faced in Achham (see Figure 1), where over time we've seen improvement on key measures.

Figure 1: Key Performance Metrics for District Health Care Delivery, Achham FY15-16



An Opportunity to Scale Integrated, Digital Health Care Systems

Dolakha also represents an opportunity for our partnerships to build off, scale, and further develop an integrated digital health care system. At the government-owned Bayalpata Hospital in Achham, we have already deployed Bahmni, a public sector, Open Medical Record System (OpenMRS)-based, [integrated electronic health record](#). This system integrates supply chain management, prescribing, laboratory, and patient care at the household, clinic, and hospital levels. It is designed specifically for rural mid-level providers and physicians in the public sector.

We are also using Bahmni for government reporting, quality improvement programs, and delivery science research, and hope to scale it up so that it can serve as the government’s national EHR. Importantly, we want the system to provide the foundation for a national, and then regional, disease surveillance system. We believe that the best hope for real-time public health surveillance systems will come from digital integration at the points of care, with data entry by providers serving their own clinical purposes.

Affordable, Adaptive Health Care Systems

Possible's public sector business strategy hinges upon achieving affordability, defined by both our operational cost efficiency (i.e. providing health care at a lower cost) and the government's ability to pay. The latter is determined by overall public sector revenue, health sector specific allocation, and the political will to invest in non-state actors. This strategy provides a strong link between Possible's and the government's interests in good governance.

Dolakha represents a unique opportunity to catalyze much-needed reform, building an effective, adaptive health care system that affordably meets the needs of rapidly evolving national and local epidemiologies.

Tags: [ACOs](#), [EHRs](#), [Nepal](#), [Nepal Health System Strategy](#), [public-private partnership](#), [triple aim](#), [universal health care](#)