Taking the temperature: Health services in Nepal and users' perceptions of the state

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Key messages

- Government health services have improved, but the free local health posts only handle minor conditions, and although hospital care is also free, access is expensive for people in remote areas.
- Health posts and sub-health posts are deemed to be failing in their limited opening hours, lack of out-of-hours services, shortages of free medicines, and lack of centralised monitoring.
- None of the survey respondents knew how to complain about health services. And the failure to establish local committees means that users are not able to offer feedback on needs.

Child and maternal mortality has reduced since the end of the Maoist insurgency in 2006

In recent years Nepal has made substantial progress in public health provision. Free local healthcare services are available through health posts and sub-health posts, the most basic healthcare units in each Village Development Committee (VDC) area, and through district hospitals. In particular, there have been impressive reductions in maternal and childhood mortality rates. For example, the under-five mortality rate has fallen from 142 per 1000 live births in 1990 to 42 per 1000 live births in 2012, boosted by a free delivery policy that provides women with cash incentives and transport subsidies to attend public health facilities to give birth.

However, the health system still suffers from the impact of Nepal's decade-long Maoist insurgency (1996-2006), when more than 1,000 health posts were destroyed, health workers were killed and kidnapped, and – in the Maoist heartland of Rolpa – the local administration ordered health centres not to supply strong antibiotics and medicines that might then be used by Maoists. There are still skills shortages in the sector, and many people still lack access to health services, particularly hospital treatment for more serious conditions.

The Nepal Centre for Contemporary Research (NCCR) set out to explore people's experiences of government healthcare, how respondents accessed and used the health system, their perceptions of its effectiveness and how this influenced their views of government performance at local and national level. The study forms part of NCCR's contribution to the Secure Livelihoods Research Consortium (SLRC), an eight-country, six-year research programme investigating how people in places affected by conflict

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make a living and access basic services such as education, health, water, social protection, and livelihood services.

Methods

The study explored users' perceptions and experiences of government health services at health post and sub-health post level, drawing on data from:

- SLRC's 2012 longitudinal survey, conducted by NCCR among 3,175 households in three districts of Nepal, including Rolpa; and
- NCCR's follow-up qualitative study in 2013 in the Liwang and Budagaon Village Development Committees (VDCs) of Rolpa District, comprising in-depth interviews with 52 respondents, broadly split by gender and caste (Paudel et al. 2015). The study interviewed users of healthcare services, rather than health professionals. Data was collected from three wards in each VDC.

Key findings

NCCR's qualitative research focussed on potential barriers to healthcare services in terms of physical access, economic access, and socio-political and administrative barriers; and then explored how these affected people's attitudes towards the state at local and national level.

1. Physical access to healthcare is a challenge, but not the most important issue

Physical access has always been one of the main challenges for the health system in Nepal where health services are still often out of reach. This is particularly true for people living in remote, rural areas, where only one in five households (21%) are within 30 minutes walk of the nearest health post or sub-health post, compared to more than four in five (83%) of urban households. We found that in Liwang the average time to a health post was 81 minutes, and in Budagaon it was 34 minutes (see Table 1). Physical distance was a particular concern for elderly and disabled people and some pregnant women, and sick people often needed to be carried on someone's back or on a makeshift stretcher to reach a health post. Nevertheless, respondents were more concerned about the quality of services at their local health centre than about physical distance.

Table 1: Time to get to a health post from home

VDC area	Mean (minutes)	Maximum (minutes)
Budagaon	34	300
Liwang	81	480

Source: Field survey data 2012

2. Healthcare users make trade-offs between cost and quality

The message about free government healthcare was not universally understood: while all the interviewees in Budagaon knew that services from government health centres are free, interviewees from the comparatively well-off bazaar area of Liwang did not. Several said they would have to pay a five-rupee registration charge – a fee that has not applied for many years.

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Challenging access: Only one in five rural households can reach their nearest health post or sub-health post in 30 minutes

People with low incomes tended to go to health posts or sub-health posts; while these interviewees often felt that services provided there are inadequate, they use them because they are free. Those with means often opted for private health services instead. For example, of 29 interviewees in Liwang, eight did not use the government health post even though it was very close to their houses, but preferred to use private services instead.

Although government hospital services are free, their concentration in urban areas meant that hospital care came at a price for poor rural people. Our study found that poorer health-post beneficiaries referred to hospitals may have to take out a loan or sell livestock to cover the costs of transport to district or zonal hospitals, lodging, food and lost income. They therefore tend to go first to private medical shops and clinics closer to home.

> ***Going to district hospital is more expensive than visiting a local private clinic.*** **(Female respondent, Budagaon)**

In emergencies, people mostly reported going to private clinics or pharmacies because they assumed that urgent treatment from government health posts and sub-health posts was not possible or effective.

3. No evidence of discrimination in accessing health services

None of the 52 respondents said they perceived discrimination at health facilities. Thirty participants said discrimination has been eliminated because of political change and the increase in voice of lower-caste people, especially as a legacy of the Maoist insurgency (which sought to eradicate caste discrimination). There is no requirement for documentation and paperwork at health facilities that might otherwise pose barriers to access for poor or illiterate people. The quantitative data showed a statistically

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Quality concerns: Some health posts are reportedly run by the office assistant when the health workers are on leave

significant variation in levels of satisfaction by ethnicity of respondent in the two study areas: Janajati, indigenous and Dalit respondents tended to be somewhat more satisfied with health services than were the higher-caste Brahmin and Chhetri respondents. However, a legacy of marginalisation and limited education has had an impact on health-seeking behaviour, with many Dalits, particularly older people, tending to visit health posts and clinics late, first seeking out traditional treatment, shamans or witchcraft.

Overall, women had higher satisfaction levels with health services than men. In the qualitative survey, none of the 26 women interviewed said they felt discriminated against at health centres and they felt it was easy to share their health problems with female community health volunteers (FCHVs). Respondents were also happy with the behaviour of health workers, whom they felt treated all patients with respect.

4. Limited health post opening times and poor medical supplies are major concerns

The greatest number of complaints from respondents were about the opening hours of local health posts, and the quality of free medicines provided.

Health post registration times are between 10 am and 2 pm, and the lack of out-of-hours services were a real cause for concern. One respondent reported that "On Friday [the sub health post] opens for just two hours [10 am to 12 pm] and is closed on Saturday, so how can poor people benefit from such a service?" Seriously ill people are forced to either visit a private clinic or wait for the next opening time. In both Liwang and Budagaon there was evidence that the limited opening hours of health posts had pushed people back into using traditional treatments. There are also not enough health workers to support the system: some health posts were reportedly run by the office assistant when the health assistant and health workers were on leave or on any kind of training.

Respondents also cited concerns about the quality and quantity of free medicines. Of the 52 participants to NCCR's qualitative survey, 30 were not satisfied with the quality of medicines provided through the government system. The Nepal Health Research Council has reported that out of 32 free medicines, only 18 were easily available at health posts. These limitations have meant that people had to buy other medicines from private shops.

> ***We mostly go to private clinics rather than the Sub-Health Post. There isn't any good medicine in Sub-Health Post. Sometimes we get medicines which are near to expiry date and some of them could even have expired.*** **(Male respondent, Budagaon)**

5. State monitoring of health services is ineffective

Overall, the quantitative survey showed that people in Rolpa have a slightly better opinion of local government than of central government: just under half (49.5%) of people think local government never reflects people's priorities, while 53.8% think the same about central government.

Respondents to the qualitative research appreciated the role of local government in providing non-discriminatory health services and in establishing numerous health posts and sub-health posts. They also appreciated the awareness programmes, vaccination campaigns, and recruitment of FCHVs, but were generally very disappointed with the quality of treatment available for anything other than minor conditions. Respondents cited central government's failure to regulate and monitor health services as an indication that it is not committed to their health.

> ***Central government is not committed to providing better health services because they have not been able to make health programmes effective.***
> **(Female respondent, Budagaon)**

Private-sector health services are allowed under government policy, but controlling and monitoring mechanisms are ineffective: respondents thought that central government should also monitor private health facilities and pharmacies. There is no mechanism to monitor or regulate the sale of prescription drugs.

Community influence over health services is very weak. Although the government introduced the concept of Health Facility Operational Management Committees (HFOMCs) to ensure community participation in the management of health services, and to include women, Dalit and marginalised people, in practice no fully functioning HFOMCs exist. And, although Nepal's Local Self-Governance Act allows District Development Committees (DDCs) and VDCs to support and enhance services according to people's needs, these local government units have not been able to make significant changes. No respondent said they knew of any committee that would give them a voice, nor did they know how to complain about health services.

Conclusions and recommendations

Irrespective of caste, ethnicity and gender, people choose health services based on affordability, quality and availability. People's biggest concerns around Nepal's health services relate to issues of effectiveness. Health posts are only open for short periods and mostly deal with minor ailments. Medicines are often unavailable, equipment is limited and there is a perceived lack of well-qualified staff. Consequently wealthier people mainly use higher-quality private clinics, while poor and less-educated people turn back to traditional treatment methods such as healers, herbalists and shamans, or use poorly regulated private providers of questionable quality.

People have more positive perceptions about maternal and child health services, with many using health posts during pregnancy and for vaccinations. Women and socially excluded Dalits are comparatively more satisfied than other users.

Respondents expressed dissatisfaction with the government's role in the health sector. As well as expecting government to do a better job of staffing and equipping government health posts, people also complained about a lack of government regulation and monitoring of private health services. They feel unable to influence local health policies or complain about problems with health services. The theoretical devolution of responsibilities and establishment of community-based health committees does not seem to be operating in the study areas.

Thus the provision of free medicines and basic health services have not improved people's perceptions of government because health services are still not seen as adequate. Neither local nor central government are seen to play an effective role in managing and monitoring services or in involving local people in accountability processes. Based on feedback from respondents, we recommend that stakeholders, policymakers and development partners consider:

Need-based services: Services at health posts and sub-health posts are not adequate to address people's needs, with poor people compelled to spend large amounts of money visiting private clinics. In rural areas like Rolpa, people also have seasonal health problems, such as the incidence of waterborne diseases in rainy season, which local health posts are not able to deal with. More needs to be done to understand health priorities in different areas and at different times of year, and to try to meet those needs.

Improve poor people's access to hospitals: Associated costs such as transport mean that free hospital services are in reality often not free to the poorest people. Government has seen success with initiatives such as transport subsidies to enable pregnant women to reach health services: how might this be replicated to enable poor and economically vulnerable people to access hospital services?

> **If they care about us, the local government must monitor why Health Posts have not been able to deliver medicines. They have not monitored anything. If they had monitored then wouldn't there be adequate medicines at the Health Post?**
> Male respondent, Liwang

Building ownership: HFOMCs are either absent or not working. There is an urgent need to activate this policy to build ownership among health beneficiaries. In the absence of local elected bodies, HFOMCs could represent an effective means for community participation in influencing health centres according to local needs.

Effective evaluation and monitoring by central government: Central government needs to intervene to both increase and improve health services: the low quality of freely distributed medicines in particular has led to negative perceptions of central government.

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