Resource Allocation in Health: Targeting Poverty Alleviation through Decentralized Planning and Program Implementation - A Commentary for the Nepalese Perspective

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Resource allocation is a reality in everyday life where choices have to be made since our wants (desires) are generally greater than our resources. The so-called hard budget constraint has made prioritizations of the different areas for fund allocation necessary for their efficient distribution and effective program implementation. This letter to the editor in essay form provides some insight to the issue of resource allocation in health through the Nepalese perspective and in the process, answers three questions: **why** prioritize the health sector?; **who** to target allocation of scarce resources?; and finally, **how** to maximize the utilization and implementation of the allocated funds in the health sector? The essay also puts forth a *cautionary* note for decentralized program implementation in Nepal and ends with a closing remark.

To understand the Nepalese perspective, it is important to be aware of the kingdom's geographical and socio-economic situation. Nepal is a kingdom located in South Asia and lies on the southern lap of the Himalayas. The kingdom is blessed with diverse geography and climates which is also reflected in the veritable mosaic of ethnic groups that is a unique reflection of Nepal being at the crossroad of two great civilizations, i.e. the Indian and the Chinese civilization. Nepal, however, is economically underdeveloped and is among the least developed countries in the world with a per capita income of approximately $236 (His Majesty's Government of Nepal, Economic Survey, 2002) and nearly 50% of the total population living below the poverty line. In terms of human development, Nepal ranked 31st from the bottom (i.e. 142) out of 173 countries in UNDP's Human Development Report 2002. This figure reflects a number of factors such a low life expectancy at birth, low levels of literacy and low levels of gross enrolment.

Given this background, it is critical to have appropriate allocation of scarce resources to ensure sustained economic growth and social development in the country. One contributing factor for sustained economic development is the health sector which has been given a clear vision of inter-linkages in the recent Report of *Macroeconomics for Health: Investing in Health for Economic Development* (2001). The channel by which this objective is mainly achieved is through a healthy work force (e.g. human and enterprise capital) which contributes productively to the country's economic development. The same relationship is ever true for Nepal where labour is a major source of income seen both in over 80% people involved in the agricultural sector and 40% of national income contributed from the same (His Majesty's Government of Nepal, Economic Survey, 2002). In other words, resource allocation for the health sector takes on greater significance for an agricultural country like Nepal, given the importance of labour in contributing to the nation's income. Further, the health sector, due to its immediate impact and burden on household welfare, is essential at providing equitable social development and ensuring social and, thereby, political stability. Fortunately, the importance of the health sector was recognized by the His Majesty's Government of Nepal (HMG/N), seen in clear enunciation of Health priorities in the National Health Policy, 1991, the supporting two subsequent development plans (the eight and ninth) and the Second Long-Term Health Plan (1997 – 2017).

The second question is who to target allocation of scarce resources? This question is all the more pertinent given the limited health budget of Nepal, which has averaged only about 1% of GDP over the last decade; to put this figure in perspective, it has been argued by the World Bank (1997) that the minimum level of health expenditure should be around 2% of the nation's income. Due to this, and the critical importance of the health sector in Nepal, I would argue that to maximize the proverbial

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"bang for the buck" of scarce funds, it is imperative to have a poverty alleviation focus to promote social and economic equity. A poverty alleviation focus is all the more necessary as sickness in poor people generally tends to be catastrophic to those households.

This is all the more crucial since it is found that certain diseases in Nepal, such as Japanese Encephalitis, Tuberculosis etc. target the poor people due to their living style resulting from poor sanitation, hygiene etc. For example, it was found that Kala-azar, a deadly and debilitating disease, targeted families below the poverty line over three quarters of the time, as seen from a cross section of Kala-azar patients in the Danusha and Mahottari Districts of Nepal (Adhikari and Maskay, 2003 a,b). This specific disease episode had enormous costs for those families which forced a majority of those households to borrow from the informal sector whose cost of funds were more than three times that of the formal sector, such as banks (i.e. 60% versus approximately 20% in the formal sector). This enormous burden eventually left those households only able to service debt, which will likely be passed from generation to generation through interest capitalization and extensions (e.g. they entered a "poverty spiral"), and would thus become a drain on the nation's economic development by preventing their productive contribution. The same is true for other such illnesses in the nation due to maternal and child health etc. In other words for Nepal, it is essential to target poverty alleviation in allocating health sector budget to maximize cost effectiveness and achieve sustainable economic development. This fact has been realized by the Nepalese government reflected in the essential health care approach put forward in the National Health Policy, 1991, supported by the recent development plans, the approach paper to the Poverty Reduction Strategy Paper (2002), and has been recently enunciated in the 2002/2003 budget speech.

Having a clear conceptual idea for whom to target, the crucial question is how to implement it. This is essential because the link to final outcomes may be tenuous if weak implementation exists. In Nepal, policy is centralized resulting in limited flexibility and accountability for the local bodies. Because of this, implementation has suffered which most likely can be seen in poor health outcomes (Adhikari, Maskay and Sharma, 2002). It may be more effective to decentralize the implementation mechanism as this would give the local bodies' greater flexibility in responding to situational episodes and, more importantly, give a sense of ownership. This later is necessary for implementation since it would increase accountability and sustainability. Encouragingly, this has been acknowledged seen in the Local Self-Governance Act, 1999, the Immediate Action Plan of HMG/N to Expedite Reforms and the 2002/2003 Budget Speech of the Nepalese Government where a number of local health units (i.e. sub-health posts) are to be transferred to the local communities during the current fiscal year, starting in ten districts and provisionally targeting twenty more by the end of 2002/2003 (there are seventy five districts in Nepal).

The above enunciation by His Majesty's Government of Nepal for decentralization is really encouraging as it gives support to that conceptual choice. However, it is of critical importance that there must be a well thought out sequencing with the presence of both effective implementation mechanism and a stable environment, to limit transitional costs. The absence of these may lead to weak performance of the local health system and disenchantment with the central government; for one example of this, see the Sri Lankan case as discussed by Attanayake (2001). Because of this danger, a *cautionary* note is put forth where when implementing a decentralization strategy, it is essential to ensure that local bodies build up the capability and desire, and that the *transition* to decentralization takes place in a deliberate and appropriate manner. The prior may entail involvement of political parties, local key persons and possibly non-governmental organizations while the later involves a well developed "road-map" with contributions from all levels. Further, it is necessary to have a peaceful and enabling environment to promote and strengthen this important process. These ingredients are essential to limit the short-term transitional costs (e.g. leakages etc.) and the potential backlash (possibly in the form of social or political instability) which may result, if any, to guarantee long-term sustainability. Unfortunately, I feel that present unstable situation in Nepal may not be conducive for implementation of decentralization at this time and thus it may be appropriate if the timing schedule is reassessed.

In sum, for Nepal there is priority of health sector with programs in the health sector targeted to poverty alleviation through decentralized program implementation. The former is to maximize the potential effect of scarce resources, the latter is to imbue a sense of ownership into the program and maximize the actual effect through effective execution. Of course for Nepal, it is important that the *transition* process to a decentralized health care system be well-planned and deliberate to minimize the possibility of backlash. I would end by remarking that the ultimate responsibility for reaping the above mentioned rewards rests with the country (i.e. government, community etc.) thus a proactive attitude with sincere implementation (rather than simply enunciation) is essential to ensure a healthy work force for contributing

significantly to the country's sustained economic development.

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References

1. Adhikari, Shiva Raj and Nephil Matangi Maskay. "The Economic Burden of Kala-azar in Households of the Danusha and Mahottari Districts of Nepal". *Forthcoming in Acta Tropica*, 2003(a).
2. "Economic Costs and Consequences of Kala-Azar on Households in the Danusha and Mahottari Districts of Nepal: A Discussion Related to Assessment of Economic Burden." Working Paper 2003(b).
3. Adhikari, Shiva Raj, Nephil Matangi Maskay and Bishnu Prasad Sharma. "Nepalese Health Policies: Some Observations from an Economic Development Perspective." *Economic Review (of Nepal Rastra [Central] Bank)*. Occasional Paper Number 14, April 2002, 55 – 72.
4. Attanayake, Nimal. "An Assessment of the Effectiviness of Decentralization of Health Services in Sri Lanka." In Public Health and the Poverty of Reforms. Imrana Qadeer, Kasturi Sen and K.R. Nayar (eds). New Delhi: Sage Publications 2001.
5. His Majesty's Government of Nepal, Ministry of Finance. "Budget Speech" Kathmandu. (Various issues).
6. *Economic Survey*. Kathmandu, 2002.
7. His Majesty's Government of Nepal. Ministry of Health. National Health Policy, 1991. Published in cooperation with World Health Organization. Kathmandu, 1993.
8. "Second Long Term Health Plan 1997 – 2017." Kathmandu, Nepal, August 1999.
9. His Majesty's Government, National Planning Commission Secretariat. The Eighth Plan (2049-2054). Kathmandu: (2049 BS - equivalent date 1992 AD).
10. The Ninth Plan (2054 - 058). Kathmandu: (2054 BS - equivalent date 1997 AD).
11. "Concept Paper of PRSP/10th Plan". Unpublished, 2002.
12. United Nations Development Program. "Human Development Report." 2002.
13. World Bank. Sector Strategy: Health, Nutrition and Population. Washington DC: The World Bank Group, 1997.
14. World Health Organization. Macroeconomics for Health; Investing in Health for Economic Development. 2001.