The Interaction of Increased Trade and the Decentralization of Health Care Delivery in Nepal: A Suggestion for Reform

Nephil Matangi Maskay, Ph.D.*

INTRODUCTION

As levels of international trade and investment have increased, national economies that were once relatively isolated have become increasingly connected as participants in one global economy. This phenomenon is reflected in the growing number of bilateral and multilateral agreements, as well as the rising membership in the World Trade Organization (WTO)—a global multilateral organization which has facilitated the trend toward greater trade in goods and services.[1] The continuing increase in WTO membership suggests that member states have found their participation in the organization to be beneficial. However, the effect of WTO membership on domestic health issues has received relatively little attention. This may be in part because there is little evidence of direct links between the health of a nation and economic development.[2] Yet the two are connected, albeit indirectly; this connection occurs primarily through the ability of good healthcare delivery to produce a productive workforce.[3]

This Case Study puts forward a perspective on health related issues

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1. The WTO was established on January 1, 1995 and to date has 148 members. World Trade Organization, *at* http://www.wto.org (last visited Apr. 14, 2004).

2. There have been some recent exceptions. *See* WORLD HEALTH ORG., MACROECONOMICS FOR HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT (2001).

3. WILLIAM HSIAO, WHAT SHOULD MACROECONOMISTS KNOW ABOUT HEALTH CARE POLICY?: A PRIMER (International Monetary Fund Working Paper No. 00/136, 2000).

from the eyes of Nepal—the youngest member of the WTO—whose protocol of accession[4] was approved by consensus at the fifth Ministerial in Cancun[5] and recently ratified by Nepal.[6] With a per capita income of approximately $236[7] and a low human development index,[8] Nepal is one of the first "least developed" countries[9] to enter the WTO through the regular process of accession.[10] The protocol of accession reflects Nepal's acceptance of the principles of the WTO, as well as the wide range of commitments Nepal has made in multilateral agreements concerning goods and services with the objective of facilitating trade. The health and social services sector in Nepal is certainly not immune to the broad impact of WTO membership.[11] For example, there is ongoing discussion of TRIPS (Trade-related Aspects of Intellectual Property Rights), one of the

4. The protocol of accession is the membership treaty and lists the member's commitments. *See* WORLD TRADE ORG., UNDERSTANDING THE WTO 100 (3d ed. 2003) [hereinafter WORLD TRADE ORG., UNDERSTANDING], *available at* http://www.wto.org/english/thewto_e/whatis_e/tif_e/understanding_e.pdf; *see also* WORLD TRADE ORG., DOC. WT/ACC/NPL/16, REPORT OF THE WORKING PARTY ON THE ACCESSION OF THE KINGDOM OF NEPAL TO THE WORLD TRADE ORGANIZATION (2003).

5. Press Release, World Trade Org., WTO Ministerial Conference Approves Nepal's Membership (Sept. 11, 2003), http://www.wto.org/english/news_e/pres03_e/pr356_e.htm.

6. Milan Mani Sharma, *Government Ratifies WTO Membership*, KATHMANDU POST, March 24, 2004, at 2, *available at* http://www.kantipuronline.com/kolnews.php?&nid=9410.

7. NEPAL MINISTRY OF FINANCE, ECONOMIC SURVEY 7 (2003), *available at* http://www.mof.gov.np/publication/budget/2003/index.php.

8. UNITED NATIONS DEVELOPMENT PROGRAM, HUMAN DEVELOPMENT REPORT 2003 (2003).

9. The United Nations uses countries' per capita gross domestic products (GDP) to designate which countries to designate as "least developed." The threshold for inclusion is generally $900, but the United Nations also considers weak human resources (as measured by life expectancy at birth, per capita calorie intake, combined primary and secondary school enrolment, and adult literacy) and the level of economic diversification. *See* Press release, U.N. Conference on Trade & Development, Least Developed Countries at a Glance (June 18, 2002), http://www.unctad.org/Templates/webflyer.asp?docid=2929&intItemID=1634&lang=1.

10. Cambodia is another one of the "least developed" countries to be approved to enter the WTO through the regular accession process. *See* Press Release, World Trade Org., Ambition Achieved as Ministers Seal Cambodia Membership Deal (Sept. 11, 2003), http://www.wto.org/english/news_e/pres03_e/pr354_e.htm; *id.*

11. WORLD TRADE ORG., DOC. S/C/W/50, HEALTH AND SOCIAL SERVICES: BACKGROUND NOTE BY THE SECRETARIAT (1998); *see also* Rupa Chanda, *General Agreement on Trade in Services: Implications for Social Policy Making*, 38 ECON. & POLITICAL WEEKLY 1567 (2003).

multilateral agreements between WTO members, and the influence that its provisions on medical patents, such as those held by pharmaceutical companies, have on the public health community.[12] Proponents of these agreements believe that the presence of greater service suppliers, both domestic and foreign, will enhance the productivity and efficiency of the health sector. The hope is that enhanced productivity and efficiency will in turn contribute to better healthcare in the nation. Since the Nepalese economy is largely agrarian, labor input is highly important;[13] as a result, the overall health of the Nepalese population has a significant influence on the state of the economy and on economic development.

The primary focus of this Case Study is the component of the WTO agreement dealing with trade in health services, as covered under the General Agreement on Trade in Services (GATS), and its interaction with current domestic reforms aimed at decentralizing the public health care system. This Case Study argues that the interaction of decentralization and increased trade, coupled with current domestic conflict in Nepal, could result in significant short-term costs. Modifying the decentralization process should help minimize the short-term costs, so that the long-term benefits of increased trade can be realized.

I. GATS AND TRADE IN HEALTH SERVICES

Using the GATS definitions, trade in health services can be supplied in four different ways: 1) cross-border delivery of health service supplies that are not present in the domestic economy through telemedicine or telediagnosis; 2) consumption of health services abroad when domestic consumers travel to a foreign country to receive health services; 3) commercial presence, such as a foreign service provider establishing a joint venture health institution in the domestic economy; and 4) movement of people, such as health care professionals, between countries.[14] There are both benefits and costs to each of these possible trade mechanisms.[15]

The potential benefits of the first mechanism (e.g., telemedicine) are,

12. *WTO Members Expected To Agree on TRIPS & Health Pre-Cancun*, BRIDGES, Aug. 28, 2003, *at* http://www.ictsd.org/weekly/03-08-28/story2.htm.

13. Shiva Raj Adhikari et al., *Nepalese Health Policies: Some Observations from an Economic Development Perspective*, 14 ECON. REVIEW: OCCASIONAL PAPER 55 (2002), *available at* http://www.nrb.org.np/red/publication/Economic_Review_Occasional_Paper_No_14-Nepalese_Health-Policies.pdf.

14. Rupa Chanda, *Trade in Health Services*, 80 BULL. OF THE WORLD HEALTH ORG. 158, 160 (2002).

15. *Id.* at 159-61.

among other things, that it allows health services to cater to remote areas, helps alleviate human resource constraints, and provides cost-effective surveillance of disease. The potential cost is the reallocation of resources from rural and primary healthcare to specialized services which cater to the affluent few, since they are able to afford the necessary technology.

The potential benefit of the second mechanism (i.e., consumption of healthcare services abroad) is its potential to improve the healthcare system by generating additional resources for investment in healthcare. It may also increase the level of foreign exchange: For example, when individuals travel abroad to consume a health service, they contribute to the local economy and bring in foreign currency. The potential cost is similar to that noted above for the first mechanism: It may create a dual market structure with higher quality care going to the affluent, and much lower quality care going to the poor. A related concern is the crowding out of the local population from the higher standard centers at the expense of the public healthcare system.

The potential benefit of the third mechanism (i.e., foreign commercial ventures) is that it helps generate additional investment in the health sector, upgrade health care infrastructure, facilitate employment generation, and provide expensive and specialized medical services. Again, the potential cost may be growing inequality to access and a two-tiered health care system. This two-tiered system results from an internal "brain drain," as the foreign commercial ventures encourage health professionals to move from the public to the private sector.

The potential benefit of the fourth mechanism (i.e., movement of healthcare professionals) is that it may promote the exchange of clinical knowledge among professionals and therefore upgrade the skills and standards in the two countries. The potential costs may be its detrimental effects on equity, quality, and availability of health care services if the health care professionals move on a permanent basis, thereby leading to a shortage of highly trained personnel.

The above description of both potential benefits and costs suggests that the countries involved must take affirmative steps if they are to maximize the net benefits of involvement in GATS. Indeed, the outcome of GATS involvement will largely depend on the nature of the nation's health care system, regulatory environment, and government policies.

Through negotiations,[16] Nepal has committed itself to the trade of a number of health services, mainly using the first three mechanisms of

16. WORLD TRADE ORG., UNDERSTANDING, *supra* note 4, at 106.

trade.[17] As a result, it is unlikely that Nepal will restrict its trade in the near future. Thus, it is important to ask the following question: What will be the short-term and long-term impact of these commitments?[18] The long term impact will likely be positive with more competition for allocation of scarce health resources, resulting in a more effective and productive health care service. The short-term effect, however, is not so clear. One thing is certain, however: The conceptual long-term is made of innumerable short-terms which must be survived to reap the long-term benefits. It is for this reason that this Case Study focuses on the short-term issues for Nepal.

II. NEPAL'S HEALTH CARE SYSTEM

Until recently, Nepal's health care system has largely been the domain of the public sector with the private sector entrants limiting themselves to the urban areas. Presently, the domestic public healthcare system is quite extensive. In many cases, only public health institutions are present in the rural areas, and these institutions are attempting to cover the whole country in line with Nepal's 1991 National Health Policy.[19] The spread of health services in the country is consistent with the national health policy's objective of "extend[ing] the primary health care system to the rural population so that they benefit from modern medical facilities and trained health care providers."[20] The healthcare system is based on referrals from the lower tiers to the upper tiers. The first points of contact are the "sub-health posts," which number approximately 2589 and strive to be in each Village Development Committee (VDC) in the country; by contrast, there are approximately 764 "later health posts," and they are each supposed to represent five VDCs in the country. In addition, hospitals and primary care centers are spread across the country.[21] Despite this extensive network, institutional weakness and ineffective program management, in part

17. WORLD TRADE ORG., DOC. WT/ACC/NPL/16/Add.2, REPORT OF THE WORKING PARTY ON THE ACCESSION OF THE KINGDOM OF NEPAL TO THE WORLD TRADE ORGANIZATION—ADDENDUM 2: SCHEDULE OF SPECIFIC COMMITMENTS IN SERVICES, *available at* http://www.moics.gov.np/wto_&_nepal/documents/Schedule%20of%20Commitments%20in%20Services1.doc (last visited Apr. 29, 2004).

18. Short-term refers to less than one year, while long-term refers to more than five years.

19. *National Health Policy, 1991*, Nepal Ministry of Health, *at* http://www.moh.gov.np/plans_policies/policy_plans.htm (last visited Apr. 29, 2004).

20. *Id.*

21. Chhatra Amatya, *The Health Services in Nepal and the World Bank Assistance*, *in* NEPAL RASTRA BANK, WORLD BANK GROUP AND NEPAL 53-65 (2003).

resulting from the poor regulatory environment, have contributed to poor public service delivery.[22] The former is reflected by the fact that the Ministry of Health used only twenty to forty percent of its development budget during the period from fiscal year 1980/81 to 1997/98.[23] It is also reflected in the trend of decreasing expenditures on primary health care[24] and in the poor allocation of health resources.[25] On the other hand, the absence of a significant correlation between government expenditures on health and various mortality and morbidity rates during the period from fiscal year 1989/1990 to 1999/2000 is evidence of the latter.[26] Furthermore, out-of-pocket spending on health care is estimated to be approximately three-quarters of total health care expenditure,[27] suggesting that healthcare financing can have equity implications.

The poor performance of the public healthcare system is reflected, in part, by certain healthcare measures on which Nepal performs below average for the South Asian region and performs even more dismally by international standards.[28] This poor performance of the public healthcare system has been a motivating force for its decentralization. Proponents of decentralization feel that if health institutions are owned and managed by

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22. WORLD BANK, REPORT NO. 19613, NEPAL OPERATIONAL ISSUES AND PRIORITIZATION OF RESOURCES IN THE HEALTH SECTOR (2000).

23. *Id.* at 24. Nepal's fiscal year begins in mid-July of one year and ends in mid-July of the following year. The exact dates are determined by the Nepalese lunar-based calendar. The current fiscal year, mid-July 2003 through mid-July 2004, corresponds to the Nepali year from Srawan 2060 through Asar 2061.

24. WORLD BANK, *supra* note 22, at 24.

25. One prime example is that healthcare personnel were often inappropriately placed. JUDITH JUSTICE, POLICIES, PLANS, & PEOPLE: FOREIGN AID AND HEALTH DEVELOPMENT (1989).

26. Shiva Raj Adhikari & Nephil Matangi Maskay, *Health Sector Policy in the First Decade of Nepal's Multiparty Democracy: Does Clear Enunciation of Health Priorities Matter?*, 68 HEALTH POL'Y 103, 103 (2004).

27. Badri Raj Pande et al., *Health Insurance Models in Nepal: Some Discussions on the Status of Social Health Insurance* (2004) (unpublished manuscript, on file with *The Yale Journal of Health Policy, Law, & Ethics*).

28. NEPAL MINISTRY OF FINANCE, *supra* note 7. For example, the child mortality rate per thousand births was 81 for males, 87 for females in 2002; the overall healthy life expectancy at birth was 51.8 years. Nepal, World Health Org., *at* http://www.who.int/country/en/ (based on *The World Health Report 2003*). During the same period in the United States, the child mortality rate per thousand births was 9 for males, 7 for females; the overall healthy life expectancy at birth was 69.3 years. United States of America, World Health Org., *at* http://www3.who.int/whosis/country/indicators.cfm?country=usa. The statistics in other countries in the region, such as Bangladesh, are superior to Nepal. See the World Health Organization's website, http://www.who.int/country/en/, for country-based statistics.

the local community, there will be greater monitoring and supervision of healthcare services, thereby ensuring their more efficient and effective provision. In this regard, one of the primary goals in the Nepal Health Sector Implementation Plan 2003-2007 is decentralization of the public health care system.[29] This process of decentralization is based on existing laws,[30] and a number of public healthcare institutions have already been handed over to local bodies.[31] However, the move to decentralization does entail transitional costs that may result in inequality to access. The absence of local bodies in some areas, and the inability of some existing local bodies to handle their new responsibilities, may significantly impair the provision of local health services, resulting in the poor having less access to, and a lower quality of, health services. Indeed, the process of decentralization seems to many to be moving blindly ahead without a full consideration of the interaction between decentralization and trade in health services and of the transitional costs associated with decentralization.

III. HEALTH CARE DECENTRALIZATION AND ITS INTERACTION WITH TRADE IN HEALTH SERVICES

As I argued above, decentralization of public healthcare will lead to greater inequality in the short-term. The trade in health services will magnify this transition cost and lead to greater inequality of access to healthcare services because affluent individuals facing the short-term transitional cost of decentralization will now have the opportunity to access quality health services through the mechanisms of trade discussed earlier. Affluent individuals may use telemedicine; travel to foreign countries for consumption of health services; and move to urban areas to access private

29. NEPAL MINISTRY OF HEALTH, NEPAL HEALTH SECTOR IMPLEMENTATION PLAN 2003-2007 (2003).

30. NEPAL MINISTRY OF LAW JUSTICE AND PARLIAMENTARY AFFAIRS, LOCAL SELF GOVERNANCE ACT 1999 (1999).

31. NEPAL MINISTRY OF FINANCE, PUBLIC STATEMENT ON INCOME AND EXPENDITURE OF THE FISCAL YEAR 2003-2004 (2003), *available at* http://www.mof.gov.np/publication/budget/pdf/bspeech2003.pdf (For FY 2003-04, the so-called "Budget Speech" has been published and distributed as the *Public Statement on Income and Expenditure.*); NEPAL MINISTRY OF FINANCE, PUBLIC STATEMENT ON INCOME AND EXPENDITURE OF THE FISCAL YEAR 2002-2003 (2002), *available at* http://www.mof.gov.np/publication/statements/2059/index.php# (Nepali version, translated by the author). The Budget Speech for 2002-2003 is available at http://www.mof.gov.np/publication/budget/pdf/bspeech2002.pdf.

healthcare services providers, such as nursing homes, private hospitals and colleges. Thus, liberal trade in services will *exacerbate* the inequality of healthcare access resulting from decentralization.

These short-term effects on the equality of access can already be seen in the growth of private healthcare institutions, such as nursing homes, private hospitals, and colleges, in urban areas and the consequent expansion of health personnel in these areas. Nonetheless, these short-term effects may give way to long-term benefits because the greater number of health service providers will result in increased competition which will likely benefit society as a whole. Yet the realization of these long-term results may be made more difficult by the present domestic security system in which over 10,000 people have fallen victim to the armed conflict commenced by the Maoist insurgency in February 1996.[32] As a result, there is an absence of local representative bodies, and this situation has resulted in the weakening of the provision of healthcare, especially in the remote, rural areas of the country.[33] This raises an important question: As decentralization proceeds, to whom should responsibility be transferred? Since a central objective of decentralization is to transfer responsibility and a feeling of ownership to the locally elected bodies to enhance their sustainability and facilitate economic development, this is an important question.

IV. THREE ISSUES FOR THE PROCESSES OF DECENTRALIZATION

The interaction of trade in health and decentralization in the present domestic situation is potentially volatile and could result in some unfortunate consequences. Given the significance of these consequences, some suggest that reassessment of these processes is appropriate. However, it is important to remember that many of Nepal's trade commitments are part of WTO membership and cannot be changed without reopening negotiations with affected countries.[34] Thus, it makes more sense to focus reform efforts on decentralization. This Case Study argues that there are three key issues related to decentralization which warrant reassessment: timing, sequencing (i.e., preparedness of local bodies), and pace.

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32. The armed conflict of the Communist Party of Nepal (Maoist) started over eight years ago from the poor governance and heightened inequality related problems prevalent in the 1990s. For a concise history, see DEEPAK THAPA & BANDITA SIJAPATI, A KINGDOM UNDER SIEGE: NEPAL'S MAOIST INSURGENCY, 1996 TO 2003 (2003).

33. *See, e.g., Health Workers Caught Between Ongoing Conflict*, KATHMANDU POST, Mar. 29, 2004, at 2, *available at* http://www.kantipuronline.com/kolnews.php?&nid=9685.

34. WORLD TRADE ORG., UNDERSTANDING, *supra* note 4.

A. Timing

The move toward decentralization will increase inequality of access to healthcare in the short-term. As mentioned earlier, liberalization of trade in health will magnify the transitional cost of decentralization and the resulting inequality of access for health care. This is doubly dangerous as the country is presently facing political turbulence and a domestic security situation where there is an absence of elected local bodies to ensure sustainability of the process. All these characteristics tend to suggest that moving ahead with decentralization for the sake of moving ahead may not be sensible and may result in high short-term costs, if not failure. It would thus make sense for the decentralization process to be postponed until the domestic situation improves.[35]

B. Sequencing

Since the process of decentralization in Nepal will necessarily interact with trade policy, the sequencing of changes in this area should be considered carefully. Decentralization should proceed in parallel with the development of local capacity to bear greater responsibility for the provision of health services. In addition, there should be strengthened monitoring and supervision from the relevant ministries in His Majesty's Government of Nepal to ensure accountability. Moreover, the potential benefits of trade in health services should be harnessed to facilitate the process of decentralization and to provide equitable access to health services. For example, greater trade in health services could help absorb temporary shortfalls in public health services. To facilitate this end, a road map should be developed which takes into consideration administrative, financial, and managerial perspectives on these issues.[36] This would ensure stability and confidence in the local health system.

C. Pace

The pace of decentralization should be determined by the domestic situation. The two extremes may be the "big bang" type of approach, such

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35. Nephil Matangi Maskay, *Resource Allocation in Health: Targeting Poverty Alleviation through Decentralized Planning and Program Implementation - A Commentary for the Nepalese Perspective*, 1 J. NEPAL HEALTH RES. COUNCIL 61-63 (2003).

36. NEPAL HEALTH ECON. ASS'N, HEALTH CARE FINANCING AND FINANCIAL MANAGEMENT IN NEPAL: REVIEW, ASSESSMENT AND SUGGESTIONS OF PRESENT AND FUTURE PUBLIC HEALTH CARE FINANCING AND FINANCIAL MANAGEMENT IN NEPAL (2002).

as that which occurred in Russia, and the gradual approach, such as that which is occurring in China. In Nepal, where there is, as of yet, limited culture for independent, regional reforms, decentralization should not be pursued hastily simply for the sake of reaching some predetermined numerical target. Rather, a gradual pace would be more appropriate. As with sequencing, attention to the pace of changes should help ensure the sustainability and success of the process.

CONCLUSION

The prior discussion suggests that the transitional cost of decentralization may be magnified if pursued concurrently with the trade commitments that WTO membership brings. This is particularly true in the present context where the political situation is fluid and there is an absence of local representation. This situation suggests that this process may not be sustainable and may, if forced, be prone to failure. As a result, this Case Study suggests three areas in which the decentralization process should be reassessed: timing, sequencing, and pace. Further, it is important to point out that any reassessment has to move away from abstract conceptualizations about the values of decentralization and focus instead on the practical challenges of implementation if it is to produce desired results.[37]

To reach the long-term benefits of increased trade, survival of the short-term transitional costs is essential. This Case Study suggests a general approach aimed at surviving these transitional costs. The Case Study is not advocating a revision in trade policy, as Nepal has already made binding trade commitments. Rather, it is pointing out that Nepal's healthcare system should focus on taking full advantage of the opportunities made possible by the increased trade in health services and should modify its existing approach to decentralization accordingly. This modification, coupled with appropriate health sector reform, should maximize the probability of sustainability and success which will enhance the country's economic development.

37. Adhikari & Maskay, *supra* note 26.