Politics
& Governance

Human resources for health in Nepal

The politics of access in remote areas

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Country Evidence

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Acronymns

ANM	Auxiliary Nurse Midwife
AHW	Assistant Health Worker
CTEVT	Council for Technical Education and Vocational Training
DFID	Department for International Development
DDC	District Development Committee
DHO	District Health Office
DoHS	Department of Health Services
HRH	Human Resources for Health
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDGP	Medical Doctor General Practitioner
MoE	Ministry of Education
MoHP	Ministry of Health and Population
NCD	Non-communicable Disease
NG	Non-gazetted
NGO	Non-governmental Organisation
NHSP II	Nepal Health Sector Programme II
NHSPIP II	Nepal Health Sector Programme Implementation Plan II
NHSSP	Nepal Health Sector Support Programme
NSI	Nick Simons Institute
PEA	Political Economy Analysis
PSC	Public Service Commission
RSSP	Rural Staff Support Programme
RHD	Regional Health Directorate
SOLID	Society for Local Integrated Development (Nepal)
SWAp	Sector-wide Approach
UK	United Kingdom
UN	United Nations
UNDP	UN Development Programme
VDC	Village Development Committee
WHO	World Health Organization

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Executive summary

This country evidence note explores the political economy dynamics associated with attempts to ensure access to qualified human resources for health (HRH) in remote rural areas of Nepal where low ratios of skilled health personnel per head of population persist. The choice of this relatively specific focus is in line with recent trends in the application of political economy analysis in the field of international development away from broader, more contextual studies outlining political economy dynamics at the country or sector level, and is intended to help maximise the capacity of the work to produce operationally relevant findings (Fritz et al., 2009). Although there are a range of important issues in the Nepalese health sector, the initial problem scoping and literature review found HRH issues to be particularly interesting given the persistence of challenges in this area, ongoing reform efforts and its consonance with expressed interests in health service delivery as a poverty reduction tool.

Like other political economy studies, this paper seeks to understand the interaction of structure and agency, making connections between the way individuals and organisations behave; the decisions they make; the actions they take; and the relevant features of the context in which all of these actions take place. We therefore begin by providing a brief overview of the substantial formal institutional framework currently in place to govern key tasks in the management of HRH in Nepal, highlighting four key areas:

- Recruitment and appointments. As elsewhere in the Nepalese civil service, the Public Service Commission (PSC) formally holds responsibility for permanent, sanctioned appointments in the health sector. However, failure to update key legislation underpinning recruitment for such positions in the sector has led to reliance on a variety of temporary recruitment measures that present practical challenges to ensuring consistent access to qualified health workers. Authority over appointments in these cases is held by Ministry of Health and Population (MoHP) employees at different levels in accordance with the level of the post in question.

- Deployment and transfers. There are formally established rules giving authority to different levels of government over transferring different levels of staff and providing criteria for transfers. Deployment of the health workforce is formally the responsibility of MoHP, involving staff members centrally (in the case of officer-level positions), as well as departments, regional health directorates and district health offices.

- Rewards and punishments. The system currently in place under the Health Service Act and other relevant legislation provides guidance on the type and level of rewards for health workers. Key features include policies on remuneration, which detail basic monthly salaries according to the class of the position and duration of service, and benefit packages, including MoHP-provided accommodation. Opportunities for promotion, upgrading, in-service training and study also provide important incentives for health workers and include both automatic and performance-based criteria.

- Additional systems in place to address issues of remoteness in public sector service delivery. These include the system of remote placement allowances for civil servants working in remote areas of Nepal, the requirements for government health workers to have worked in a remote area for at least two years in order to be a candidate for promotion and the prioritisation of those health workers with experience in different geographical regions in nomination for scholarship and training opportunities.

However, despite the existence of fairly clear legislation intended to guide HRH management, there remains a significant gap between *de jure* policies in the areas given above and *de facto* practices in the sector. It is clear that the formal systems currently in place are strongly influenced and even undermined by other factors that often have roots in features of contemporary Nepal, including deeply embedded cultural norms, the nature of political competition, the structure of the labour market and the role played by external actors. The precise ways in which formal rules and these informal, but nevertheless powerful, factors interact thus have important implications for the management of HRH.

Three major themes emerge from the available evidence. For each, we present the issues, consider potential plausible theories of change and provide initial thinking on how external actors might contribute to such change processes.

First there are incentive and informational problems, resulting in a reported mismatch between the health workers currently being trained and recruited and the service needs of the population in Nepal. While the failure to update the Health Service Act is perhaps the clearest binding constraint to HRH management, we

suggest the resolution of this formal legislation may be insufficient to guarantee HRH supply needs are met. The available information on health worker production suggests the dominance of HRH training by urban-based private sector organisations also raises a number of challenges. Issues include imperfect information held by prospective health workers regarding the future of the labour market; urban bias in intake; and incentives to maximise profit leading to prioritisation of quantity over quality and potentially the production of types of health workers in demand internationally but not locally.

Updating the Health Service Act to resolve the current inability to make permanent appointments is a clear priority for sustainable solutions to HRH management challenges, although this clearly depends on progress in the wider political environment. Alongside this process, improving outcomes here appears to depend in part on improving information on the health workforce. Existing information, particularly on production and employment of health workers in the private sector, is patchy, leading to a partial picture, even as districts continue to report on these issues. The labour market assessment currently underway with external support through the Nepal Health Sector Support Programme appears well suited to this task, but should be linked to existing monitoring and reporting practices (e.g. at the district level) to ensure data can be kept up to date.

Second, we describe the creation of a market for transfers that underpins distributional concerns regarding the deployment of human resources in the sector. The argument advanced is that the rent-seeking behaviour that affects *de facto* practice of key HRH functions is happening in the context of, and indeed is driven by, the presence of a specific institutional reality: the dominance of patronage networks in Nepal's political system. In this dynamic, control over parts of the health system (including the distribution of preferred posts) entails opportunities for revenue generation (to fund further political competition) and other politically valuable resources (appointments that help ensure political loyalty), both of which constitute valuable commodities.

Addressing these constraints head-on will be extraordinarily challenging. The available evidence suggests that current practices are closely tied to party politics and a large number of trade unions that maintain informal ties to political parties. At the health facility level, there are some reported successes in managing political interference by gaining collective adherence across parties, but it is not clear that this level of coordination can be achieved at national level. A number of intermediate options are proposed, largely involving improvements in information, both in the health sector (e.g. on transfers and the extent to which staff meet eligibility criteria) and with respect to party financing.

Third, the functioning of the market for transfers, and indeed challenges in ensuring access more broadly, appears to be driven on the demand side by incentives for health workers that affect retention and willingness to work in remote locations. Specifically, the relative appeal of urban posts arises from differences in the posts relating to i) conditions in service; ii) immediate opportunity costs; and iii) future opportunities for advancement. For the current health workforce, the relative gap in the perceived value between rural and urban posts appears often to exceed the value of remote allowances and other incentives put in place to encourage service in rural areas.

A transformational change here seems unlikely, but there are a number of incremental changes that appear plausible in the current context. Without advocating permanent limitations on the working opportunities for health workers, there may be the potential for temporary restrictions through the extension of rural service requirements currently applied only to scholarship students. There also appears to be room to build on existing initiatives to improve conditions in rural areas by addressing a wide range of monetary *and non-monetary* concerns raised by health workers in a number of surveys. Other ideas include changing patterns of recruitment to support the training of health workers for whom the perceived gap between urban and rural practices is smaller (e.g. through affirmative action policies that support recruitment of students from rural origins). These ideas ought not to be seen as mutually exclusive, and together might provide a package of interventions capable of indirectly eroding (at least partially) the market for transfers.

In summary, the environment for those seeking to effect or support improvements in HRH management and ensure access to qualified health workers in remote rural areas of Nepal is clearly a challenging one. However, there do appear to be change processes that seem plausible even in the light of current constraints. These processes often consist of a series of small changes at the margin rather than transformational change and therefore may demand a longer-term view towards results, but there are a number of steps that can be taken in the shorter term to which external actors might usefully contribute. Further, given the potential for rapid political change in the country, external actors would do well to maintain a flexible approach, building relationships that allow them to identify and pursue windows of opportunity when and where they do arise.

1 Introduction

1.1 Putting the problem in perspective

While the literature has used various definitions of a health system (e.g. Hsiao, 2003; Plsak, 2001, in World Bank, 2007; Romer, 1991, in World Bank, 2007; WHO, 2000; World Bank, 2007), there is widespread consensus that the effective management of human resources is a vital component of the effective delivery of health services in any context. Other inputs, such as medical equipment and medications, and other components, such as system stewardship and health financing, clearly have important roles in the functioning of a health system and therefore are deserving of attention in attempts to improve health outcomes. This paper should therefore be seen as complementary to other analytical work currently underway addressing issues relating to the management of financial resources (Krause et al., 2013). However, the very nature of health services, and specifically the information asymmetries that exist in the sector, demands qualified, capable, knowledgeable and motivated health workers (McLoughlin, 2012).

The challenge of ensuring access to qualified health workers in Nepal has been widely recognised as a constraint to sector performance (SOLID, 2012a-f). Notably, these issues have not gone unnoticed in the policy community, with human resource issues drawing attention from both domestic policymakers and international development partners as an area in which improvements should be a priority (MoHP, 2010; MoHP/NHSSP, [1] 2012). This emphasis is reflected in recent policy documents, which note a wide range of human resources for health (HRH) issues in the country. For example, the NHSP II explicitly identifies access to quality of health care and its delivery by skilled HRH as a continuing challenge, citing health worker shortages across multiple health worker types including generalists and specialists, fragmented human resource information and management systems and an underskilled health workforce as just some of the challenges facing policymakers (MoHP, 2010).

In particular, our concern in this paper is with a particular aspect of HRH challenges, or rather one lens through which to examine HRH issues: that of the need to ensure access to qualified health workers in remote rural areas. Spatial inequalities in Nepal are overlaid on a complex web of ethnic and caste distinctions that have been associated with forms of exclusion in a number of dimensions (social, economic etc.) (UNDP, 2009). Yet the spatial dimension retains importance. Available work on health system performance in Nepal has clearly identified geographic factors, namely, remoteness and terrain, as a key determinant of access to health services and health outcomes (e.g. Chin et al., 2011; Engel et al., 2013). Crucially, in addition to noting the challenges presented by remoteness, Engel et al.'s work on reductions in maternal mortality suggests it is possible to make substantial improvements in health service delivery and associated health outcomes even in the face of relatively unchanging geographic realities, by developing strategies that facilitate access to HRH (skilled birth attendants in the case of maternal mortality; see Buor and Bream, 2004, in Engel et al., 2013).

That the challenges of ensuring access to qualified health workers in Nepal's remote rural areas have been widely recognised is to be welcomed. However, this raises the question of why this particular problem has persisted over time. The Ministry of Health and Population (MoHP)/NHSSP Strategic Plan acknowledges that deployment and retention of essential health workers has remained a longstanding problem, especially in rural and remote areas (MoHP/NHSSP, 2012). In this paper, we do not attempt to provide significant new insights on the extent of these challenges, accepting the widely held view that 'maldistribution has been a major concern over the years in the health sector in regard to deployment of health personnel to the rural and remote areas of the country' (ibid.: 40). Indeed, the anecdotal accounts gathered during consultations for this work tend to confirm the concerns raised regarding understaffing, vacant posts and inappropriate or inefficient skills mixes (ibid.; Powell-Jackson et al., 2008; SOLID, 2012b-d). Rather, we seek to shed some light on the persistence of these problems over time by exploring a set of key themes in the political economy of HRH.

[1] The Nepal Health Sector Support Programme (NHSSP) is a Department for International Development (DFID) funded and managed technical assistance programme designed to enhance government capacity to achieve the objectives of the Nepal Health Sector Programme II (NHSP II). Further detail is available at http://www.nhssp.org.np/

1.2 Analytical approach and methodology

The framework for political economy analysis (PEA) set out in Annex 1 provides a more structured form of PEA to identify policy options and feasible theories of change within a given sector and country context. The framework, which structures the analysis around a particular policy or programmatic challenge, suggests an approach in which institutional and structural features of the context in question shape the incentives facing relevant stakeholders and therefore their behaviour, leading to particular sector outcomes.

During the inception period of the project, the 'problem' or key developmental challenge to be addressed in the study was fairly open with respect to what aspect of HRH would be addressed. While this meant early conversations were more general than they might otherwise have been, this was useful as it allowed the research team to proceed through an assessment of which key priorities were shared more broadly among sector stakeholders. Given what we learned about other initiatives underway in the sector and about the nature of HRH challenges, the focal point for the research project increasingly centred on the challenge of **ensuring access to qualified health workers in remote rural areas**. In practice, we feel the issues raised in consultations and in the recent literature showed strong consonance with those raised in discussions with staff members in the DFID Nepal office, and are highly relevant to DFID's expressed interest in health service delivery as a poverty reduction tool.

In practice, the use of this framework was informed by two recent reviews that offer a more systematised approach to exploring governance aspects of service delivery at sector levels. First, Wild et al. (2012) review available evidence documenting governance constraints present in political systems that often undermine service delivery. Second, Mcloughlin (2012) maps technical characteristics of service provision in particular sectors and sub-sectors and identifies the political and governance implications of these characteristics for provision. These papers have facilitated our understanding by providing an analytical toolbox of sorts to give shape to the complex web of incentive structures that affect sector performance.

Methods used included a desk-based review of available quantitative and qualitative data on sector performance in relation to the identified problem and of relevant sector policies and reports, to map relevant institutions and their relationships and set out how, in theory, systems should work around the problem identified. This desk-based work was supplemented by a series of key informant interviews carried out in and around Kathmandu and in Kaski district in December 2012 in order to help determine how systems and processes work in practice and the relevant incentive structures that shape actors' decision logics.

1.3 Summary of emerging themes and structure of the paper

With this challenge as the central HRH issue to be explored, the emerging evidence suggests three key themes:

1. Incentive and informational problems resulting in a reported mismatch between the health workers currently being trained and recruited and the service needs of the population in Nepal;
2. Distributional concerns, the politicisation of HRH and the market for transfers; and
3. Incentives for health workers affecting retention and willingness to work in remote locations.

The paper proceeds as follows: Section 2 presents a brief overview of HRH issues in Nepal, identifying three basic components of HRH (training and recruitment; deployment and transfers; and training, reward and career development) and describing the current institutional framework in place to govern these tasks, before looking explicitly at systems intended to address issues of remoteness. Section 3 then explores each of the three major emerging themes in greater detail, focusing on the key incentives generated by the context and the way those incentives undermine attempts to address HRH needs. Section 4 then draws directly on the diagnosis in the preceding section to consider theories of change that would address existing blockages and what the role of external assistance might be in such change processes. Section 5 briefly concludes.

2 HRH in Nepal: Review of existing policy framework

The underlying assumption in this paper is that the persistence of HRH challenges in Nepal, including that of ensuring access to HRH in remote rural areas, can be seen as the result of the (generally, though not

necessarily universally rational) actions of individuals and organisations within a particular context. In other words, the decisions and behaviour of key actors are determined at the intersection of structure and agency. In this section, we establish some of the basic 'rules of the game' that should nominally comprise the system intended to ensure effective HRH management.

Consultations conducted for this study largely confirm the existing literature regarding the state of the institutional framework underpinning HRH in Nepal. Following SOLID (2012d), we provide here a brief overview of that framework with respect to the following key tasks in HRH:

- Recruitment and appointments, including authority of different levels of government over hiring for permanent sanctioned and temporary posts;
- Deployment and transfers, including the authority of different levels of government over transferring different levels of staff; and
- Rewards and punishments system, including the current rules covering the type and level of rewards for health workers, entailing existing remuneration and benefit packages as well as opportunities for in-service training and study.

Additionally, we pay particular attention to the system categorising different degrees of remoteness and implications for incentives.

2.1 Recruitment and appointment

The formal rules and regulations regarding various modalities of contracting services of HRH are derived from a number of different policy documents governing the procurement of services, including the Public Procurement Act (2007), the Civil Service Act (1993) and the Health Service Act (1997). Here, we distinguish between the two dominant modalities of contracting HRH, permanent appointments to sanctioned, funded posts and temporary or daily wage contracts.

As is the case with civil servant appointments in other sectors in Nepal, the Public Service Commission (PSC) is responsible for permanent appointments in the health sector. Multiple informants and the literature (e.g. SOLID, 2012d) noted that, when the PSC process does function, the recruitment process is cumbersome and complex, requiring multiple authorisations. The PSC has to be notified of the vacancies by MoHP authorities at the relevant level, but this process is often delayed, leading to gaps in access even before the initiation of the recruitment process. Further, the PSC has a set timeframe for recruitment steps, advertising one time per year for officer-level vacancies and two times per year for non-officer-level vacancies. The process of final selection by the PSC takes almost a year, followed by deployment. Taken together, administrative delays at MoHP level and the lengthy selection process of the PSC, which is not taken into account in human resources planning, result in the frequent occurrence of extended vacancies for frontline health service provider positions.

In recent years, these inefficiencies have been compounded by a more specific problem. Partly in response to perceptions that exclusion of various forms was a contributing factor to the civil war (e.g. Deraniyagala, 2005), the Interim Constitution of Nepal, promulgated in 2007, includes a provision requiring the adoption of inclusiveness criteria in permanent government appointments, with 45% of government posts reserved for ethnic communities, members of marginalised populations and women. While the Civil Service Act has been updated accordingly, the Health Service Act has not yet been revised to comply with the inclusion provision, generating significant problems in the management of HRH. Not least among these is the 2008 Supreme Court decision to suspend recruitment through the PSC where inclusion provisions have not been adopted, resulting in the cancellation of advertising and recruitment for health sector jobs. [2] Positions reportedly affected include permanent hire of public health officers, health education officers, senior specialist and medical doctor positions and many others in MoHP.

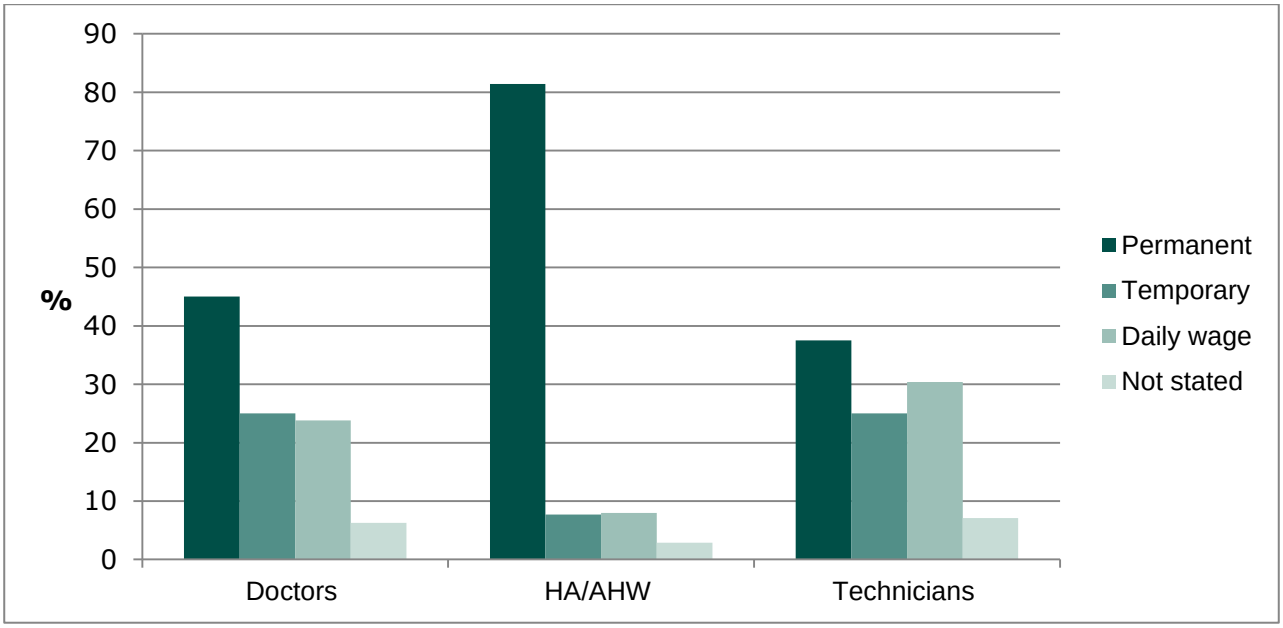
With the dissolution of the Constituent Assembly on 27 May 2012, the potential resolution of this issue was further complicated as the adoption of changes to the Health Service Act now depends on a presidential

[2] During this period of suspension, there has been no recruitment for new sanctioned posts. Contractual recruitment has taken place, as have appointments via internal promotions for government health workers who have met seniority criteria and fulfilled remote posting criteria. Around 10% of such promotions are to be filled by open competition to which the requirements of the inclusion act do not apply.

ordinance. However, the current President, Ram Baran Yadav, elected by the now-dissolved Constituent Assembly in 2008, is generally seen to have limited authority. While President Yadav is a qualified doctor and twice former Minister of Health, and therefore has some understanding of HRH challenges in the country, he has displayed little inclination to legislate extensively via ordinance, instead focusing his efforts on the attempt to move the country towards new Constituent Assembly elections. External development partners and non-governmental organisations (NGOs) consulted for this study largely expressed agreement on the need to avoid 'business by ordinance', but the deadlock, even for relatively uncontroversial issues, clearly frustrates those endeavouring to contribute to improvements in the sector.

As a result of these unresolved constitutional issues and the complexities of filling posts via PSC permanent appointments, numerous positions in the sector are now being filled on a temporary contractual or daily wage basis. Survey work by the Society for Local Integrated Development (SOLID) and Merlin Nepal estimates that non-permanent contracts are used for roughly one-third of total HRH positions, a figure confirmed during interviews, although there is variation by position type (Figure 1).

Figure 1: HRH contract type, by position



Source: Authors' interpretation of data from HRH Survey 2011, in SOLID (2012b).

The Health Service Act makes provision for temporary appointments to be made for a fixed term of up to six months. In the case of temporary appointments, MoHP manages officer-level recruitment (Classes 6-12), while authority for assistant-level appointments (Classes 3-5) [3] rests with the regional health directorates (RHDs). The consent of the PSC is still required for such appointments, and MoHP is responsible for informing the Ministry of General Administration of the appointment within seven days of the appointment (SOLID, 2012d). At the village development committee (VDC) level, health facility management and operation committees also report recruitment and management of local-level contract staff (e.g. laboratory assistants and auxiliary nurse midwives (AMNs) at sub-health post level) according to local needs and using district development committee (DDC) and VDC funding. This study was not able to assess the extent to which these practices are widespread among VDCs, although some government reports suggest the number of locally hired staff may be 'quite large' (MoHP/NHSSP, 2012: 38). For example, MoHP figures indicate '586 ANMs and 40 staff nurses recruited on local contracts to support 24-hour delivery services in PHCCs [primary health care centres] and HPs [health posts] in 2009/10' (MoHP, 2011: 96, in MoHP/NHSSP, 2012: 35).

[3] There is the potential for considerable confusion in the terminology and systems used to classify health workers. Please see Annex 2 for additional detail.

While this practice of temporary appointment has provided some relief and allowed health facilities to implement health programmes, informants cited regulations limiting the duration of temporary contracts, delays in budget release and the lengthy duration of the contracting process (reportedly up to five months) as contributing to high turnover among contract staff and the prevalence of gaps in access.

2.2 Deployment and transfer

Following appointments by the PSC (permanent) and various levels of MoHP administration (temporary), deployment of the health workforce is undertaken by MoHP departments, RHDs and district health offices. Authority over deployment and transfer rests with MoHP centrally for officer level (Classes 6-12). Departments are responsible for Classes 6-7. RHDs and district health offices (DHOs) are responsible positions from Classes 3 to 5. Specifically with regard to transfers, health workers are eligible for transfer once they have completed at least one year of a posting in the most remote areas in the mountains and high hills or at least two years in remote districts, mainly hills. In accordance with the Health Service Act, authority is delegated to DHOs for transfers and deputation for less than three months within the district, to the regional director for transfers and deputation outside the district but within the region and to the Department of Health Services (DoHS) and MoHP for the officer-level health workforce.

Despite the promulgation of the wide variety of regulations noted above, the system responsible for the transfer of health professionals is widely acknowledged to operate in contravention of existing formal rules (including those regarding years of service in remote areas), and these practices are associated with health worker dissatisfaction. Interviews with key informants undertaken as a part of this study, including several informants involved in management of HRH as well as medical professionals, suggest that informal practices dominate. These reports indicate that irregularities including favouritism, nepotism, rent seeking and other forms of corruption have been common practice in MoHP. We return to these in greater detail in Sections 3 and 4.

2.3 Rewards, training and career development

Salaries for health workers are given under Section 9 of the Health Service Act, with basic salaries indicated in Table 1 below paid on a monthly [4] basis, including during periods of leave. Salaries range from NRs 11,290 to NRs 31,680 across the 11 active classes. Each class is then divided into a specific number of salary grades (between 5 and 20 depending on the class) on the basis of the duration of service.[5] In addition, government health workers are provided with a range of allowances, including an annual dress allowance of NRs 7,500, allowances for those in remote postings (see Section 2.5 below) and travel, daily and lodging allowances when traveling within Nepal (SOLID, 2012e).

Table 1: Salary scales of government health workers effective from 2068/04/01 (15 June 2011) (NRs)

Class	Beginning salary	No. of grades	Rate of grade	Total grade	Total	Special provision for employees recruited before 2057/04/01 and getting technical salary scale		
						No. of grades	Addition on beginning salary	Final salary
Asst. 3rd	11,290	15	100	1,500	12,790	2	200	12,990
Asst. 4th	13,650	15	110	1,650	15,300	2	220	15,520
Asst. 5th	14,480	17	120	2,040	16,520	2	240	16,760

[4] Employees receive an additional (13th) month's salary each year for festival expenses (SOLID, 2013e).

[5] 'The employees serving in the first and second classes of the Nepal Health Service were adjusted to the third class in the amendment in 2006, so levels three to five are Assistant positions and levels six to twelve are Officer Positions' (SOLID, 2012e: 9-10).

Senior 5th	15,820	10	130	1,300	17,120	2	260	17,380
Officer 6th	18,790	8	160	1,280	20,070	2	320	20,390
Officer 7th	19,770	7	180	1,260	21,030	2	360	21,390
Officer 8th	21,080	7	190	1,330	22,410	2	380	22,790
Officer 9th	22,750	5	200	1,000	23,750	2	400	24,150
Officer 10th	24,740	5	230	1,150	25,890	2	460	26,350
Officer 11th	26,420	6	230	1,380	27,800	2	460	28,260
Officer 12th	31,680	0	0	0	31,680	0	0	31,680

Source: Adapted from Government of Nepal (2007), in SOLID (2012e).

Performance rewards for health workers are formally governed according to the Health Service Act (1997). The Act includes provisions covering a range of reward mechanisms, including salary increments, the upgrading of positions and promotion. Employees receiving excellent marks on annual work performance evaluations and who have completed the minimum service period required for promotion but have not been promoted receive a performance reward of five salary grade increments. [6] This depends on nomination by the health facility officer in-charge or the DHO, with the final decision by the relevant head of department in MoHP, who will also provide a letter of appreciation. Interviews suggest that in practice, performance assessment tends to be highly subjective rather than being based on the regular assessment of clearly defined criteria.

Upgrading of a health worker's position, based on years of service in the original position, performance evaluations from the period of work in that position and the successful completion of any training required for the post to which the worker is to be upgraded, is listed among the potential rewards for health workers. For example, an ANM may be upgraded to a senior ANM (equivalent to a staff nurse) and an assistant health worker (AHW) may be upgraded to a senior AHW (equivalent to a health assistant). However, owing to the inability to increase the number of sanctioned positions (as noted above with respect to recruitment and appointment), in practice health workers may be compelled to continue working in their original position (health post interviews; SOLID, 2012d).

The formal regulations covering career development opportunities, including postgraduate study, in-service training and national or international study tours, are given by the Health Service Act. The Act dictates a range of criteria according to which such opportunities are to be made available to health workers, including:

- Relevance of the training to the employee's work;
- Marks in educational qualifications;
- Seniority;
- Experience of service in geographical region;
- Work performance evaluation; and
- Age (in cases of training that culminates in an educational degree, candidates must be under the age of 45).

[6] For example, the performance reward for a top-performing third class health worker would be NRs 500 (5 x NRs 100, the rate of each salary grade at the third class level as given in Table 1).

Participation in study or training programmes, for which leave is available for up to four to six years in the case of advanced degrees, was widely cited in key informant interviews, and also in the literature (e.g. SOLID, 2012e), as a key cause of absenteeism. However, additional annual leave entitlements given under the Health Service Regulation 1999 (last amendment 2012) also likely play a role, including:

- 30 days of home leave;
- 12 days of sick leave; and
- 12 days of casual/festival leave (*excluding* leave for Dashain and Tihar, which is additional) (SOLID, 2012e).[7]

2.4 Linking remoteness to human resource management

As noted above, the issue of remoteness has not gone unnoticed by policymakers, who have put in place a set of institutional arrangements meant to encourage health workers to take up positions in remote areas. The current institutional framework comprises both push and pull mechanisms that address HRH issues, primarily through reward mechanisms and other positive incentives. For example, since the promulgation of the Health Service Act in 1997, government health workers must have worked in a remote area for at least two years in order to be a candidate for promotion, and those health workers with experience in different geographical regions are to be given priority in nomination for scholarship and training opportunities. This incentive for taking on remote postings is applied to all technical officials, including nurses, which has posed a challenge to some qualified health specialists for whom posts are not provided in remote district health facilities and who are thus unable to achieve promotion.

The 75 districts of the country are divided into various categories as ABCDE, with A most remote, B very remote, C medium remote, D mildly remote and E remote (in the Nepali alphabet they are named as *ka, kha, ga, gha, ngha,* respectively, in order of classification) (Table 2). Other districts apart from those mentioned in Table 2 are defined as not remote. Distinctions are also made between posts within these types of districts. For VDCs in remote districts, HRH staff receive remote allowances, with differential amounts depending on whether they are deployed within 6 miles of district headquarters or at or beyond 6 miles from them. There are 41 remote category districts (Table 2).

Table 2: Classification of districts by remoteness

Remoteness classification	Districts
A (ka) – 4	Manang, Dolpa, Mugu, Humla
B (kha) – 6	Mustang, Bajhang, Bajura, Jumla, Kalikot, Darchula
C (ga) – 4	Rukum, Jajarkot, Dailekh, Acchham
D (gha) – 14	Taplejung, Sankhuasava, Bhojpur, Tehrathum, Khotang, Okhaldhunga, Solukhumbu, Myagdi, Rolpa, Salyan, Pyuthan, Dadeldhura, Doti, Baitadi
E (nga) – 13	Panchthar, Dhankuta, Ramechap, Dolakha, Sindhupalchok, Rasuwa, Dhading, Gorkha, Lamjung, Baglung, Parbat, Gulmi, Arghakhachi

Source: Government of Nepal (2007), in SOLID (2012e).

[7] Accumulation of leave entitlements by civil servants for the purposes of monetary compensation was reported as a general practice. While the legislative origins of this practice could not be found, it was reported that if one accumulates annual leave equivalent to 180 days it is paid in terms of amount of salary rate earned at the time of retirement. It is, however, unclear whether these practices of accumulating leave occur evenly across the location of health worker posts. It is possible leave accumulation may take place while health workers are in preferred posts and leave used when in less desirable posts, but it was not possible to verify whether or not this was the case.

This classification system is linked to a system of allowances for work in remote areas, the details of which can be seen in Table 3. These allowances are meant to provide a financial incentive for health workers at all levels to take up posts in remote areas, and the amount available varies according to the level of the post, the categorisation of the district and whether the post itself is in close proximity to the district headquarters or more than 6 miles from headquarters. The result is a system with substantial variation in the size of allowances. 'Those districts in category A receive the highest amount for remote location and lowest for the districts under E category. The monthly remote incentive amount ranges from NRs.460 to NRs.4,500 for support staff and NRs.1,820 to NRs.20,370 for the special class staff' (SOLID, 2012e: 12).

Table 3: Allowances for government civil servants (including health workers) in remote postings

Designation	Category A		Category B		Category C		Category D		Category E	
	HQ and within 6 miles of HQ	6 miles and more than 6 miles from the HQ	HQ and within 6 miles of HQ	6 miles and more than 6 miles from the HQ	HQ and within 6 miles of HQ	6 miles and more than 6 miles from the HQ	HQ and within 6 miles of HQ	6 miles and more than 6 miles from the HQ	HQ and within 6 miles of HQ	6 miles and more than 6 miles from the HQ
Support Staff	4500	4730	3600	3780	2700	2840	1400	1790	460	490
NG 4th	4950	5200	3960	4160	2970	3120	1600	1680	510	540
NG 3rd	5400	5670	4320	4540	3240	3400	1820	2000	560	590
NG 2nd	6150	6460	4920	5170	3500	3680	2050	2210	630	660
NG 1st	7350	7720	5880	6170	4200	4410	2450	2570	740	680
Gazetted 3rd	11250	11810	9000	9450	6700	7040	3000	3150	1030	1080
Gazetted 2nd	12980	13630	10380	10900	7500	6880	4000	4200	1320	1380
Gazetted 1st	15750	16540	12600	13230	8600	9030	5000	5360	1680	1770
Special class	19400	20370	14400	15120	10400	10920	8400	8820	1820	1920

Note: NG = non-gazetted.

Source: SOLID (2012e).

3 Emerging themes in the political economy of HRH

As indicated by the range of national and sector policies currently in place, key aspects of HRH, including recruitment, deployment and training and reward functions, should be managed according to health needs and the skills and qualifications of health workers. However, the fundamental point to be made here is that other factors tend to easily and often strongly undermine the formal systems currently in place. Low levels of

professionalism (defined as adherence to the principles and procedures that underpin *de jure* approaches within the sector) and high levels of politicisation of the civil service are key factors in this (and are symptomatic of broad national trends). These factors in turn have their roots in deeply embedded cultural norms that provide a set of informal, but nevertheless powerful, rules that help structure the choices available to key individuals and organisations. The precise way in which these norms are manifested and their implications for HRH issues are, of course, influenced by features of the contemporary Nepal, where the form of political competition and the scale of networks and financing differ substantially from in the historical period. The remainder of this section provides an analysis of what, in practice, follows from this; that is, how other factors function in the absence of strong formal systems and why.

Three key themes, or ways of interpreting key barriers to more effective HRH performance in Nepal and improved access to qualified health workers in remote rural areas, emerged from consultations:

1. Incentive and informational problems resulting in a reported mismatch between the health workers currently being trained and recruited and the service needs of the population in Nepal;
2. Distributional concerns, the politicisation of HRH and the market for transfers; and
3. Incentives for health workers affecting retention and willingness to work in remote locations.

The sections below explore these three themes in greater detail.

3.1 Conflicting incentives in HRH development: training and recruitment problems

Meeting the challenge of ensuring access to qualified health workers in remote rural areas depends on i) the availability of a sufficient number of qualified health workers and ii) the appropriate distribution of those health workers. In other words, access problems may arise as a result of an inadequate supply of health workers, maldistribution of an adequate health workforce, or some combination of the two. In this sub-section, we consider the dynamics that might underlie the first of these potential constraints.

More recently, the ability of the government to effectively manage the training and recruitment of health workers needed to supply health services in rural areas has clearly been constrained by the particularities of the current political situation. Specifically, planning failures have been reinforced by the inability of the public sector (MoHP and the PSC) to engage in longer-term planning and hiring in response to recognised trends and needs. As described above, this is attributable to the fact that the Health Service Act has not been updated in accordance with the reservation requirement as mandated by the Interim Constitution, preventing the creation of sanctioned posts. Thus, despite the fact that MoHP has identified several hundred new positions required to deliver necessary services (including medical doctor general practitioner (MDGP), gynaecologist, anaesthetist and anaesthesia assistant posts), the need for those posts 'to be sanctioned and funded to ensure that the MoHP can recruit and deploy the staff required' (MoHP/NHSSP, 2012: 38) essentially prohibits recruitment.

Temporary contracting has been employed by some actors within MoHP to address HRH needs in the short run, but has raised challenges of its own. Restrictions on local government's ability to engage in multi-year contracting (for fear of the implications for total expenditure commitments in subsequent years) have led to an inability to ensure access from one financial year to the next. In some cases, hiring has been possible through existing programmatic budgets. However, where such budgets have been released, as in the case of hiring of skilled birth attendants as a part of the Maternal and Child Health Programme under the family division of MoHP, they have been released for periods of such short duration that contracting and hiring have become even more complex, increasing transaction costs and further inhibiting effective management of HRH.

However, it is worth asking whether, were the current political deadlock sufficiently resolved such that the Health Service Act could be amended appropriately and the necessary sanctioned posts created, training and recruitment of health workers would be sufficient to meet the needs to the population and of the rural population in particular. In fact, there was widespread agreement among individuals consulted for this work, and between findings from key informant interviews and the available literature, that there is a more deeply rooted issue, namely, the lack of a coherent approach to the training and recruitment of HRH. This belief

reflects the longer-term failure of MoHP to sufficiently manage the country's health workforce in response to changing demographics.[8] Our approach suggests that this can be traced, at least in part, to differing incentives and practices between those actors responsible for training of a qualified health workforce (Ministry of Education (MoE), Council for Technical Education and Vocational Training (CTEVT) and the large number of private medical colleges) and those responsible for managing that workforce (particularly MoHP as the leading employer of health workers).

A number of informants suggested that the lack of a coherent system to train and recruit HRH is attributable in part to the fact that the public sector budget for HRH training is severely constrained and the country is therefore largely reliant on the private sector for training (particularly pre-service training) of health workers. In fact, private sector academic institutions account for 89.9% of total academic institutions providing HRH training in Nepal (SOLID, 2012a). Available figures for trainees (Bachelor of Medicine and Bachelor of Surgery (MBBS) and staff nurses) are similar (MoHP, 2010, in MoHP/NHSSP, 2012).

This overwhelming reliance on the private sector has arguably allowed for the training of more health workers than would have been possible under a purely public system. However, several key informants (including MoHP officials and academics involved in public sector training) argued that the motivations of private sector academic institutions were primarily financial, which tends to encourage behaviour that does not contribute to the development of the HRH needed in the country. This perception aligns with views expressed in earlier studies that 'private institutions are established for profit-making motives' (SOLID, 2012a: 6), and tends to be associated with at least three main concerns.

First, with regard to the quality of HRH, multiple key informants confirmed the position that private sector training institutions often do not abide by the standard guidelines and specified criteria for medical education developed by relevant professional councils, thus leading to the creation of a poorly skilled workforce (SOLID, 2012b). The prevalence of insufficiently skilled workers has in some cases contributed to 'a poor public opinion of the various cadres of health workers, and those from the community often do not feel confident to be seen by such health workers' (SOLID, 2012b: 7). In conjunction with weak oversight of lower-level training programmes by CTEVT, the absence of effective monitoring and regulatory mechanisms reportedly allows the production of insufficiently skilled health workers to continue relatively unchecked, without sanction of institutions producing HRH of questionable quality. This is a problem that has been noted by policymakers (e.g. in the Nepal Health Sector Programme Implementation Plan II (NHSPIP II) 2010-2015); however, regulations drafted as early as 2002 for quality control remain unimplemented (ibid.).

Second, the need to attract a sufficient number of fee-paying students arguably leads to an urban bias, as urban centres (mainly Kathmandu) are home to the largest concentrations of those with sufficient purchasing power to self-fund private training courses. Work by SOLID has confirmed this bias, noting that '96 per cent of academic institutions are in urban areas, and 58 per cent are located in the Central Development Region (CDR). By contrast, only 2.4 per cent are located in the Mountain belt and 2.9 per cent are in the Far-Western Development Region (FWDR)' (SOLID, 2012e). While the location of academic institutions in urban areas does not prohibit the training and development of rural populations, it does constitute an additional barrier, with significant implications for the origins of the health workforce. We return to this issue when considering distribution of the workforce in the sections that follow.

Third, interviews suggested that the profit motive of training institutions has a negative impact on the development of the health workforce by incentivising the production of particular categories of health workers, which may not be the most appropriate from the perspective of the equity and efficiency of the health system at delivering improved health outcomes. Some key informants argued that a reliance on a training system that responds purely to the demand for training from applicants (a more likely scenario where private sector institutions dominate) is leading to the overproduction of certain types of health workers and the underproduction of others relative to the needs of the health system in Nepal.

Concerns regarding overproduction were voiced specifically with respect to overproduction of particular types of health workers that have historically been in demand but may not continue to be so as the disease burden and available technologies continue to change (e.g. ANMs). An assessment of the skills mix needed in Nepal in the coming years is beyond the scope of this study, so we cannot comment on whether or not particular

[8] For example, population growth has been estimated at 45% between 1991 and 2011, while HRH staffing increased by just 3.4% over that same period (MoHP/NHSSP, 2012). Similarly, non-communicable diseases (NCDs) have in recent years constituted a growing proportion of the disease burden, yet awareness and training on NCD is lacking among many health workers (SOLID, 2012b).

positions meet this criteria; however, this contention rests largely on the possibility that prospective trainees may be responding to the existing or historical perceptions of the labour market rather than to an accurate perception of the future labour market communicated by planners.

References to other forms of overproduction and underproduction relative to the needs of the health system, and particularly those that associate these problems with private sector training institutions, require further explanation. With respect to this point, we should note first and foremost that it is difficult to draw firm conclusions regarding the appropriateness of the composition of health workers produced in the private sector, as the data available regarding private sector components of both health worker training and the HRH labour market are insufficient. Neither of the two most comprehensive studies on HRH in Nepal has found complete data on the production of health workers from the private sector, nor is there any indication that MoHP or MoE currently hold such information (MoHP/NHSSP, 2012; SOLID, 2012d).

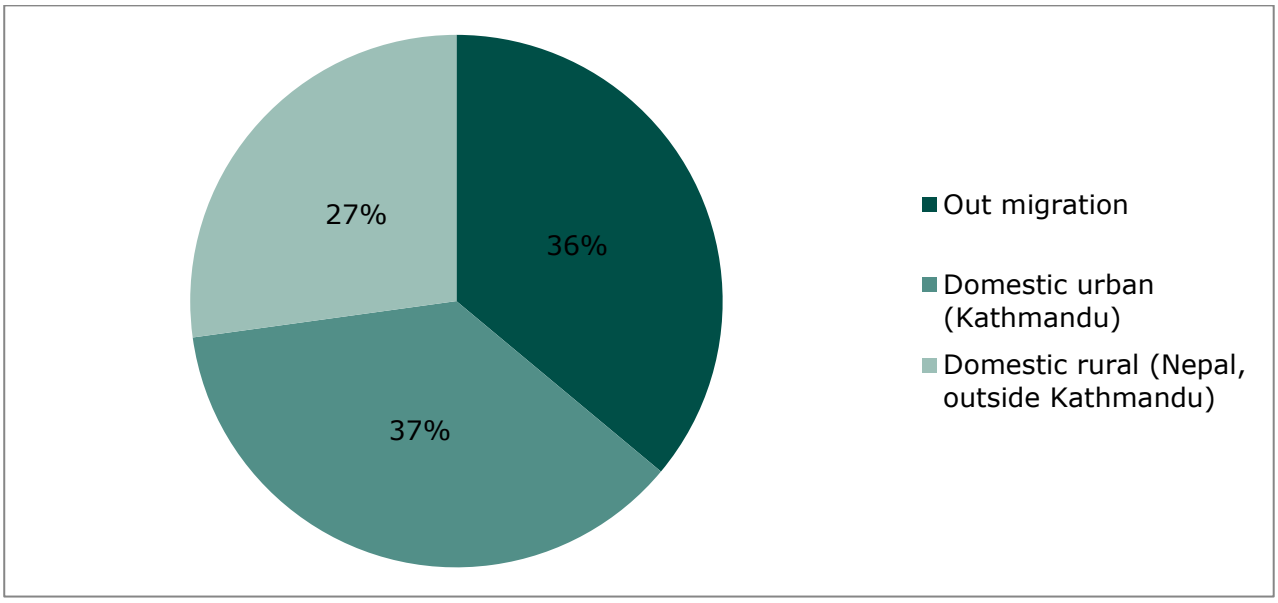
Accurate information regarding current levels, production rates of different types of health workers and future demand for different types of health workers is clearly a priority. Provided they capture relevant information for public *and private* sectors, the workforce assessment and workforce planning exercises currently being supported by the NHSSP will be important in filling this gap in the data. Prior to the completion of these exercises, we limit ourselves here to more general discussion of the potential motivations of key actors in the current context.

The challenge is that a demand-driven system relies on individuals maximising the returns to their own (significant) investments in training by pursuing training opportunities for the types of professions where they expect there to be jobs. While this might be expected to produce the right composition of health workers in a perfect labour market,[9] the labour market in which Nepal's health workers find themselves is often anything but a single, closed system, and information about the availability and value of future opportunities is often imperfect (as noted above with respect to 'overproduction' of ANMs).

As is the case in many other low-income countries, a significant number of health workers trained in Nepal choose to emigrate. While complete data on migration in the sector were not available, Zimmerman et al.'s (2012) analysis of the first 22 graduating MBBS classes (totalling 710 doctors) from the Institute of Medicine (1983-2004) finds 36% of MBBS students to be working outside of Nepal (Figure 2). The ability of doctors (and other health workers) to opt out of the system of public provision of health services following training in Nepal to valued positions in the private sector or outside the country would tend to reinforce a dynamic in which private sector training institutions maximise the number of doctors produced, as suggested in the NHSSP account and those of key informants. This, then, helps reconcile the perception of shortages of particular types of health workers and the inability to fill empty posts with the apparent 'overproduction' of other types of health workers and claims that 'sufficient stocks of most categories of health workers are being produced' (MoHP/NHSSP, 2012: 29).

[9] In a perfect labour market, demand for places on training courses should correspond to their actual value to health workers. While there are a number of factors that might be relevant determinants of that value, and the labour market is in practice unlikely to provide perfect signals regarding future value, we suggest that one of the major factors determining demand for training is likely to be the presence of opportunities for employment following the completion of training, itself determined by the needs of the health system.

Figure 2: Working location of Institution of Medicine MBBS graduates (1983-2004)



Source: Zimmerman et al. (2012).

In response, the government's HRH Strategic Plan states the 'Government is planning to improve the regulation of the private health training institutions in order to ensure that production meets requirements' (MoHP/NHSSP, 2012: 15). What precisely 'regulation' refers to is not certain, but will be critical in determining whether or not the intervention addresses the root cause of shortages. While improved regulation in the sense of quality control would likely be welcome given some of the concerns noted above,[10] it is not immediately clear that regulating the production of particular types of health workers would necessarily make a significant difference to the features of the labour market motivating individual health worker choices resulting in current shortages that exist in the health system, and therefore may not ensure production meets requirements. Indeed, as argued by Michael Clemens (2009), while some health workers trained in private institutions clearly do emigrate in many contexts, the net effect of private investment in health worker training stimulated by demand for training (even in excess of domestic needs) may nevertheless be to increase the stock of health workers relative to what it would be without the existence of such programmes.[11] Nor is it apparent that trainees of public institutions would be exempt from these labour market dynamics. While the absence of data on the career paths and practice locations of private sector-trained health workers prevents meaningful comparison, the Institute of Medicine, from which the above data come, is a public institution, suggesting migration dynamics apply to trainees from across sectors.

From the perspective of production of health workers, what would matter is if academic institutions, public or private, can change the perceptions and incentives of health workers, whether through admissions policies, curriculum (ideational change) or other leverage mechanisms (e.g. refusal to fully certify health workers prior to the successful completion of a period of rural service). These forms of changed practice may be more useful entry points than regulation that seeks to match production to requirements. Here, public sector training institutions may indeed be better able to enforce leverage mechanisms, as demonstrated by current attempts at scholarship programmes. However, where private sector students are dependent on the loan funding, similar conditional service requirements may be feasible. We return to these ideas in our discussion of distributional issues below, and again in Section 4 when discussing possible theories of change.

[10] We should note the possibility that, in the absence of other changes, if improved quality improves the attractiveness of Nepali health professionals abroad, quality improvements may even increase challenges of retention within the public system.

[11] Further, Clemens argues that emigration is an expression of health worker agency and thus constitutive of development as defined by Amartya Sen and others who emphasise the importance of choice in determining well-being.

3.2 Distributional concerns, the politicisation of HRH and the market for transfers

We noted above the way the existing formal rules and regulations (e.g. the Health Services Act and other relevant legislation) for the management of several key HRH functions, including transfers to and from remote areas, access to in-service training opportunities and promotions, have been undermined by 'irregularities'. The results of this include not only lack of access to health professionals in lesspreferred remote rural areas, but also overstaffing and overqualified staff in health facilities in Kathmandu Valley. Problematically, the widespread (and largely justified) belief that the rotational system does not function has a secondary negative effect on the distribution of health workers. Not only is there an inappropriate distribution of workers and skills at any given time, but a lack of trust in the prospects for rotation likely contributes to the subsequent unwillingness of staff to be posted in remote locations, even where health workers might otherwise accept a short-term posting.

In order to think constructively about how to address this problem, we must first understand the form of subversion; that is, understand what enables certain health workers to avoid service in remote rural areas in favour of urban postings. In this section and the one that follows, we focus on the continued dominance of informal practices (in particular the prevalence of rent-seeking behaviour) leading to maldistribution of the health workforce and access challenges in rural areas.

The market for transfers

One way of understanding the problem is through the concept of a 'market for transfers'. Reports from key informants suggest that access to preferred positions and other benefits often depends on the provision of some form of payment to those in positions of *de facto* authority, often including a bargaining process and the assignment of a particular value to each position. While a detailed assessment of human resource management practices elsewhere in the civil service is beyond the immediate scope of this paper, it is important to note that this form of rent seeking in the management of human resources is by no means limited to the health sector in Nepal (Dix, 2011), nor is it unique to Nepal, with other authors noting the creation of similar markets in civil services elsewhere in the region (e.g. Davis, 2004; Wade, 1982; 1985).

In this interpretation, we may be concerned with the drivers of 'supply' in this market; that is, why those with administrative control over human resources choose to create and sustain a market for preferred posts (and other benefits), or 'demand'. In this section we address the former; Section 3.3 addresses issues of 'demand'.

Drivers of supply

As described by Dix, the generalised market for transfers operates throughout the public sector, linking various levels of administration, and eventually service users as well: 'ministers and high level bureaucrats directly or indirectly participate in the system in which officials pay large sums for a job transfer, who in turn recover their costs by collecting smaller sums from the public in exchange for delivery of services' (2011: 18). In Nepal, these practices have the potential to be particularly destructive, as rapid turnover means 'Officials may have a limited time period in which to maintain their position before it is bought by someone else, so there is an incentive to generate as much revenue as possible, in the shortest amount of time' (ibid.).

The informality of the system makes it difficult to confirm the full extent to which these dynamics apply in the health sector. There are a significant number of reports indicating payments being made for posts, particularly at the highest levels, where posts entail some control over the resources of the state, either human resource decisions (and therefore additional opportunities for rent seeking or political favouritism) or financial resources (and therefore opportunities for other forms of corrupt practices). These reports come from a variety of key informants and appear believable in the current context as a reasonably common practice, even if the details of individual cases remain opaque.

The links between the various levels of administration are arguably less clear. Some reports suggest that control over the deployment of the health workforce is now to a large degree centralised, with the DoHS, RHDs and DHOs given a transfer list by the high-level MoHP political bodies. While the secretary of MoHP is given authority over all administrative decisions within the ministry, including human resource decisions, by Clause 11.2 of the 2008 Good Governance Act,[12] he has reportedly been increasingly sidelined with respect

12 This marks a significant departure from past practices under which roles for the minister and the secretary in relation to human resources decisions were seen as unclear.

to personnel decisions by higher-level political interests. Transfer orders may indeed come from the centre, but it seems unlikely that a small number of individuals at the highest levels are directly monitoring, directing and enforcing all transfer decisions at the lower level. In other words, there is a system in place managing the transfer process.

In the model described by Dix, the imperative to raise funds at the highest levels in turn requires raising of funds at lower levels, with rent-seeking practices becoming systemic through a filtering-down process through the DoHS via director general level to frontline providers. Yet there is little firm evidence of Dix's point that costs are being recovered from the public through informal user fees. The Service Tracking Survey carried out by MoHP and the NHSSP in 2011 suggests that some patients (31.4%) continue to pay for services that should be free following the introduction of free basic care in 2009; that in most of those cases payments (98.7%) were made when patients paid tips to health service providers involuntarily rather than voluntarily; and that in most cases (73.1%) patients paid because they felt they would not receive care if they did not (Suvedi et al., 2012). However, there is no clear indication as to whether requests for these payments, apparently fulfilled on the basis of the potential of withholding care, can be attributed to systematic rent seeking filtering down to the level of frontline service providers.

This requires an important clarification regarding the form of payments that can be made by health workers. We suggest that a distinction between economic rent seeking and political favouritism in appointments may be useful in some cases, but the point to emphasise is that both constitute a similar patronage relationship and may in fact be mixed in practice. In other words, in the case of Nepal, in a broader conceptualisation of what we mean when we talk about rents, which are often defined in purely economic terms as 'value above and beyond market value', it might be more useful to include both monetary value (payments) and political value (loyalty). Different types of 'value' may be more or less important at different levels.

It is possible that the creation of a market for transfers occurs for the personal financial gain of individuals with authority and discretion in the absence of effective accountability mechanisms. This view has informed a substantial body of work on corruption (see, e.g., Klitgaard, 1991). However, the argument advanced here is that the rent-seeking behaviour that affects *de facto* practice of key HRH functions is happening in the context of, and indeed is driven by, the presence of a specific institutional reality: the dominance of patronage networks in Nepal's political system. In other words, the evidence gathered through consultations suggests that a significant portion of rent-seeking behaviour is not simply *ad hoc* opportunism, but rather part of the broader system of political competition in Nepal. In this competitive dynamic, control over parts of the health system (including the distribution of preferred posts) entails opportunities for revenue generation (to fund further political competition) and other politically valuable resources (appointments that help ensure political loyalty), both of which constitute valuable commodities. The geographical spread, 'purpose' and effects of these networks shape the implications for the placing of health workers in remote posts.

Political parties and associated unions

Which networks, then, are important drivers of behaviour with respect to HRH? Consultations conducted as a part of this study suggest that the most dominant of these networks are arguably those of the political parties and the significant number of trade unions and associations with which they are associated. Previous work on political parties in Nepal has noted the extent to which parties across the ideological spectrum have 'sustained their power base through patronage, with systems established to link rewards to party clients in exchange for services' (Wild and Subedi, 2010: 3). These patronage dynamics do not necessarily extend to the majority of the population, but rather focus on elites (either affluent or influential) (ibid.), a dynamic that applies in this case within the civil service. Political party networks tend to be regional, if not nationwide, in reach, are in competition with each other in many sectors and reportedly function in part to extract resources from the periphery and channel those resources to the centre, where higherlevel political competition takes place. Any hope of local people demanding something in return is made difficult by the fact that those with discretionary power are in Kathmandu.

With the post-Comprehensive Peace Agreement resurgence of multiparty competition, the need for parties to raise substantial sums to spend, particularly during and immediately prior to elections, has increased significantly. Yet information regarding sources of financing and the management of party finances remains extremely limited (Transparency International Nepal, 2010; Wild and Subedi, 2010), and so therefore does any form of regulation. Recent media reports regarding the Maoists' donation drive have highlighted the extent to which party financing remains an area in which the boundaries between licit and illicit activities are far from clear (e.g. Ekantipur, 2013; MyRepublica, 2013b), creating space for a wide range of practices. While confirmation of political party financing needs as a significant driver of the presence of a market for transfers is difficult, given the historically rooted lack of transparency, this logic is reflected in the literature on public sector corruption (Dix, 2011) and in the views of some interviewees, who suggested that, once a new

government is formed and a new minister joins MoHP (or any other ministry), the use of the transfer list forms an important component of strategies to maximise rent collection for the relevant political party.

Particularly concerning regarding HRH is the role of *de facto* politically affiliated unions. Again, this is not a dynamic unique to the health sector. Work by Tony Vaux documents the deleterious effects of the politicisation of teachers' unions in the health sector, arguing that '[b]ecause of the unions, teachers cannot be redeployed to where they are needed' (2011: 6), similarly resulting in disparities in access (manifested in the education sector as disparities in class size). A significant number of trade unions and associations representing various levels of health workers[13] are informally, though widely, acknowledged to be affiliated with various major political parties. These unions and associations, several of which may be affiliated with any single political party (or at least to a faction within a party), are seen to interfere with the transfer system in a systemic way.

Some aspects of this involvement are relatively clearly defined. For example, it is reported that MoHP has agreed with trade unions that the central committee members and affiliated officers of the various unions will not be transferred without their consent (as per the Labour Act and the Civil Service Act). Union activity is also highly visible with respect to local-level transfers, including through interventions in Kathmandu. At the local level, interference in the transfer system has reportedly led to an unsafe situation for those with *de jure* responsibility for human resource management at all administrative levels. As described above, authority over transfers of lower officer-level staff and all assistant-level staff falls variously to the DoHS, RHDs and DHOs, who have been subject to threats, intimidation and other aggressive actions from the trade unions. One regional director consulted for this project reported having to resort to secret meetings and shutting off phone lines in order to avoid pressure and interference in carrying out human resource-related activities.

Local-level manifestations of the patron–client practices of political parties may further disrupt effective and efficient distribution of HRH. Reports suggest the practice of distribution of benefits through parties undermines collective action and investment in public goods. Interviews conducted as a part of a recent report on lessons learned in corruption and anti-corruption in Nepal suggested that:

> *'[W]hen funds are transferred from the central government, or donors give grants at the district or local level, a portion of these funds are allocated among the political parties or their sister organizations, in proportion to their representation in the district or local area. In some areas of Nepal, political parties, in turn, are forced by threat of physical violence to give a portion of their revenues to the different armed groups'*
>
> (Dix, 2011: 17).

In other areas, evidence is scarce and the role of unions is less clear. It is worth noting, however, that while unions are more visibly interventionist at the lower levels, when health workers are often openly affiliated with particular parties and expect representation and protection, they remain intricately connected to the political party interests that control appointments at the highest levels and even at the middle levels, where the political affiliations of civil servants tend to be less explicit. Unconfirmed reports suggest that one form of this linkage may include unions playing a coordination function, gathering large numbers of small contributions from members to make significant payments either for transfers and appointments to preferred positions or to prevent the transfer of members currently in preferred posts.

Again, we should be clear that the details of individual reports are largely unconfirmed and, without detailed survey work it is difficult to confirm exactly how widespread these practices are in the health sector. Indeed, given the illicit nature of these activities, even a comprehensive survey may not capture the reality of the situation. However, numerous accounts from key informants interviewed for this study suggest this dynamic is a powerful one in this context, and awareness of it ought to inform strategies for improved HRH in Nepal.

Beyond political parties

With regard to HRH, we should note the potential that systemic patronage dynamics extend beyond the bounds of political parties. More specifically, reports suggest that access to preferred positions in the health

[13] A partial list of organisations mentioned in news reports and interviews includes the Nepal Health Workers Union, Nepal Health Workers' Association , Nepal Health Professional Association, Nepal Health Technician Association, National Health Technicians Association, All Nepal Progressive Health Workers Association, Nepal Democratic Health Workers Association, Akhil Nepal Progressive Public Health Association, Akhil Nepal Health Workers' Association, Akhil Nepal Public Health Workers Association, Akhil Nepal Nursing Association, Akhil Nepal Public Health Workers Forum, Madeshi Health Workers' Manch, Madeshi Health Workers' Union, Medical Lab Technician's Association and National Civil Servants Association (National Health Group).

sector is a mechanism by which those in authority can attempt to achieve a greater degree of political security. In this context, in which there has been rapid turnover of those in positions of authority at all levels of the political system, the ability to preserve one's position depends on the establishment of informal (cross-party) elite bargains. This dynamic may be particularly significant for those belonging to minor parties (e.g. the current minister), whose own-party networks are likely to be more limited.

In a context in which patronage dynamics are significant, there is also a logical question as to whether ethnic or location-based patronage networks are likely influencing the distribution of health workers. Such a dynamic, in which those in power channel money or other resources to their own social/ethnic group or home area, may have more localised geographic spreads and could also have better implications for the problem identified. However, apart from a single example of the relocation of a particularly good doctor from a remote posting to the constituency of a powerful political actor, the notion of the purposeful redirection of HRH to particular localities as a mechanism for gaining political support was not a significant feature in interviews. Reports do suggest that where (particularly higher-level) HRH are sent from Kathmandu to regions outside the Valley, this occurs where directors or other public sector health workers fall out of favour and can be transferred while maintaining their rank. This dynamic is difficult to confirm, but such turnover could be seen as logically consistent with the need for mechanisms to make preferred posts available. In other contexts, retirement has been seen to play that role.

3.3 Drivers of demand for preferred posts: Health worker incentives

The market for transfers exists in Nepal not simply because of a rotational system designed to prevent opportunities to develop unhealthy relationships between staff, local politicians and residents that increase the potential for kickbacks, corrupt practices in local tendering, etc. (Davis, 2004; Klitgaard, 1991), but rather because of the differences in the posts themselves and their relative attractiveness to health workers. The appeal of urban posts is threefold, encompassing:

- Conditions in service;
- Immediate opportunity costs; and
- Future opportunities for advancement.

Conditions in service

A major element of dissatisfaction with rural posts relates to the initial training of health workers, which generally does not include experience in rural regions or operating under the constraints that apply there. This has the dual effect of making the initial shock of rural conditions all the more severe and also allowing the proliferation of rumours, whether true or false, surrounding likely conditions that will deter health workers from accepting or applying for rural posts. The Patan Academy of Health Sciences has begun to incorporate a period of rural service into its training, which allows medical students to gain a realistic understanding of likely conditions in rural areas while maintaining the presence of senior health workers who can provide mentoring. However, it trains only a fraction of Nepalese medical students and so its impact will be limited.

Conditions in post are a major area of concern for health workers and a range were cited in interviews with professional associations, NGOs working in the sector, such as the Nick Simons Institute (NSI), and health workers themselves. Research by NSI and the academic community (e.g. Shankar and Thapa, 2012) and various anecdotal accounts given in key informant interviews suggest health workers consider a wide variety of living conditions when making judgements about a posting.

Access to services: Rural areas generally have less by way of services, entertainment and conveniences than urban areas and this difference is felt sharply by those who have spent many years training in Kathmandu. Boredom can be dismissed as a relatively minor issue but it can have a strong long-term impact on morale.

A more serious concern often expressed by health workers is that in remote and isolated regions they will not be able to access good health care themselves. They also express concerns over access to adequate housing. While all health workers should be allocated free accommodation, in many areas it is of poor quality or run down. Local government bodies should in theory maintain these facilities, but it is reported that, in practice, their budgets are often, though not always, spent on more politically high-profile public works projects such as road building, schools and water taps. The quality of MoHP-provided housing is likely to be

less of a concern for locally recruited health workers who already have their own housing, but is an important factor when hiring additional health workers from other locations.

Concerns regarding access to services also extend beyond the health workers themselves in the common circumstance in which they have immediate family. NSI research suggests health workers generally place a premium on education and are often concerned that, if they are stationed in remote rural regions, they will not be able to send their children to good schools. In such cases, health workers feel it is necessary to send their children to boarding schools in urban areas, entailing both added expense and potentially unwanted separation from family members.

Physical security: Threats to the physical security of health workers is perceived to be higher in remote rural areas. Some such threats are specific to female health workers, who are often acutely aware of the dangers of sexual harassment and violence in some regions. Other sources of tension and security concerns apply more broadly and reflect wider changes in the demographic, political and social climate. Although the recent civil war largely spared health workers, partly because of the Maoists' use of service delivery as a mechanism for garnering support, there are still perceived to be significant risks. Population growth has outstripped the growth in the overall health workforce, the population has begun to age and the abolition of user fees for most groups and services has allowed health care access to many Nepalese who were previously unable to afford it, leading to significant increases in demand (MoHP, 2010). Many interviewees also emphasised that rural people now had a much stronger sense of their rights and had developed much higher expectations in terms of quality of care and outcomes (driven in part by political appeals).

These expectations often outstrip what is feasible for rural health posts to provide given existing resourcing. There is an absence of the necessary equipment and facilities, and health posts, whether or not they are understaffed according to the total number of posts, often lack the skills mix needed to deal with more complex cases and operations. With health workers seen as responsible for performance in health service delivery, as opposed to political representatives, this mix of high demand, rising expectations and at best static resources can cause tensions between service users and health workers.

A significant body of work on the politics of service delivery has emphasised the empowerment of service users as an important mechanism to improve performance by strengthening of the direct accountability relationship between service user and service provider (e.g. the 2004 World Development Report: World Bank, 2005). While there may be some benefits to such a process of 'empowerment' (e.g. in terms of deterring health worker abuse of patients), consultations conducted for this study and elsewhere suggest service users do not necessarily act in the well-intentioned, constructive accountability-enhancing manner envisioned in simple empowerment models. Rather, there is a 'dark side of empowerment', whereby health workers are reported to be the targets of popular anger over failings in rural health clinics, leading some to fear for their security.

This dynamic is particularly problematic when combined with the inherent asymmetries of information between health worker and patient, with the latter lacking the specialist knowledge necessary to judge the appropriateness of care (Arrow, 1963; Mcloughlin, 2012) and rural people's lack of experience with health care systems. Health workers may be blamed for death or injury to patients that was inevitable at any level of care, or given the lack of necessary equipment and support staff, putting them at risk from the local population or placing the latter in an antagonistic position towards them, with survey work indicating at least seven recent deaths from such conflicts (SOLID, 2012d).

Anecdotal evidence suggests that, as well as deterring health workers from serving in rural regions, this situation creates further perverse incentives. Health workers may be more likely to refer patients to other facilities in cases where they are uncertain of success in order to avoid culpability in the event of adverse outcomes. This not only leads to wasted resources in terms of transfer, but also can unnecessarily overload higher-level facilities and is riskier for many patients, as urgent care may be unnecessarily delayed.

Isolation: Isolation, in both a personal and a professional sense, is also a major strain for health workers in rural regions. In personal terms, staff are often moving to areas and conditions that they have little experience with, and the differences in region, caste and language can make the process of adapting very difficult. Although the lack of a comprehensive workforce survey makes it hard to judge how major these cultural and ethno-linguistic difficulties are, studies using partial data suggest this is a matter for concern. Most graduating medical students are born and grow up outside of Kathmandu (Zimmerman et al., 2012), but there is no information on how many are from remote rural regions, and there is certainly still a very low level of participation in the health workforce among Dalits and other highly excluded groups (MoHP, 2010). The Nepalese government has established a series of reserved places for these groups in the civil service in

general, and there are plans to expand these into the health sector, as there is recognition of the need to recruit more health workers from disadvantaged and marginalised communities. However, the general political deadlock means these reforms are currently on hold. The Patan Academy of Health Sciences is attempting to make incremental changes, specifically prioritising the selection of students from poor rural regions and disadvantaged groups. The difficulties of the transfer system also mean it is not easy for spouses who both work in the health sector to ensure they are posted to the same place.

In professional terms, the unpopularity of rural postings means those who are in post will often lack a supporting team, which is necessary for some procedures and also provides a degree of collegial company. Overall, 24% of posts are unfilled and, of those with appointed staff, between 10% and 40% of health workers are absent when their facilities are surveyed. These figures are also considerably worse in remote regions (MoHP, 2010). The absence of senior staff in many areas is particularly damaging for morale as it means newly qualified staff often lack colleagues who can provide structure as well as mentor and advise them. This has an impact on both the ability of health workers to deliver health care on a day-to-day basis and their long-term career prospects, as explored below.

Immediate opportunity costs

Beyond conditions in post, the immediate opportunity costs of rural service are considerable, and only partially rooted in official salaries. Financial incentives can play a key role in solving issues of deployment: studies show actual and anticipated levels of pay have an impact on the employment and location decisions of health workers (see, e.g., in the UK, Arnold et al., 2003). However, despite additional financial allowances for remote postings, salaries are generally comparable between urban and rural areas. The strong financial incentives for positions in urban areas are thus related to the opportunities for private practice.

Health workers in Nepal are able to engage in private practice provided it does not interfere with their state service provision and that they are self-employed. Urban private practice can be highly profitable, with anecdotal evidence of nurses doubling their incomes through this route. In rural areas, high levels of poverty mean that private income-generation opportunities for health workers tend to be seen as limited. Indeed, none of the actors interviewed believed there was a viable market for private health care in rural Nepal. While there is every possibility of variations in the private sector earning potential across different types of health workers, the levels of remote location allowances given in Table 3 above do not appear to be able to match this level of income supplementation.

This is not to say that private sector health facilities have not played an important contributory role in the improvement of health outcomes in rural Nepal. Engel et al. (2013) note the role played by a massive expansion in private pharmacies since the formal introduction of private health services in 1991. Private pharmacies are thought to have increased access to family planning and antibiotics, thereby plausibly contributing to the impressive reductions in maternal mortality achieved over the past two decades. The authors also cite research from the late 1990s which indicates more broadly that '[private] pharmacies were particularly relevant for treatment of illnesses in rural areas and for the poor, given their much greater prevalence in remote areas (Hotchkiss et al., 1998 found that 38% of rural communities were within one hour of a pharmacy as opposed to only 17.6% being within an hour of a nurse or doctor), while the cost of consultation was lower than in a health post during this time period' (ibid.). These facilities, which were 'frequently run by clinical medical auxiliaries and auxiliary health workers who had been trained but could not be incorporated into the government system continue to play an important role in service delivery' (ibid.), and continue to be relevant even after the introduction of policies intended to provide free essential drugs via government clinics in 2007.

However, while the private sector has clearly played an important role in providing certain types of health services, the majority of those living in such areas simply do not have the purchasing power necessary to provide sufficient effective demand for a market for the full spectrum of health services at a level anywhere near that in major urban centres. In other words, the point to be made is a *comparative* one, emphasising greater opportunity for supplemental incomes in urban areas, rather than an *absolute* statement that such opportunities do not exist in rural areas. While ecological belt classifications do not map exactly onto remoteness, survey work by SOLID (2012e) provides an indication of this disparity, with 56% of health workers in the Terai involved in activities, including private practice, that offer opportunities for additional income compared with just 17% in the mountains.

There is anecdotal evidence of regional-level health officers using their budgeting autonomy to provide financial incentives for attracting and retaining health workers. The piloting of three incentive packages, aimed at increasing performance and retention, is also underway (MoHP, 2010), with the aim of scaling up these incentives if they prove effective. However, the difficulties of successfully monitoring attendance and

performance in remote rural health posts may prove an obstacle to this, and it is unclear if expansion would be politically and fiscally feasible. Attempts to introduce a national policy are alleged to have been blocked by the Ministry of Finance owing to concerns that it would have to adopt a similar policy across all other government employees, creating the potential for significant costs.

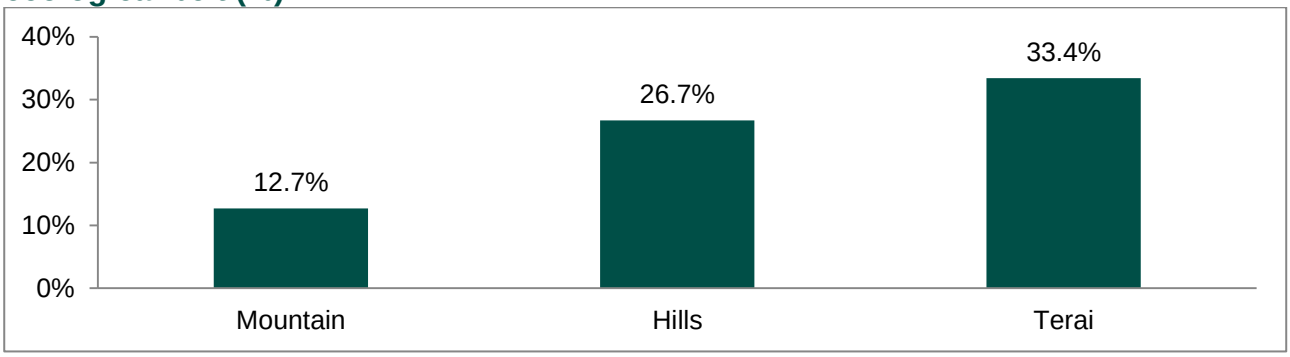
The relatively low level of health professional income in rural regions is particularly disadvantageous when set against the high levels of fees charged for studying in the predominantly private medical colleges and universities. In 2006, medical degrees cost $25,000-55,000, meaning students must recoup considerable costs unless they can secure a scholarship (Bhatt, 2006). Rural posts thus represent a significant opportunity cost in terms of forgone income and likely slower repayment of university debts.

Opportunities for advancement

Rural postings also present their holders with a long-term opportunity cost in terms of their potential for career advancement. While the Health Service Act states that access to 'career development opportunities should be encouraged in remote areas, through a system which allows HWs [health workers] to obtain more marks during assessments for promotions or scholarship schemes' (SOLID, 2012e), in practice there are severe difficulties with the national training system, with a large number of vacancies at all levels of the system and few districts possessing training facilities (MoHP, 2010). This reduces the ability of staff to maintain existing skills or acquire new ones, particularly when combined with the lack of in-service mentoring and support experienced in many remote regions. SOLID (2012e) finds that health workers in urban areas report having greater access to career development opportunities (in-service training) than those in rural areas, and those in the Terai have greater access than those in the hills and mountains (Figure 3). SOLID attributes this to the presence of institutions and nearby facilities for training in urban areas (especially Kathmandu) and the Terai. [14] Access to postgraduate study is reportedly subject to similar constraints, and the remoteness of rural postings means health workers in these areas are less likely to be aware of opportunities, and their lack of training and mentoring makes it less likely that they will be accepted for positions.

Interviews also suggested that the softer aspects of and unofficial routes towards career advancement were harder in rural posts. Health workers' immediate superiors and other gatekeepers of promotion are less likely to visit remote posts or will do so only irregularly, meaning there is less opportunity to build up social links, and increasing the likelihood that performance reports will be inaccurate or generic in nature. Political patronage is also much harder to acquire in rural posts, as health workers generally lack experience with local political machines and may be from backgrounds and regions that make establishing links and relationships much more difficult. This corresponds closely with findings from previous work on informal practices of *Chakari*, in which political favour is cultivated through 'greetings, gifts, services or attendance at a patron's house or office, for up to several hours […] Gifts are not necessary, Chakari is commonly spending time in the presence of the person whose favour is sought, and this is seen as merit and worth rewarding. Positions in the public service are filled, and government decisions are made this way' (Dix, 2011: 17).

Figure 3: Career development opportunities according to health workers by ecological belt (%)



Source: HRH Survey 2011, in SOLID (2012d).

[14] Even in the broad category of 'rural areas', conditions and access to career development opportunities are likely to differ by district.

Health workers thus have clear incentives for the long term to avoid placements in rural areas, particularly if they are at the beginning of their career and lack significant levels of experience or established networks within the health sector.

The incentives of many health workers are therefore highly conducive to the development of a market for transfers between urban and rural regions. Conditions are generally poor and the reasons for this have underlying political causes. Local-level spending priorities are driven by short-term political priorities; broader trends in rural mobilisation and political appeals raise tensions between health workers and rural people; the high-level political deadlock contributes to an inability to move beyond pilot initiatives on many issues or prevents funding of potential solutions; and issues of political patronage contribute to the failings of the National Health Training Centre. However, underlying all of these issues is a basic problem of collective action. Health workers are still willing, despite all this, to serve in rural regions on a temporary basis. However, they need to believe they will not be abandoned in their post once they are there, that others are not cheating the system and that, after their rural tour is complete, they will be able to return to the comfort and financial advantages of the urban health sector.

4 Theories of change and implications for action by external development partners

4.1 Addressing incoherence in training and recruitment of health workers

How might change happen?

The analysis in Section 3.1 suggests that longer-term improvements may require a number of changes to the way health workers are produced; namely, through the reconciliation of incentives of training institutions and trained health workers with the needs of the health system. However, as noted above, the absence of reliable data on the distribution of vacancies and training across public and private sector institutions, including on issues of quality, has hampered attempts to develop a more coherent approach to training and recruitment. Improved information is therefore a critical first step towards any plausible change process.

Reform here is underway. The government HRH Strategic Plan, supported by the NHSSP, was passed by the Cabinet in early 2013 after significant delays. Improved forecasting, based on an accurate assessment of the HRH labour market, is the next step, with a labour market assessment including both public and private sector HRH underway (30 of 75 districts complete, with the remainder to be completed by February 2013). It does not appear that there are likely to be significant barriers to achieving this arising from the current political economy context, though clarification on how this baseline assessment can best be utilised in the future, potentially through linking it to annual district reporting and other information systems investments (e.g. HuRIS), would be worth considering. This labour market assessment would then need to form the basis for some degree of coordination between MoHP and health training providers outside its immediate sphere of influence (e.g. via MoE, CTEVT, professional councils and medical colleges).

In parallel, sustainable solutions that minimise the uncertainty associated with temporary contracting will require increased capacity for longer-term HRH planning and associated coordination with HRH production. The amendment of the Health Services Act is a crucial part of this process, as the inability of the PSC to create additional sanctioned posts is clearly a binding constraint on HRH management. Whether that amendment is immediately feasible or ought to be a priority is a matter of some debate. The cabinet has submitted the Health Service (fourth amendment) Ordinance necessary to bring the Act into line with constitutional requirements (MyRepublica, 2013a), and the minister is reportedly pushing for its issuance.

However, the reticence of the president to legislate via ordinance (itself reflecting mixed public sentiment regarding the legitimacy of such a move, particularly given similar practices in the last years of the monarchy), and disagreement among international donor partners as to whether he should do so, indicate the extent to which this ordinance, while not politically controversial in its content, is now subject to wider political constraints. Withholding issuance of the Health Service Ordinance along with several other ordinances is one of the few tactics available to the president as he seeks to push the political parties towards new elections. A similar attempt was used in the case of the fiscal year 2012/13 budget, although to little effect, as the president was eventually forced to issue the Budget Ordinance. It seems unlikely that similar pressures exist in the case of the Health Service Ordinance, but, with the apparent agreement of the

parties to a chief justice-led government to work towards new Constituent Assembly elections, there may be some flexibility on the president's commitment. Further, the 15 February 2013 passage of the ordinance on organised crime suggests international pressures do have the potential to help drive the passage of ordinances.

Given that the content of the Health Service Ordinance is largely uncontroversial, and given its progress to the final stage of issuance, it seems plausible to proceed with some of the planning exercises required on the assumption that the ordinance will be issued (or equivalent legislation passed) once the legislative process recommences. The composition of the criteria for HRH allocation (as well as the implied budget allocation) in the subsequent workforce planning exercise is, however, likely to be controversial. Some technically minded staff expressed frustration with delays in the exercise, attributed to political uncertainty, arguing that technical features of the context (disease burden, population dynamics, etc.) will not change regardless of the administrative and bureaucratic procedures that will be put into place as and when political/administrative reforms proceed. However, while the implications of such technical features for workforce planning might be clear, the selection and weighting of those criteria will have significant implications for the distribution of resources (i.e. budgeting) under any system, and is currently subject to significant uncertainty regarding how authority and budgets would be distributed. For example, population size would likely be a factor in HRH planning (e.g. establishing health worker to 10,000 population ratios); however, given the significant proportion of the population in the Terai, if such ratios are given substantial weight, it may entail a substantial redistribution of spending towards what may be one component of a federal system. Reticence to commit to workforce planning prior to clarity on subsequent political organisational arrangements may be attributable to this dynamic.

How might external actors contribute?

Support from donor partners, both directly and through the health sector sector-wide approach (SWAp) has contributed to improvements in information for both monitoring and planning. Interviews suggest MoHP is increasingly able to engage in evidence-based discussions regarding HRH issues, including DFID survey work directed at answering the question of where their posts are filled and where high vacancy rates persist. Expansions to these efforts might include current donor partner ambitions to embed a system capable of tracking health professionals. An investment in improving the accuracy and availability of information systems of this type would be useful in both feeding into workforce planning and improving capacity for tracking transfers more systematically. Again, as indicated above, the data will be most useful if they capture the public *and private sectors* over time. The analysis suggests there is no reason why such support could not continue, particularly if improved information availability strengthens the hand of technically minded staff for the upcoming workforce planning exercise.

In the shorter term, streamlining of procedures for short-term hiring and the development of strategies to facilitate longer-term contracting by local bodies and relevant local-level MoHP personnel would be extremely important. While DFID has indicated a desire to make DHOs more aware of the potential to hire on temporary contracts, increased awareness of this mechanism will not necessarily address the gaps that emerge, given the limited duration of those contracts and the time it takes to complete the contracting process. If multi-year contracting proves impossible, donor partners may consider bridging mechanisms that allow the provision of funding, perhaps on a loan basis, to local bodies to enable them to continue payments to contracted staff in the period between contracts and fiscal year budgets.

4.2 The market for transfers: Collective action solutions

How might change happen?

It is difficult to envision a plausible change process here because the analysis suggests the drivers of HRH improvements are linked to systemic governance issues relating to political party financing and party competition. There are reports of some instances in which strong administrators at the health facility level have reported being able to resist or manage the pressures placed on them by local political parties, thus minimising interference in management of HRH; however, it is not immediately apparent to the research team that there is an individual capable of playing the same role at the national level. Change is necessary from the highest administrative levels down, which are also those positions where the technical expertise of medical professionals (a key factor in the independence of health facility managers) is less relevant owing to the distance from service users.

Addressing these issues directly could theoretically involve significant improvements in the external monitoring and regulation of political party financing. In such an approach, forcing parties to make clear their

sources of financing might reduce the opportunities for the use of illicit financing. There has been some progress here, with major political parties recently submitting financial statements for audit[15] (Election Commission, 2012). However, given the lack of clarity on the boundary between party finances and personal finances of party members (and related party-affiliated organisations, including NGOs) noted above, it is unclear that such reporting will provide a disincentive capable of addressing the market for transfers or the rapid rate of transfer. Substantial change here, therefore, does not seem likely in the short to medium term.

If external control of behaviour does not seem likely in the current context, one alternative way to change the behaviour of those driving the market for transfers would be to focus on changing motivations among the actors involved. This would seem to require some form of substantial coordinated efforts on the part of all political parties, as action by any one group/party within the sector (e.g. refusal to pay for positions, or a failure to reward supporters with access to preferred positions) would likely lead to them becoming sidelined in remote areas or other less preferred posts (the costs of not playing the game). The issue here is potentially one of trust, ensuring each actor that if they were to refrain from the politicisation of transfers, others would not resort to current rent-seeking practices. Some form of collective action, in which parties agree to collectively oppose problematic behaviour, could potentially address the market for transfers without relying on an external sanction mechanism.

Despite their differing political affiliations, unions have shown the capacity to come together, as in the case of the November 2012 padlocking of the office of Dr. Mingmar Gyaljen Sherpa, Director General at the DoHS, in opposition to ‘politicised’ transfers and appointments. The consensus among informants was that the transfers that sparked the November incident may in fact have been an attempt at technocratic allocation rather than being ‘politicised’, suggesting that, in this case, collective action by the unions may have undermined rather than promoted better outcomes. Improved management of transfers would therefore require a wholesale shift in the perceptions of the unions in question.

How might external actors contribute?

- While it may be difficult for donors to engage with relevant unions, given sensitivities towards international interference, it may nevertheless be possible for donor partners to contribute to a forum for cross-party coordination. This contribution, in the form of a brokering function, could potentially operate through arms-length support to locally based and networked organisations. While the search for a consensual prime minister has proven it is not easy to find a leadership figure acceptable across parties, a well-respected individual without a strong political affiliation could facilitate a process of building trust among the unions. Interactions could begin with cooperative action on issues of clear mutual interest among the unions (to which the international donor community could then respond), before proceeding to addressing collective action challenges in HRH once sufficient trust had been built.

- At the same time, there appears to be room for better analysis and information regarding the extent to which transfer orders like that which sparked the November 2012 protests are truly politicised. Debates continue to be dominated by anecdotal accounts and rumour. Beginning to systematically collect information on transfers, whether through links to payroll or via medium-term improvements in HuRIS that ensure information on transfer eligibility can be cross-checked with transfer lists, would help clarify the extent to which the anecdotal evidence is truly representative of broader practices in the sector. If, in fact, there are a significant number of genuine transfers or even pockets of effectiveness where individuals are transferring staff in accordance with existing regulations, this could help shift perceptions that payment for transfers is simply a rule of the game, thus contributing to ideational change among health workers and administrators in MoHP.

- External actors, who provide a substantial amount of funding to the sector through the SWAp, may wish to consider putting in place one or two indicators as benchmarks for releasing funding tranches, namely, setting targets for reducing vacancies and reducing transfer speed. It is, however, not clear whether the impact of reductions in sector funding would provide a sufficient incentive to deter the types of short-

[15] In the audit findings released, sources of revenue and areas of spending are vague, with the comments across listing ‘donation’ or ‘income’, with no areas of spending specified. The amounts of declared revenue and expenditure, however, vary widely. Total revenue for the three fiscal years 2007/08 to 2009/10 ranges from the Nepali Congress's figure of NRs 62.89 million to the UML's NRs 185.13 million and the Maoists' NRs 294.19 million. For 2010/11, UML's revenue is NRs 40.39 million and the Maoists' NRs 132.64 million. The Nepali Congress did not submit 2010/11 revenue. Total expenditure for the three fiscal years 2007/08 to 2009/10 ranges from NRs 24.55 million for the Nepali Congress, to the UML's NRs 137.98 million and the Maoists' NRs 284.37 million. For 2010/11, UML's spending is NRs 26.51 and the Maoists' NRs 128.30. The Nepali Congress did not submit 2010/11 expenditure (Election Commission, 2012).

termist behaviour associated with the market for transfers in the health sector. Such a reduction relies on the assumption that a reduction in the quantity of resources available would put pressure on for dissemination through patronage networks, but interruptions to funding could have a significant detrimental effect on service delivery. Interviews suggest donor partners working in local governance are currently considering this, so a useful first step may be to monitor the effectiveness of that intervention.

4.3 The market for transfers: Eroding demand by narrowing the gap in health worker incentives

How might change happen?

The analysis in Section 3.3 suggests three sets of factors that influence health worker perceptions of the value of particular postings:

- Conditions in service;
- Immediate opportunity costs; and
- Future opportunities for advancement.

Taken together, the differences in these factors create a gap between preferred posts in major urban areas, and those posts in remote rural areas. This suggests that reductions in the size of this gap may lead to reductions in the 'value' of postings in Kathmandu and other urban areas, thereby undermining the market for transfers. Given the ways in which politicisation of the transfer system undermines the distribution of HRH, and the extent to which this system is entrenched across sectors in the country, external development partners may need to consider whether they are able to influence that system directly or if they might be better off making marginal improvements within the constraints of politicisation that could address the issue indirectly. In other words, by considering the various drivers of the market for transfers, it may be possible to undermine the market without addressing it head-on.

Of the three factors, conditions in service are the element that is often focused on most closely and that potentially represents the easiest area in which to improve incentives. Four proposals emerged from consultations and are consistent with the subsequent analysis: i) changing the delivery model; ii) expanding mandated rural service; iii) improving conditions; and iv) changing the composition of health workers.

First, many of the disadvantages are predicated on a particular model of rural health provision where health workers are stationed for multiple years in a particular rural health centre or hospital. A number of alternative arrangements might be possible that would alter incentives quite radically by reducing the number of permanent postings needed in remote areas. Such models could rely on rural services to be provided by urban-based medical staff (e.g. with mobile clinics undertaking preventative care), or health workers being mandated a certain number of months in rural regions every year (see Frehywot et al., 2010 for a discussion of various systems for ensuring rural service for health workers). Proceeding with this option would, however, require negotiating the local political debates likely to arise in response to such proposals.

Second, there may be room to expand on a two-year compulsory service scheme, started during the NHSP I period for physicians who studied under the government's scholarship scheme. Currently, around 280 medical doctors in the scheme are working in the various districts, including in the remote hills and mountains. However, these doctors reportedly face uncertainty regarding their ability to be regularised into government services and the scope for higher studies, as non-scholarship classmates are not subject to a similar requirement and may therefore proceed more quickly to advanced studies. An extension of rural service requirements to all graduates of training programmes would simultaneously increase the health workforce available in remote rural areas and level the playing field for graduates. While the scholarships provide some leverage for training institutions to ensure rural service under the current model, other options may be available, including the requirement for service to be completed prior to the confirmation of the training qualification itself. The Patan Academy of Health Sciences has experimented with various forms of compulsory rural service as a part of the curriculum, and lesson-learning here may be possible.

Third, given the range of conditions that contribute to the differentiation between rural and urban postings, there are several potential changes that might affect health workers' calculations.

- Financial considerations of health workers are certainly relevant here. While allowances for remote postings do exist, they do not appear to be sufficient to incentivise service in remote rural areas, given the income generation opportunities that exist in urban locations and internationally, [16] and changes in remuneration packages may help address this.
- Improvements to non-salary benefits are also likely to be important. Here, it may also be useful to consider the potential of continued longer-term investment in complementary sectors. For example, Engel et al. (2013) suggest an important link between developments in transport infrastructure and access to health centres. It is reasonable to believe that investments in such sectors may reduce the degree of remoteness and isolation felt by health workers. In the short run, schooling allowances for the children of health workers or other such measures may mitigate some of the costs facing those working in remote rural areas.

Financial viability is likely the chief constraint with respect to the two points above: one interviewee indicated that the Ministry of Finance blocked earlier attempts at the expansion of remuneration and non-salary benefits owing to concerns of having to expand them to other public sector workers. Negotiations of such changes would therefore involve coordination with other sectors where such issues are likely to arise (e.g. posting of teachers in the education sector).

Improvements to the personal security of health workers may offer another opportunity. Health facility operations and management committees represent one option for improving the relationship between health workers and the communities in which they work. Such mechanisms, as well as initiatives such as social audits that seek to manage the interface between service users and providers, and longer-term systematic investments in public health education to promote realistic expectations[17] of what can and should be expected of health workers, may help reduce the incidence of tensions and security incidents. In the meantime, there remains the need for on-demand crisis management by local security services.

Fourth, in recognition of the urban bias in the training of health workers, there appears to be some potential to build off evidence that suggests that local hires, particularly lower-caste health workers, may face fewer barriers to working effectively in remote rural areas (near to their origin), [18] for example language capacity, socio-cultural distance and sensitisation, distance from family, etc. These groups, however, face significant barriers to entry in the market for training, with the costs of training, even of attending examinations in Kathmandu, resulting in selection bias favouring the upper classes and those in central locations. Spatial affirmative action policies that give preferential access to educational opportunities to candidates from remote areas as well as financial support for such individuals could help address these barriers, as could initiatives that seek to take the training to remote rural areas through remote classrooms and other distance learning tools.

How might external actors contribute?

- The systematic incorporation of expanded requirements for rural service (e.g. urban-based staff spending a minimum number of weeks per year in remote rural areas or an expansion of the rural service requirements from scholarship students to all students) would require policy change within government. However, given the challenges indicated above with respect to coordination between MoHP, MoE, CTEVT and the large number of private training organisations, there may be a role for donors in brokering a process of dialogue and interministerial communication. In the shorter term, ideas might include offering salary top-ups to staff (or financial incentives to hospitals) that send travelling clinics to rural areas

[16] It is also possible that allowances indicated in the policy framework are not effective because they are not being received, rather than because they are insufficient. Little evidence on this emerged in consultations, but the available literature (SOLID, 2012d-e) suggests the size of allowances is indeed an issue.

[17] Note we do not suggest that high expectations are, in themselves, necessarily a problem, as they may help incentivise improved performance. However, in this case, the direction of discontent at frontline providers rather than those upstream whose capacity to address shortcomings may be greater creates a problematic dynamic.

[18] For Nepal, see Zimmerman et al. (2012). A broader international literature confirms, including a systematic review of existing studies as of 2003, Laven and Wilkinson (2003). A number of subsequent studies also find a similar effect, including Eley and Baker (2006); Matsumoto et al. (2008); Rabinowitz et al. (2005); and Walker et al. (2012), all in Zimmerman et al., 2012. A more recent review by Grobler et al. conclude that, while there are a large number of observational studies of the determinants of practice location, there is an absence of well-designed studies 'to confirm or refute findings of various observational studies regarding educational, financial, regulatory and supportive interventions that may influence health care professionals' choice to practice in underserved areas' (2009: 2).

(perhaps funded from the salaries budgeted for posts that are vacant), or an expansion of the number of scholarship students at the Patan Academy of Health Sciences and similar schemes.

- The Rural Staff Support Programme (RSSP), run by NSI and the National Health Training Centre, has established a series of pilot projects aimed at improving these conditions, one element of which is to support the education of staff children. MoHP documentation does note that 'MOHP recently asked the NSI to "rapidly and widely scale up" the Rural Staff Support Programme' (MoHP/NHSSP, 2012: 38), but consultations with key informants suggested the question of who is ultimately responsible for bringing pilot programmes to scale remained unresolved. The position put forth in the strategic plan indicates MoHP is understandably willing to have NSI expand its programming, but may be unwilling to take ownership of a larger programme of support to rural staff. NSI, for its part, is a small organisation reliant on the government for programme effectiveness, particularly with respect to any large-scale operations.
- The impact of professional isolation on morale and retention rates has begun to be recognised and solutions proposed. Connecting health facilities by phone and internet, as well as establishing stronger links between remote health centres and larger hospitals, is an important element of RSSP pilot projects being pursued by NSI and the National Health Training Centre. The Patan Academy of Health Sciences is also in the process of developing a system for remote mentoring ('telemedicine'), which will allow doctors access to support and information when they need it. There are currently no plans for the expansion of these systems beyond their current areas of operation.
- Solutions for issues of isolation are being piloted by the Safe Motherhood Network Federation, which has conducted a series of public hearings in which community members, local leaders and health workers discuss the issues they face in accessing or providing health care. These meetings and similar social audit practices have the potential to defuse tensions, as they provide not only a mechanism for holding health workers to account but also an opportunity for health workers to explain the challenges they face and for a diverse set of actors to come together to solve problems. There may be room for additional support from external development partners to support such initiatives, although evidence from other contexts suggests in practice it is often crucial that activities are carried out by well-networked local organisations (Wild and Harris, 2011).[19] Experience from programmes conducted by Pro-public also highlights the need for such meetings to involve those with the agency required to address service short-comings, or there is a risk of meetings becoming simply a forum for the airing of problems rather than a mechanism to facilitate improvements.
- There may be the potential for health workers to be given rural training in teams, which could then form the basis for initial deployment. This could solve some of the issues of isolation, ensure doctors have supporting staff to provide adequate care and also create moral and social pressures for health staff to complete their rural term rather than abandoning their comrades.

5 Conclusion

This country evidence note has presented findings from a structured exploration of the political economy dynamics associated with access to qualified HRH in remote rural areas of Nepal. Our approach has emphasised the need to develop intervention logics that are consistent with a diagnosis of the underlying political economy challenges affecting the management of HRH. The implications for action presented in the previous section provide an initial set of ideas regarding how theories of developmental change might occur given constraints and opportunities associated with the three major themes identified.

While the environment for those seeking to effect or support improvements in HRH management and ensure access to qualified health workers in remote rural areas of Nepal is clearly a challenging one, there do appear to be change processes that appear plausible, even in light of current constraints. These processes often consist of a series of small changes at the margin rather than transformational change, and therefore may demand a longer-term view towards results, but there are a number of steps that can be taken in the shorter term to which external actors might usefully contribute.

[19] There is, of course, an extensive literature on participatory development that draws on similar concepts regarding the involvement of concerned parties in the improvement of service delivery or other aspects of development. In this case, whether or not the Safe Motherhood Network Federation meetings result in some form of co-production or community-based delivery mechanisms for health services, there is value in such processes as mechanisms to mediate disputes and thus contribute to the personal security of health workers in remote rural areas.

These suggestions, however, are best seen as a starting point for a broader discussion of operational implications of the diagnostic findings. Particularly with respect to the strategies one might adopt in the light of the underlying dynamics, we expect that individuals and organisations working in Nepal might draw on their own considerable experience in thinking about what opportunities might exist, and may very well identify alternative strategies that are consistent with the types of incentive problems identified.

References

Arnold, J., Loan-Clarke, J., Coombs, C., Park, J., Wilkinson, A. and Preston, D. (2003) 'Looking Good? The Attractiveness of the NHS as an Employer to Potential Nursing and Allied Health Profession Staff'. Final Report for the Department of Health. Loughborough: Loughborough University Business School.

Arrow, K.J. (1963) 'Uncertainty and the Welfare Economics of Medical Care'. *The American Economic Review* 53(5): 941-973.

Bhatt, V.R. (2006) 'Medical Education: At What Cost?' Student BMJ 14: 265-308.

Chin, B. Montana, L. and Basagaña, X. (2011) 'Spatial Modeling of Geographic Inequalities in Infant and Child Mortality across Nepal'. *Health & Place* 17(4) 929-936.

Clemens, M. (2009) 'Skill Flow: A Fundamental Reconsideration of Skilled-Worker Mobility and Development'. Working Paper 180. Washington, DC: CGD.

Davis, J. (2004) 'Corruption in Public Service Delivery: Experience from South Asia's Water and Sanitation Sector'. *World Development* 32(1): 53-71

Deraniyagala, S. (2005) 'The Political Economy of Civil Conflict in Nepal'. *Oxford Development Studies* 33(1): 47-62.

Dix, S. (2011) 'Corruption and Anti-Corruption in Nepal: Lessons Learned and Possible Future Initiatives'. Discussion Report 18/2011. Olso: Norad.

Ekantipur (2013) 'Funding Politics: A Political Party Financing Law Is Long Overdue'. 24 January, http://ekantipur.com/2013/01/24/editorial/funding-politics/366030.html

Election Commission (2012) 'Nirbachan Ayog – Rajnitik Dalharuko Barshik Aya Byayako Bibaran Bishleshan Pratibedan, 2068' ('Report on Analysis of Annual Statement of Income and Expenditures of Political Parties, 2068'). Kathmandu: B. K. Man Singh and Co., Chartered Accountants.

Engel, J., Glennie, J., Adhikari, S., Bhattarai, S., Prasai, D. and Samuels, F. (2013) 'Understanding Nepal's Improvements in Maternal Health'. Development Progress Case Study Report. London: ODI. Forthcoming.

Fritz, V., Kaiser, K. and Levy, B. (2009) 'Problem Driven Governance and Political Economy Analysis: Good Practice Framework'. Washington, DC: World Bank.

Grobler, L., Marais, B.J., Mabunda, S.A., Marindi, P.N., Reuter, H. and Volmink, J. (2009) 'Interventions for Increasing the Proportion of Health Professionals Practising in Rural and Other Underserved Areas'. Cochrane Database of Systematic Reviews 1, http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005314.pub2/abstract

Frhywot, S., Mullan, F., Payne, P.W. and Ross, H. (2010) 'Compulsory Service Programmes for Recruiting Health Workers in Remote and Rural Areas: Do They Work?' *Bulletin of the World Health Organization* 88: 364-370.

Hsiao, W. (2003) *What is a Health System? Why Should We Care?* Cambridge, MA: Harvard School of Public Health.

Klitgaard, R. (1991) *Controlling Corruption*. Berkeley: University of California Press.

Krause, P., Chalise, B., Hedger, E. and Sweet, S. (2013) 'Operational Risk Assessment of Public Financial Management Reforms in Nepal'. Forthcoming.

Laven, G. and Wilkinson, D. (2003) 'Rural Doctors and Rural Backgrounds: How Strong Is the Evidence? A Systematic Review'. *Australian Journal of Rural Health* 11: 277-284.

Mcloughlin, C., with Batley, R. (2012) 'The Effects of Sector Characteristics on Accountability Relationships in Service Delivery'. Working Paper 350. London: ODI.

MoHP (Ministry of Health and Population) (2010) NHSPIP II – Nepal Health Sector Programme – Implementation Plan II 2010-2015.

MoHP (Ministry of Health and Population)/NHSSP (Nepal Health Sector Support Programme) (2012) 'Human Resources for Health Strategic Plan 2011-2015'. Draft, January. Kathmandu: MoHP.

MyRepublica (2013a) 'President Can't Be Quizzed for Shelving Ordinances: Experts'. 17 January, www.myrepublica.com/portal/index.php?action=news_details&news_id=48402&show_comments=true

MyRepublica (2013b) 'Editorial: Party Pooper'. 24 January, www.myrepublica.com/portal/index.php?action=news_details&news_id=48745

Powell-Jackson, T., Neupane, B.D., Tiwari, S., Morrison, J. and Costello, A. (2008) 'Evaluation of the Safe Delivery Incentive Programme: Final Report of the Evaluation'. Government of Nepal National Safe Motherhood Programme. Kathmandu: MoHP/SSMP Nepal.

Shankar, P.R. and Thapa, T.P. (2012) 'Student Perception about Working in Rural Nepal after Graduation: A Study among First- and Second-year Medical Students'. *Human Resources for Health* 10: 27.

SOLID (Society for Local Integrated Development) (2012a) 'Distribution and Skill Mix of Human Resources for Health in Nepal: Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

SOLID (Society for Local Integrated Development) (2012b) 'Training, Recruitment, Placement and Retention of Health Professionals with an Emphasis on Public Private Partnership (PPP): Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

SOLID (Society for Local Integrated Development) (2012c) 'Health Workforce Performance and Accountability (Availability, Competency, Responsiveness and Productivity): Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

SOLID (Society for Local Integrated Development) (2012d) 'Human Resources for Health Management from Central to District Level in Nepal: Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

SOLID (Society for Local Integrated Development) (2012e) 'Working Conditions of the Health Workforce in Nepal: Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

SOLID (Society for Local Integrated Development) (2012f) 'Role of Civil Society in Human Resources for Health: Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal'. Kathmandu: SOLID Nepal.

Suvedi, B.K., Chand, P.B., Marasini, B.R., Tiwari, S., Poudel, P., Mehata, S., Pradhan, A., Acharya, L.B., Lievens, T., Hepworth, S. and Barnett, S. (2012) 'Service Tracking Survey 2011'. Kathmandu: MoHP.

Transparency International Nepal (2010) 'Report on Transparency in Political Finance in Nepal'. Pilot Study conducted under the Crinis Project in Bangladesh, Indonesia and Nepal. Kathmandu: Transparency International Nepal.

UNDP (UN Development Programme) (2009) Nepal Human Development Report 2009. New York: UNDP.

Vauz, T. (2011) 'The Role of Education in Peacebuilding: Case Study – Nepal'. New York: UNICEF.

Wade, R. (1982) 'The System of Administrative and Political Corruption: Canal Irrigation in South India'. *Journal of Development Studies* 18(3): 287-328.

Wade, R. (1985) 'The Market for Public Office: Why the Indian State is not Better at Development'. *World Development* 13(4): 467-497.

WHO (World Health Organization) (2000) World Health Report 2000 – Health Systems: Improving Performance. Geneva: WHO.

Wild, L. and Harris, D. (2011) 'The Political Economy of Community Scorecards in Malawi'. London: ODI.

Wild, L. and Subedi, J. (2010) 'Review of International Assistance to Political Party and Party System Development – Case Study Report: Nepal'. London: ODI.

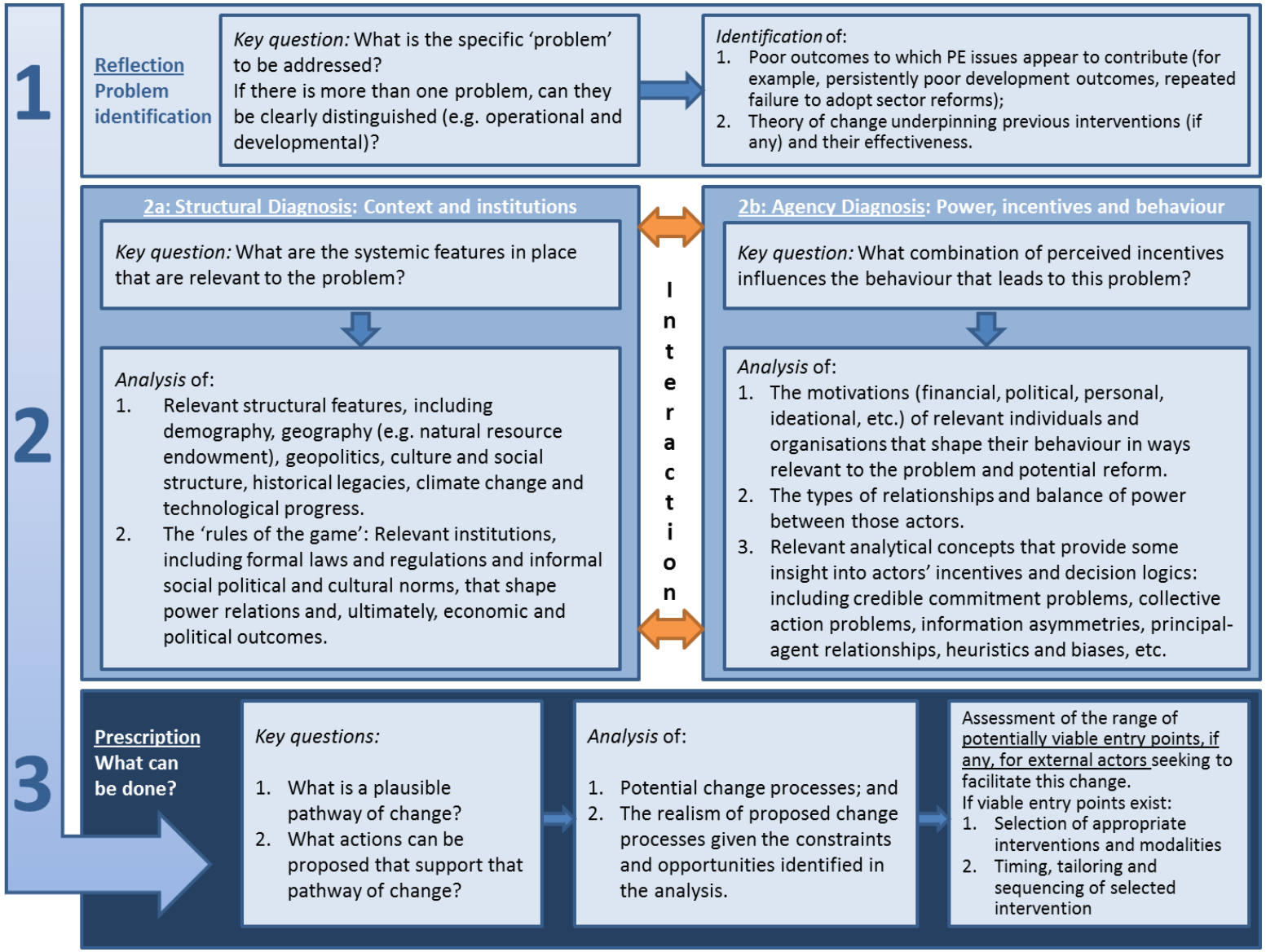
Wild, L., Chambers, V., King, M. and Harris, D. (2012) 'Common Constraints and Incentive Problems in Service Delivery'. Working Paper 351. London: ODI.

World Bank (2005) Making Services Work for Poor People: World Development Report 2004. Washington, DC: World Bank.

World Bank, (2007) 'Healthy Development: The World Bank Strategy for HNP Results, Annex L: What is a Health System?' Washington, DC: World Bank.

Zimmerman, M., Shakya, R., Pokhrel, B., Eyal, N., Rijal, B.P., Shrestha, R.N. and Sayami, A. (2012) 'Medical Students' Characteristics as Predictors of Career Practice Location: Retrospective Cohort Study Tracking Graduates of Nepal's First Medical College'. *British Medical Journal* http://dx.doi.org/10.1136/bmj.e4826

Annex 1: Framework for political economy analysis



Annex 2: Clarification of HRH designations

There is the potential for significant confusion regarding the classification systems used to designate health workers. This confusion arises in part from the origins of the various health worker classifications in the Civil Service Act, 2049 (1993) and the Nepal Health Service Act, 2053 (1997). Section 4 of the Civil Service Act, 2049 (1993) enumerated a total of eight classes in the civil service, including four gazetted classes (special, first, second, third) and four non-gazetted classes (first, second, third, fourth). [20] From 1993 to 1997, the public sector health workforce was managed according to these classifications.

However, with the promulgation of the Nepal Health Service Act in 1997, a new classification system was put in place for the health sector. This new system included 13 classes, including 6 assistant-level posts (asst. 1st, asst. 2nd, asst. 3rd, asst. 4th, asst. 5th, senior 5th), and 7 officer-level posts (officer 6th, officer 7th, officer 8th, officer 9th, officer 10th, officer 11th, officer 12th). The asst. 1st and asst. 2nd levels were subsequently abolished with the Nepal Health Service (Third Amendment) Act, 2063, and health workers at those levels adjusted to asst. 3rd-level posts. Each class is then divided into a specific number of grades (between 5 and 20 depending on the class) on the basis of the duration of service.

Formally, the Health Service Act makes some provisions for the creation of the new health sector-specific classification system, linking some classifications under the Civil Service Act to the new classifications. For example, Section 4.4 states 'The non-gazette third class employees appointed pursuant to the Civil Service Act, 2049 (1993) prior to 14 Jestha 2054 shall be adjusted to the fourth class' (MoHP, 2010). Sections 9.4, 9.5 and 9.6 make similar clarifications regarding upgrading practices. However, there remains a considerable grey area with respect to equivalencies, as few of the Civil Service classifications are directly linked to Health Service classifications. The table below provides a rough guide to equivalencies between the two systems as well as example positions from the health sector for each class.

Entry-level civil service and health service classifications, approximate equivalencies

Civil service designation	Health service class	Examples*
NG 3rd	Asst. 3rd	VHW/MCHW
NG 2nd	Asst. 4th	AHW, ANM, laboratory assistant
NG 1st	Asst. 5th	HA, SN, laboratory technician, pharmacy (PCL), sr. AHW
NG 1st	Senior 5th	Sr. HA, sr. SN inspector
Gazetted 3rd	Officer 6th	PHO and other officer level of health services
Gazetted 3rd	Officer 7th	Officer (medical officer) and senior PHO
Gazetted 2nd	Officer 8th	Health/nursing administrator/public health consultant
Gazetted 2nd	Officer 9th	Sr. public health administrator, sr. nursing administrator, sr. health administrator
Gazetted 1st	Officer 10th	Chief public health administrator, chief nursing administrator, chief health administrator
Gazetted 1st	Officer 11th	Medical specialist
Special class	Officer 12th	Secretary

[20] This was subsequently increased to nine, with the addition of the fifth NG class with the Civil Service (Second Amendment) Act, 2064 (2007).

Note: * Promotion and changes to the classification system can change the classification of health workers after entry, a practice that has generated some controversy. For example, from 2007, asst. 3-level VHW and MCHW posts have been cancelled and automatically upgraded to asst. 4-level AHW and ANM posts, respectively. There are some concerns that a significant number of those upgraded were not sufficiently technically qualified. Reportedly, while roughly 1,000 MCHWs were trained as ANMs during 2004/05, the remainder (more than 2,000) are trained only as MCHWs and did not qualify for ANM training (e.g. because the requirement for a basic school leaving certificate was not met). However, many of those MCHWs, as well as many VHWs, have now been promoted to asst. 5-level HA and SN posts due to seniority automatic promotion that occurs after five years in post, although the relevant professional council (the Nursing Council) does not recognise them as SN qualitatively. There is no automatic promotion for those who entered as VHW or MCHW after asst. 5 level, although health workers entering in asst. 5-level HA and SN posts are promoted to asst. 6 level after five years' service.

Source: Authors' interviews, various.

In practice, the two Acts provide the foundation for parallel systems, both of which apply at times to health workers. Particularly relevant to the discussion in this paper is the provision made in Section 86B of the Nepal Health Service Act, 2053 (1997) titled 'Entitlement to facilities pursuant to the Civil Service Act, 2049 (1993)', which states:

> *'Notwithstanding anything contained elsewhere in this Act, if provisions are made under the Civil Service Act, 2049 (1993) for more facilities than those set forth in this Act in relation to salary, allowances, leave, gratuity and pension to the civil employees, such provisions shall also apply to the employees of the health service.'*
>
> *MoHP, 2010*

Thus, the information provided in the paper regarding the remote location allowances is given according to civil service classifications as allowances of that type are provided across the civil service.

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