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**Title**

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**Permalink**

<https://escholarship.org/uc/item/0pn0p265>

**Journal**

Health Prospect, 12(2)

**ISSN**

2091-203X 2091-2021

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**Publication Date**

2013-09-01

**DOI**

10.3126/hprospect.v12i2.9870

Peer reviewed

## User-provider relations pertaining to health care delivery in Jumla district

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### Abstract

#### Background

Nepal's health policy making and programming shifted over the past six decades in tune with international milieu. After 2006 revolution, radical new leadership of health ministry wrote health as a fundamental right in the interim constitution and scrapped hitherto existing user fees in peripheral health facilities. This work aimed to understand user-provider interaction at facility and community setting while people attempt utilising fee-less health care.

#### Methods

We used key informant interviews to explore the mechanism of health care delivery and general reality of Jumla district in north-west Nepal. We used semi-structured interviews with respondents at both the providing and receiving sides. We asked open ended questions and used answers to preceding questions to generate new questions around the area of discussion.

#### Results

Health care machinery in Jumla struggled between constrained supply and elevating demand side factors. District hospital endured this challenge more than primary health care centre and health posts studied. User-provider relations were more turbulent in the hospital where targeted approach to fee removal was effected, than other facilities where charges were abolished altogether. Users and providers had their own side of the story, exemplified by experiences in accessing and delivering fee-removed health care.

#### Conclusion

We conclude that user-provider dynamics manifest in Jumla originate elsewhere. Health care programmes are crafted without people's meaningful participation. Prescriptions trickle down all the way from international health rings to rural villages like that of Jumla – through national systems – founded on economic and political interests as contrasted to citizen's legitimate needs. We recommend further ethnographic work to fully explore and address factors that determine user-provider relations at point of health care use.

**Keywords:** cost recovery; ethnography; health services; medical anthropology; Nepal; social medicine; user fees.

### Introduction

The health care delivery system in Nepal made organised attempt to deliver health care services in the decadal waves confirming to the global shifts in paradigms. Cemented with several vertical programmes aimed at controlling individual diseases with little or no co-ordination among these programmes in the 1950s and 1960s; it underwent a phase of nation-wide extension of health facilities and integration of interventions fitting into the hardware components of Primary Health Care approach in the 1970s and 1980s, (1) done with little consideration of the politico-economic changes warranted by the approach itself. In 1990, multiparty governance was staged after a movement against party-less autocracy. The product was a new constitution that embraced neo-liberal economic prescriptions. (2) Within its ambit, the national health policy of 1991 opened market in the health sector piggybacked by the newly imported liberal economic

framework. (3,4) User fees were soon introduced in Nepali health care delivery system, first as payment for medicines and later registration and consultation fees, and charges for clinical interventions, laboratory investigation, and other applicable services in public health facilities.

These shifts suggest an attempt by the government to adapt to changing health-economic landscape both globally and locally. What upset the activist mind is that these moves were not rooted in the needs and inspiration of

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Nepali people but were imposed down from high in the echelons of power in international health.

Recent global recognition that user fees are a major impediment to accessing health care by the people pushed to the margins (5-9) is related to a change in Nepal's health sector. The radical leadership of Ministry of Health and Population removed user fees hitherto applicable in emergency, in-patient and out-patient curative services across district hospitals (upto 25 bed capacity), primary health care centres (PHCC), health posts (HP) and sub-health posts (SHP), in two phases. First a targeted approach was taken (considering ultra-poor, poor, elderly, destitute, female community health volunteers, and disabled) for full or partial waiver at the former two types of facilities; followed by a total abolition of fees for everyone at the latter two categories. (10)

This interesting shift, contrasting to the earlier trajectories of health policy, attracted discussion around the cost implication of abolishing fees, whether it could be sustained et cetera. However, one question remained unquestioned and unanswered until the conduct of this work: has the fee removal accommodated the marginalised groups of people into health care utilisation or reflects a reiteration of privileged continuing to benefit? This work aimed to respond to this question and to understand the user-provider relationship at the health care facilities setting while the health workers implement fee removal so that users would access emergency, in-patient, and out-patient services.

The work was conducted in Jumla district during mid-August to end of September 2008. Jumla stood at 69th position among the 75 districts by composite development indicator. (11) The Jumli society was diverse in its cultural composition whereby hierarchical relations based on gender, ethnicity and economic class were inherent influentially in people's life every day.

Languishing perennially neglected (by the Nepali state) in the Karnali zone, health care machinery of Jumla was enduring the challenge of tackling several constraints and meeting the nationally set (often numerical targets driven) standards of health care delivery. The machinery was a conglomeration of these ingredients held somewhat together with fluidity: the government health apparatus (including a district hospital, a PHCC, eight HPs, 20 SHPs and an Ayurved health centre), government line agencies, a plethora of what Nepal's health development nexus calls external development partners (EDP) (more than half a dozen of them had health interventions in their worklist, and well over two dozens were doing activities that affect health), approximately a dozen of non-governmental organisations (NGO), and the relatively small profit sector (solely represented by close to a dozen medicine shops of which half were operating in the vicinity of district hospital in district headquarters and the remainder scattered in several villages). The district hospital provided emergency, in-patient, and out-patient services, while the other three types of government health facilities offered out-patient services only.

## Methods

In an attempt to analyse the changes in health care utilisation corresponding to the periods before and after fee removal, qualitative techniques were adapted to understand the mechanism by which health care was delivered in association with such changes. Initially, a series of key informant interviews were conducted among farmers, a shopkeeper, a civil society activist, health care staff (at all levels from district health officer to the peon), and a restaurateur, all met in either of Chandannath, Mahatgaun and Kartikswami village development committees (VDC), to understand the social context in which Jumli people live. This discussion series was also used to construct local definitions founded on their opinions on categorising financially poor and rich, under-privileged and privileged caste groups, and gender relations, which were used to gauge changes in health service utilisation following fee removal. Aspects of techniques and results related to this quantitative component of the study were briefly presented elsewhere. (12,13) Scope of this paper is focused on the qualitative component of the research.

We used semi-structured interviews with respondents at both the providing and receiving sides. We asked open ended questions and used answers to preceding questions to generate new questions around the area of discussion.

The providing side comprised of health workers at district hospital, PHCC and four out of eight HPs selected to represent geographical and cultural diversity of Jumla (medical officer, staff nurse, health posts and PHCC in-charges, senior/auxiliary health workers, village health workers, auxiliary nurse midwife), *Kharidar* (clerical staff at health facilities), female community health volunteers (FCHV) and peon. The main area of discussion was district health care machinery – its structure and function, implementation mechanism of fee removal – called as free essential health care services (FECHS), and resultant effects on the modes of delivery and use of health services. In addition, district health office (DHO) chief, district focal person for FECHS programme, and representatives of NGOs were interviewed.

The consuming side comprised of users visiting health facilities, other local residents of the catchment area of these facilities, key informants noted above, and development workers in Jumla. We asked them about their views on the implementation of FECHS and other questions pertinent to delivery of health services.

We ensured credibility of the research in three ways. We used interview techniques that were well established in qualitative research. We had experience in using these techniques prior to conducting this research. We familiarised with the context of health care delivery in Jumla before starting to use the data collection techniques.

However, the research is not free of limitation. It relies on the views expressed by the users and providers of health care, which we have interpreted to draw conclusions. We encourage readers to judge the transferability of this re-

search on the basis of contextual description.

## Results

### Health care mechanism in Jumla

Delivery of health services to the people of Jumla presented two contrasting pictures. The DHO was confronted with too many programmes to run with little resources. Except for control of a few tropical diseases (such as kala-azar, encephalitis, malaria, which are endemic in lowlands), DHO Jumla conducted all the regular programmes of the health ministry. Resource constraint was manifest in both areas – materials and people. Logistics supply had remained a perennial challenge. Human resources were also insufficient to run activities smoothly. Most of the health workers stationed in the district hospital had to perform multiple tasks for inadequate filling in of the sanctioned positions.

An encouraging picture appeared when moving away from the district headquarters into the peripheral health facilities. Most of the health post staff were local people of Jumla. This permitted them to understand and respond to the cultural context of illness presented by their patients. Two out of the four health post in-charges, interviewed in this study, had bachelor level education, in addition to their qualification as health assistants. Most of the health post staff resided in the village where the health post was situated. This was translated in their work whereby they were seen attending to patients, even out of the duty hours, sometimes even during late night.

We found that the health post staff in all visited health posts were good in their clinical skills, with an added advantage conferred by understanding of local people's culture. However, the health post staff were dissatisfied with the DHO team. They complained of late receipt of salaries and allowances (usually provided between 1-2 weeks after due date). They were also dissatisfied by the late arrival of medicines, vaccines and other logistics such as reporting forms. They expressed this during our interview as well as in the DHO annual review meeting, September 2008. A health post in-charge complained:

*"The main problem I face is shortage of medicines and HMIS forms. Both of these are stock out for the last six months. Regular immunisation was impossible two times because vaccines did not arrive. I came to the DHO so many times to get the supplies but always had to return empty handed."*

-In-charge of a health post located at a distance of 10-hour walk from the DHO

Another health post in-charge humorously expressed his frustration over non-availability of reporting forms:

*"I have a question. Can the DHO make photocopies of HMIS-32? If not let's ask the donors for photocopy support. I have been recording patient information on blank papers which I formatted into the shape of HMIS-32. Sometimes, I travelled to Mugu district and borrowed the forms."*

-In-charge of a health post located at a distance of 12-

### hour walk from the DHO

Further, some of them were not happy with their little involvement in the activities run by EDPs and local NGOs, who sometimes bypassed the local health facilities and even produced false claims in their reporting. A health post in-charge reported:

*"NGOs in my health post catchment area are not doing what they claim. I encountered only one organisation which supported the villagers genuinely, others are thugs. They don't even inform us, let collaboration alone. When I try to contact them for co-ordination, they say that the health post does not deserve collaboration because they had already done so at higher levels of authority. Last year, a multilateral agency reported that it conducted training involving villagers. It was a surprise that none of the villagers were aware of the training. I was present during the reporting and straight away said that it was false claim."*

-A health post in-charge

We identified that some of the EDPs and NGOs were engaged in activities in which the target people had little or no control. Local residents in Chautha of Bumramadi-chaur VDC heavily criticised these for non-consideration of local voices in their work. They were furious that they produced false reports claiming things they did not do in the villages. They demanded people's participation in the activities to be conducted in their name.

### Delivery of fee removal

#### Start dates of implementation

Partial removal of fees were made effective in the in-patient and emergency units of the district hospital whereby such waivers were available to eligible candidates, constituted of the ultra-poor, poor, disabled, elderly and FCHVs, since mid-January 2008. Effective from the same time, total fee removal was implemented across PHCC, health posts and sub-health posts to all patients seeking services from these facilities. Since the middle of March 2008, the partial removal scheme was expanded to the out-patient unit of the district hospital as well.

#### Mechanism of partial FECHS delivery

The delivery mechanism of FECHS required three major steps, namely: screening patients for eligibility and recommendation by the attending health worker; declaration by the unit (for example hospital out-patient) in-charge of whether a patient should benefit from partial FECHS.

For subsequent visits, patients were required to obtain an identification signed by the DHO chief by submitting photograph and documentary evidence of their eligibility (such as citizenship certificate for verification of age, recommendation from the respective village development committee, and identification card (in case of FHCVs)). Thus accessed identification was mandatory requirement for utilising FECHS during every next visit to the hospital.

However, all steps were not always followed. Sometimes, providers could not fill up the FECHS forms, for heavy



patient traffic. Usually, patients could not comply to the requirement of documentary evidence, because it was cumbersome. Moreover, patients complained that most of the times, aforementioned steps were a mere ritual – decisions were based on personal preference of the providers.

### User-provider relations

We identified that implementation of FECHS encountered with problems. In the Health posts and PHCC, the main problem was lack of medicines to cater to needs of increasing patient influx, aggravated by lack of HMIS forms and increased load on the health workers.

In the district hospital, some patients were denied FECHS despite their eligibility. At times, conflict erupted between health workers and users of their services. As medicines were insufficient to cater to increasing patient arrivals, some patients were denied partial or full removal of fees. Providers said that the situation compelled them to deny some patients with free medicines. This happened at two situations – one when medicines ran out of stock. Next, when an ineligible patient requested for consideration. In the latter, patients were “got rid of” under pretense of non-availability of medicines they required. Yet, some users would later discover that medicines were actually available. Then, a hot tussle between provider and user erupted.

However, patients and local people said that FECHS delivery mechanism was cumbersome. Obtaining documentary evidence of their age and economic status from respective VDC offices consumed some days, and the patient’s chances of obtaining FECHS were low.

A villager expressed his experience and opinion about FECHS delivery:

*If it goes this way, free service programme is bound to fail. You see, the patient is lying in hospital bed and health workers ask for proof of poverty, old age and disability. It takes as long as one week to gather any of these from VDC offices. In the meanwhile, who cares for the patient? It is cold and calculating, you know...government, if it is really determined to people’s health, should have guts to declare universally free services. If not, just don’t tease us, and retrogress to collection of fees...government is there not to make excuses but to get resources needed for free services, from wherever!”*

-A 50 year old man from Mahatgaon VDC

(also former member of district hospital development committee)

Others complained that the FECHS were offered to those favoured by providers in the hospital. One patient reported that he does not like to go to the hospital unless the disease is very severe because he was frustrated by denial of FECHS during last two visits:

*“I am very reluctant to go to hospital. But I was not so, my earlier experience made me so. For no obvious reasons, I was denied FECHS. At one time they said that I did not have proof of my economic status. Another time*

*they said that medicines were unavailable in the store. They always have excuses to ward you off. Frustrated from denial, I went to a medicine shop and bought medicines to treat my eye problem.”*

-A 48 year old man from KartikSwami VDC

The providers had their side of the story:

*“We are compelled to do so. Medicines are in short supply. Everyone asks for free medicines. We can’t say you don’t deserve. We say that you deserve but we don’t have the stuff in our store. That is how we turn them off to avert conflict.”*

-Focal person for FECHS

A clinical staff at the hospital claimed that he did not recommend patients for FECHS if they use tobacco or alcohol. He strongly argued that FECHS programme was a blunder:

*“...fee removal has invited quarrel between us and the patients. Government rejoices on this tussle...look, I don’t give free services to smokers, drinkers and their relatives. This is my style of controlling bad habits. Then the patients complain with other staff in the hospital. I snatch and throw their cigarettes in my attempt to make them healthy...Fee removal is a mistake. We have to quarrel with the patients over delivery of free services. So, it’s wise to stop FECHS programme.”*

-A clinical staff in the hospital

The users, lamented on the clinician’s behaviour. They described that he exploited his power to belittle and abuse them:

*“This person is a kid. He may have got high degree in medicine but it hardly does matter. He does not even know how to behave as a human. He is too charged with his education and power which he uses to humiliate us with derogatory language and gesture. Sometimes, he asks embarrassing questions about our individual life. Sir, we don’t go to the hospital to be punished. We go there for medical care. However, we need not endure this for long. He has been here for less than a year and will soon go away on his own. Most of the time, he is not in the hospital. So we usually need not avoid him. For us, he is a tourist, who either gambles with friends or frequently goes hiking with the beautiful nurse and a few NGO boys. Anyway, before long, he will return to city for higher study or profitable medical practice.”*

-A 30 year old married woman from Garjyangkot VDC

### Discussion

Organisation and delivery of health services by the district health care machinery was manifest as a culmination of complex relations between receiving and providing sides. DHO in Jumla confirmed to national health care machinery’s modus operandi whereby patients and their caretakers are passive recipients, while bureaucrats of health ministry and EDPs decide what is to be delivered to people and in what approach, based on their judgment of quantitative information received through several data generating systems (such as routine service delivery data,

periodic health surveys) that always don't reflect reality on the ground; their consensus of priorities and ideological belief; and often what is propelled by powerful international health players working at their headquarters level. Involving people and responding to their sensitivities is a rare phenomenon in Nepal's health care activities. (14) Insufficient number of health workers actually available at the facilities, inadequate supplies of medicines and related logistics, obligation to tread between people's needs, the interests of EDPs and NGOs, and constrained health management capacity on part of the DHO team have all boiled down to the mismatches between people's aspiration driven health care needs and limited delivery of health services. Observation made and deduction augmented with some intuitive thinking can lead us to note that there remains a substantial need to nurture an element of people first sensitivity among health workers and managers in DHO and the health facilities it manages.

On greener side of the fence, individual traits such as motivation of health workers are perceived to be a strong determinant of seamless delivery of services in some health facilities far-flung from district headquarters. Knowledge combined with a commitment to serve the best interests of people might have led to such exemplary performance. Such commitment might also have come because some health workers have a natural affinity to their district dwellers or village neighbours.

We identified turbulent relationship between health service users and providers as a product of several factors related to health care machinery itself, delivery mechanism of fee removal, health workers' coping strategies to machinery's pitfalls, and contextual realities of Jumla district.

One of the biggest problems was related with targeted approach to fee removal. It was observed that issues related to obtaining FECHS was manifest more in the district hospital, where a targeted approach was taken, than any other facilities, where blanket removal was effected. The machinery's compromise between duties and resources has obliged health workers to work through eligibility criteria set for accessing fee removed services by patients. Very often, health workers found it problematic, given the catering capacity of district hospital and their skills at handling denial of fee removal to some patients who might not have been sufficiently eligible. This could be interpreted as DHO's management limitation.

As a response to system's shortcomings, health workers would resort to short supply of medicines as an excuse to justify denial of fee removal to patients who might have qualified through the set of eligibility processes. Health workers appeared most comfortable to project the limited capacities of district health system to avert brewing up user-provider clash. Use of patient's "unhealthy" behaviours as weapons to impede them accessing fee removal is an example of hierarchical provider-user relationship which might have been acquired during medical education that dwells on traditional niche of delivering from teachers to students, in somewhat military-style top-down cultural ar-

chitecture of medical schools.

Jumla has been in no way aloof of growing level of people's awareness following several waves of democratisation of Nepali state. Intensification of this long evolved process into history, took effect in the last six decades –anti-oligarchy movement in 1950s (that ended with the fall of Rana regime), anti-Panchayat struggle (particularly student protests during 1970s and 1980s), multi-party demonstration of 1990, Maoist people's war between 1996 and 2006, and most importantly the massive people's movement of April 2006. This has encouraged assertiveness by people to their entitlements to state responsibilities, including health care. Jumli people were knowledgeable of emerging socio-political direction of the country. They were also cognisant of health care constitutionally enshrined as fundamental human right. Ultimately they became more encouraged to make use of health services, and thus increasing the influx at health facilities. Some well-off people at district headquarters might also have perceived that with little effort, they also might be considered for targeted fee removal, thus leading to some insistence despite ineligibility.

We conclude that involving people actively in delivery of health services would decrease likelihood that they feel left out and thus, smoothen user-provider relationship. Concurrently, health care machinery needs to be equipped with sufficient, trained and motivated health workers enabling it to cater in culturally appropriate manner. There are several other factors that have not been sufficiently unfolded by this study. To identify them and develop strategies to respond them, we recommend further work to explore user-provider interaction. Ethnographic methods may be used at facility setting and in communities where people, live, work, and attempt to seek health care to lessen their suffering produced of livelihood strategies.

### Acknowledgements

We thank the supervisors of this research – Amod K Poudyal (PhD), Professor, Institute of Medicine, Tribhuvan University; and Dr Mahesh K Maskey (DSc), Executive Chairperson, Nepal Health Research Council. They guided us in the conceptualisation and conduct of this work, and helped us reduce the methodological fallacies. Mary DesChene (PhD) provided technical advice during the design and conduct of the work. Dhundi R Sharma (PhD Cand.) provided technical input in conceptualisation and reporting of the work. Faculty members in the Department of Community Medicine and Public Health, Institute of Medicine provided technical input during the research.

### Contributions

AB and DA conceptualised and conducted the work. AB wrote the draft manuscript. DA revised and finalised it. Both AB and DA have approved the final version submitted for publication. Both AB and DA have read and adhere to ICMJE authorship requirements. AB is the guarantor.

### Ethical approval

Institutional Review Board, Institute of Medicine, Tribhuvan University, Kathmandu, approved the research proposal in 2008.

## Funding

German Technical Cooperation's Health Sector Support Programme (GTZ/HSSP) and World Health Organisation (through Nepal health Research Council) partially covered fieldwork expenses.

## Conflict of Interest

AB worked in the policy team at health minister's secretariat when user fees were removed. He translated, for the government, fee removal guidelines. We have no conflicting interest to declare. Funding agencies did not have access to findings of the work until final report was submitted; they did not influence the results.

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