Budget Analysis of Health Sector

Ministry of Health and Population

Policy Planning and Monitoring Division

Government of Nepal

November, 2020

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Study team
November 2020

EXECUTIVE SUMMARY

The Budget Analysis (BA) of Health Sector intends to enable the Ministry of Health and Population (MoHP), Department of Health Services (DoHS), policy makers, planners, programme managers and External Development Partners (EDPs) to understand the trend of budget for the five-year period and expenditure for four years from Fiscal Year (FY) 2016/17 to FY 2019/20. The expenditure of FY 2020/21 has not been included in the analysis. The BA also provides analysis of conditional grants provided to Provincial Government (PG) and Local Government (LG). The health conditional grant is distributed across all three levels of government, viz. the federal, provincial and local. A brief overview of the pattern of health budget allocation using conditional and other forms of grants at the provincial and local level is also included in this report. A dedicated chapter analysing budget and expenditure for FY 2019/20 for the Coronavirus Disease 2019 (COVID-19) response, and budget for FY 2020/21, is also included. For comparability purposes, macro-level indicators have been reported on since 2015. This analysis is performed using electronic Annual Work Plans and Budgets (eAWPBs), the Government of Nepal's (GoN's) Red Book (from FY 2016/17 to FY 2020/21), Financial Monitoring Reports (FMRs), the Transaction Accounting and Budget Control System (TABUCS) and conditional grants provided to LGs. The adjusted budgets of consecutive FYs have been used to capture final expenditures. For this reason, some minor changes compared to the previous BA report might be apparent. For FY 2020/21, the initial budget is used in the analysis.

Findings

Government spending on health as a share of Gross Domestic Product (GDP) has slowly increased from 1.4 per cent in FY 2015/16 to 1.8 per cent in FY 2018/19. Evidence suggests that countries should strive to spend five per cent of their GDP to progress towards Universal Health Coverage (UHC) (Mcintyre et al, 2017). The health sector budget (MoHP and other ministries) has gradually been increasing over the years from 49.8bn Nepalese Rupees (NPR) in FY 2016/17 to NPR 115.1bn in FY 2020/21. Between FY 2014/15 and FY 2018/19, the per capita government spending gradually increased in real terms from NPR 1072 to NPR 2,295 (10.8 United States Dollars (USD) to USD 20.2). However, in constant terms (base year fixed to FY 2000/01), the share of government spending increased very little within the same time, from NPR 394 (USD 4) to NPR 664 (USD 5.8). It is to be noted that Chatham House recommends that low-income countries spend USD 86 per capita to ensure universal access to primary care services (Mcintyre, 2014).

In FY 2020/21, the GoN has provided NPR 90.6bn as health budget, out of which MoHP received NPR 60.7bn (67%), PGs were allocated NPR 4.5bn (5%) and LGs were allocated NPR 25.4bn (28%). Seventy-five per cent of the health budget is allocated under programme headings. Fifty-seven per cent of the health budget is funded through government sources with only a per cent of the bilateral funding. Ninety per cent of the health conditional grant is budgeted for priority one programmes and 69 per cent of these programme activities directly contribute to women. Almost 41 per cent of the health budget is allocated as hospital grants, followed by 21 per cent in wages and salaries. The majority of the health budget under wages and salaries, support services and programme activities has been devolved to LGs. At the same time, the majority of the health budget for medicines, grants to hospital, capital construction and capital goods remains at the federal level. It is to be noted that 25 per cent of the health budget is allocated to physical infrastructure development and improvement.

Ninety-seven per cent of the budget for equipment remains at the federal level; almost half of this is allocated to purchasing medical equipment. Almost 39 per cent of the health budget allocated under free care is allocated to Maternal and Child Health (MCH), followed by treatment of target populations (37%). Vaccines, diluents and syringes occupy 23 per cent of budget under drug procurement, followed by procurement of COVID-19 medicines (20%)

The MoHP conditional grant increased by 64 per cent from NPR 39bn in FY 2019/20 to NPR 60.6bn in FY 2020/21, though the GoN's share is recorded to be the lowest since FY 2009/10 at 37 per cent. However, MoHP's budget absorption has declined as compared to the last four years to 79.8 per cent; this is nevertheless higher than the national absorption of 70 per cent. NRP 5.9bn was budgeted for COVID-19 under MoHP, out of which NPR 4.7bn was spent. This also includes budget provided to other line ministries active in COVID-19 response. MoHP alone was provide 54 per cent budget out of which only 67 per cent was absorbed. In FY 2020/21 NPR 6.1bn has been allocated for COVID-19. This analysis supports the fact that both PGs and LGs have started allocating budget towards the health sector using different resources, which suggests that the health sector budget is more than NPR 90.6bn. There are no policy directives that provide a basis for determining the volume of health conditional grants to PGs and LGs. Initial analysis and anecdotal evidence suggest that some Palikas delayed their assemblies and, as a result, the health conditional grant could not be transferred; new layers of delay have also been created at both federal and provincial levels in sending the budget to Spending Units (SUs) in a timely manner. The analysis raises important questions around allocative efficiency. A sizeable budget under programmes and procurement remains at the federal level, whereas the administrative budget has been allocated to PGs and LGs. Most of the budget for the procurement of free drugs has been provided to PGs and LGs.

Health is an important development agenda and it must therefore be included in all policies (at all levels of government). A coherent health policy that is acceptable to Federal, Provincial and Local Government would help in setting priorities in budget allocation. Evidence-based annual work planning and budgeting at all spheres of government needs to be harmonised through a comprehensive policy framework. This is important because the Constitution of Nepal has mandated 'concurrent rights' to all levels of government. In order to have a complete BA of PGs and LGs, a separate exercise is recommended. The MoHP must initiate the process of preparing a health sector transition plan, which will support in securing and allocating the resources required. In the devolved context, this could be additionally challenging, as the plans of Sub-national Governments (SNGs) may not be aligned with the GoN's/ National Planning Commission's (NPC's) priority areas. A costed Health Financing (HF) strategy that is applicable to all levels of government needs to be formulated. This strategy should set out the roadmap for achieving at least USD 86 per capita to improve access to primary care or spending five per cent of GDP to progress towards UHC. Finally, Health Accounts (HAs) applicable to Federal, Provincial and Local Government would be required to capture total health expenditure in the country.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AWPB	Annual Work Plan and Budget
BA	Budget Analysis
CG	Conditional Grant
COVID-19	Coronavirus Disease 2019
DDA	Department of Drug Administration
DoA	Department of Ayurveda
DoHS	Department of Health Services
DPHO	District Public Health Office
DTCO	District Treasury Comptroller Office
e-AWPB	electronic Annual Work Plan and Budget
EDP	External Development Partner
EHCS	Essential Health Care Services
FCGO	Financial Comptroller General Office
FCHV	Female Community Health Volunteer
FMIS	Financial Management Information System
FMR	Financial Monitoring Report
FWD	Family Welfare Division
FY	Fiscal Year
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GFS	Government Financial Statistics
GoN	Government of Nepal
HA	Health Account
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
I/NGO	International Non-governmental Organisation
IDA	International Development Association
IMCI	Integrated Management of Childhood Illness
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
LG	Local Government
LMBIS	Line Ministry Budget Information System
MCH	Maternal and Child Health
MoF	Ministry of Finance
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MTEF	Medium-term Expenditure Framework
NA	Not Applicable

NHSP-1	First Nepal Health Sector Programme
NHSP-2	Second Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NNRFC	National Natural Resource and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese Rupees
OAG	Office of the Auditor General
PBGA	Performance-based Grant Agreement
PFM	Public Financial Management
PFMSF	Public Financial Management Strategic Framework
PG	Provincial Government
PIP	Procurement Improvement Plan
PLMBIS	Provincial Line Ministry Budget and Information System
PMoSD	Provincial Ministry of Social Development
PPMD	Policy Planning and Monitoring Division
SDG	Sustainable Development Goal
SNG	Sub-national Government
SOP	Standard Operating Procedure
SU	Spending Unit
SuTRA	Sub-national Treasury Regulatory Application
SWAp	Sector-wide Approach
TABUCS	Transaction Accounting and Budget Control System
TB	Tuberculosis
TSA	Treasury Single Account
UHC	Universal Health Coverage
USD	United States Dollars
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

This chapter provides a brief background that sets out the current context of the health systems, objective of the budget analysis and methodology used.

1.1 Background

The Constitution of Nepal, 2015 mandates health as a fundamental right of the people (Government of Nepal (GoN), 2015). The National Health Policy, 2019, which comes under the overarching framework of the Constitution, aims to implement this right by ensuring equitable access to high-quality health care services for all (GoN, 2019). The Nepal Health Sector Strategy (NHSS) 2016–2021 lays out the strategic direction and specific roadmap to implement the constitutional mandate (GoN, 2016). The Ministry of Health and Population (MoHP) has endorsed the NHSS implementation plan, which provides the budgetary framework to ensure Nepal's commitment to achieve Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) by 2030. The recent initiative in localising SDGs has contributed to Sub-national Government (SNG) prioritising social indicators in their planning and budgeting. In this context, Nepal's health sector has an opportunity to have greater fiscal space through resource allocation from all spheres of governments.

All spheres of government aim to continue to improve their financial management and, in particular, the timely disbursement of funds to their SUs. The Public Financial Management Strategic Framework (PFMSF) 2020/21–2024/25, and Procurement Improvement Plan (PIP) 2017/18–2022/23 have been developed and subsequently implemented by the federal government. Their implementation has also improved the efficiency of resource allocation in the sector. These practices need to be implemented in both Provincial Government (PG) and Local Government (LG). Financial planning and budgeting provides the foundation for effective, efficient and high-quality service delivery. The annual budget reflects the policy and resource allocation decisions that determine the activities, programmes and services to be implemented by the MoHP. The integration of the Line Ministry Budget Information System (LMBIS) and electronic Annual Work Plan and Budget (e-AWPB) into the Transaction Accounting and Budget Control System (TABUCS) captures the budget and expenditure information of all of the MoHP's cost centres, making them easily available. The recent addition of a *chart of activity* module in TABUCS also provides the opportunity to capture health sector budget from SNG. The GoN has allocated conditional grant health budget to LGs and PGs for the past three and two Fiscal Years (FYs) respectively. In the last FY, the Federal Government made it a mandatory provision to use the Sub-national Treasury Regulatory Application (SuTRA) for planning and expenditure tracking at LGs. This analysis primarily captures the health budget channelled to MoHP and its Spending Units (SUs) in addition to the conditional grants provided to provincial and local levels. An attempt has been also made to capture the budget allocated to health from PGs' and LGs' internal sources.

1.2 Objectives of the Analysis

The purpose of this Budget Analysis (BA) is to enable the MoHP, Provincial Ministry of Social Development (PMoSD), LGs, External Development Partners (EDPs), policy makers and planners by providing disaggregated information on health sector budget for FY 2020/21. It also aims to provide the reader with a synthesis of the main features of budget allocations and comparisons with actual spending from the last four FYs by source, programme and disbursement level. Government spending on the response to Coronavirus Disease 2019 (COVID-19) will be a key feature of this year's BA.

The specific objectives of BA are as follows, to:

1. Analyse the health sector and MoHP budget for FY 2020/21;
2. Compare MoHP budget allocation and expenditure from FY 2016/17, FY 2017/18, FY 2018/19 and FY 2019/20;

3. Analyse the budget allocated under conditional grants to 753 local authorities, seven provinces and FMoHP for FY 2020/21;
4. Analyse budget allocation by PG and LG to health other than conditional grants;
5. Analyse budget and expenditure in responding to COVID-19 from Federal, Provincial and Local Governments; and
6. Prepare a policy recommendation based on the budget analysis.

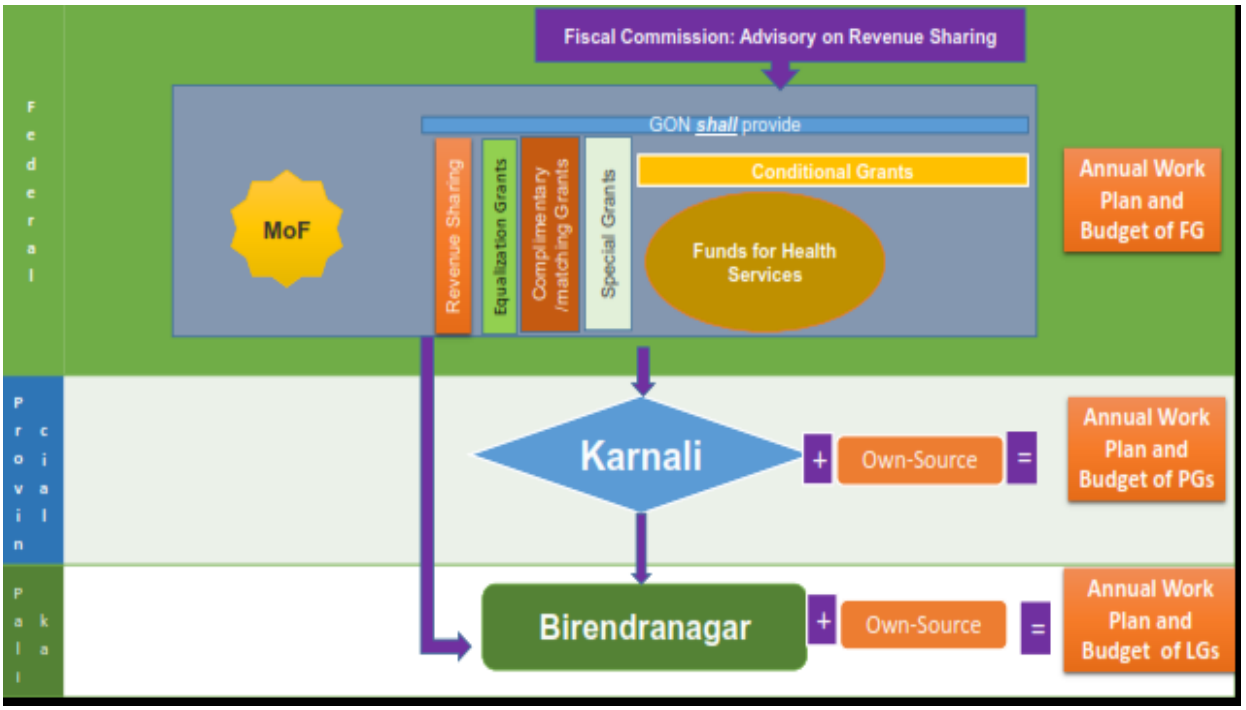
1.3 Methodology

The analysis of secondary data using the GoN's LMBIS, eAWPB, TABUCS and SuTRA from FY 2016/17, 2017/18, 2018/19 and 2019/20 has been carried out as outlined in Figure 1. For comparability purposes, macro-level indicators have also been reported since FY 2016/17. The main sources of information were obtained from the Federal and Local Government budget books. The task was performed in three phases:

1. Collect, review, organise and analyse budget and expenditure data
2. Conduct a workshop to validate data
3. Prepare the policy briefs.

This year's BA also reported on revenue generated by MoHP SUs and the audit status. This analysis also attempted to analyse the budget provided to the health sector using different sources at all spheres of government. Figure 1 demonstrates an optimum picture of the possibilities of allocating budget in health sector.

Figure 1: Example of Sources of Fund Available at all Spheres of Government



The adjusted budgets of consecutive FYs have been used to reflect the final expenditures. Some minor changes to these amounts are therefore possible if referring to the previous BA report. However, the total budget remains the same. For FY 2020/21, initial budget is used in the analysis. The analysis of conditional grants was carried out by collecting information from the Ministry of Federal Affairs and General Administration (MoFAGA). The data was compiled into standard templates, which then provided the platform for analysis. Technical consultations with the MoHP's planning section and discussions with the MoHP and the Department of Health Services' (DoHS's) planning and financial officials also provided useful comments, provincial health directorates, which have been incorporated into this report. It is to be noted

that budget and its execution started at PG from FY 2018/19 and LG from FY 2017/18. For the purpose of this analysis, we analysed the total budget and health budget at Federal, Provincial and Local Governments.

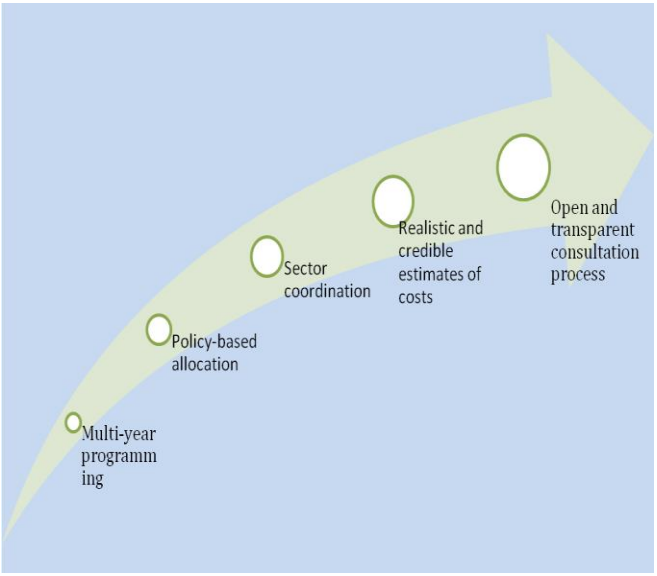
CHAPTER 2: PLANNING, BUDGETING AND EXPENDITURE PATTERN

This chapter provides some theoretical background on budget characteristics and the budget planning and preparation process at Federal, Provincial and Local Government level, and the underlying challenges in the changed context.

2.1 Budget Characteristics

The public sector planning and budgeting process is important in ensuring the proper implementation of fundamental rights, legal provisions, strategic plans and international commitments. In the public sector, budget is a primary instrument for strategic resource allocation. The way budget allocations are presented, organised and classified in policy and programmes has a direct impact on actual spending and ultimately on the performance of the health sector. Health budgets are formulated and executed based on goal-oriented programmes (rather than a list of inputs) to help to build better alignment between budget allocations, sectoral priorities and reform indicators.

From the perspective of Public Financial Management (PFM), robust public budgeting serves several important functions: it sets expenditure ceilings, promotes fiscal discipline and financial accountability and enhances efficiency in public spending. The key features of a well-functioning budgeting system typically include multi-year programming, policy-based allocation definition, sector coordination for budget formulation; realistic and credible estimates of costs; and an open and transparent consultation process.



The “health sector budget” refers to allocations to the MoHP, related authorities and other ministries involved in the delivery of health-related expenditure. Thus, a clear understanding of the core principles of health budgeting includes standardised processes, guidelines, systems, structures and professional planners. Nepal's commitment to achieving UHC and SDGs by 2030 largely depend on a dominant share of public funds. It is important to note that even increased resources for the health sector will not help achieve UHC and SDGs in the absence of well-functioning planning and budgeting systems.

2.2 Budget Preparation Process in FY 2020/21

2.2.1 Planning in FY 2020/21 at the federal level

The MoHP's Policy Planning and Monitoring Division (PPMD) is responsible for the entire planning process. Based on the budget ceilings provided by the Ministry Finance (MoF), the PPMD takes the lead role in preparing the budget details required for all departments, divisions, centres, hospitals and councils. The concerned departments are responsible for preparing the budget of the centres and divisions that function under them. The PPMD's Planning Unit reviews the draft budget from all departments, centres, hospitals and councils.

The MoF compiles the sectoral budgets and prepares the national budget with policy and programmes; announces it publicly through the budget speech; and submits the final budget to Parliament for endorsement. The Parliament endorses the budget of the coming FY and the Red Book is a budget authorisation. The provision for giving authorisation to SUs has formally been abolished by Parliament since FY 2017/18. Before the budget speech, the MoF locks the respective Annual Work Plan and Budget (AWPB) in the LMBIS. Approval of the budget also signals the approval of the AWPB in LMBIS and thus further authorisation by line ministries or departments is not required. The sequence of events by which national plans are developed by the MoHP within the framework of central government practice is as follows (see Table 2.1).

Table 2.1: Annual Calendar for Health AWPB

Date	Major activities
January	GoN's National Natural Resource Fiscal Commission (NNRFC) defines the overall budget for the country. This includes the budget for the MoHP and conditional grants to the PGs and LGs. As per the decision of the NNRFC, the MoF provides budget ceilings and guidelines for sectoral ministries.
January/February	PPMD of the MoHP allocates the budget ceiling for all departments, divisions, centres and hospitals based on priority, programmes, performance and actual expenditure. The MoHP asks for preliminary budgetary commitment from EDPs during the Joint Annual Review (JAR). MoHP organises four Joint Consultative Meetings (JCMs) per year with EDPs to discuss the budget and priority areas. EDPs make their official annual commitments to the MoHP at the fourth JCM.
March	MoHP's entities prepare their AWPBs based on their priorities and the previous year's budget. This also includes details of conditional grants to be provided to PGs and LGs. MoHP involves all EDPs and supporting stakeholders.
March	PPMD submits the compiled planning and budgeting to the MoF.
Towards end of March	Discussions at MoF. First JCM with EDPs.
April	In practice, the MoF calls the PPMD and concerned officials (individually and in a team) to discuss item-wise justifications on their planned budgeted lines with which they are dissatisfied. This is a crucial juncture where adjustments may be made to the budget by the MoF. In the last phase, the MoF invites the MoHP secretary, head of the PPMD, Planning Section, and Finance Section for a final hearing and finalisation of the plan and budget. Second and Third JCM with EDPs.
May – June	MoF compiles the sectoral budgets and prepares the national budget with policy and programmes. The Red Book is compiled, finalised and announced by Parliament by 29 May (15 Jestha). Fourth JCM with EDPs who make their commitments.

Date	Major activities
16 July	Start of the new FY

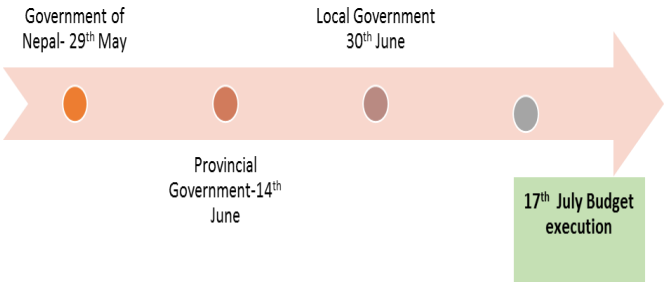
Source: MoHP, 2019

2.2.2 Planning in FY 2019/20 at PG level

In FY 2020/21, PGs were provided with NPR 4.60bn as a conditional grant through the Red-Book, channelled through MoFAGA. The MoHP and the DoHS gave support in planning and budgeting the conditional grant activities. The PG budget included in the Red Book does not need further authorisation. PGs have to announce their budget by 14 June (31 Jestha). The MoF sends a circular through its website to all District Treasury Comptroller Offices (DTCOs) to release the first quarter budget as per the Red Book, irrespective of type of grant (equalisation or conditional grant). The PMoSD prepares the social sector budget, including the health budget.

The health budget for PGs can include different types of fiscal transfers (revenue transfer, equalisation, conditional, special and matching funds) from Federal Government, including their own revenue and foreign sources. Their budget should be executed by 16 July.

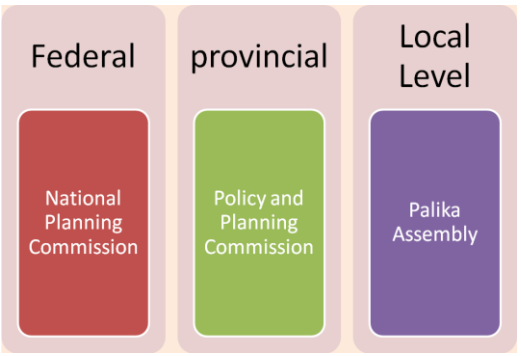
2.2.3 Planning in FY 2020/21 at LG level



In FY 2020/21, LGs were provided with NPR 25.4bn as conditional grants through the Red Book; these funds are channelled through the Red Book. The LG budget included in the Red Book does not need further authorisation. The MoF sent a circular through its website to all DTCOs to release the first quarter budget as per the Red Book, irrespective of type of grant (equalisation or conditional grant). The health budget for LG can include different types of fiscal transfers (viz. revenue transfer, equalisation, conditional, special and matching funds) from Federal and Provincial Government, including their own revenue and foreign sources. The LGs should finalise their budget by mid-July (end of Ashad) and budget execution should start from the 16 of July (Shrawan 1).

2.3 Budget Preparation Process and Issues in the Changing Context

Planning and budgeting functions often operate in parallel in the Nepalese context. In practice, planners are only involved in planning while budget implementers (finance officers) are only involved in keeping expenditure records. This separation has been a major issue during the first and second Nepal Health Sector Programmes (NHSP-1 and NHSP-2) and the early stages of NHSS implementation. In the changed context, budget preparation and endorsement at different levels of government are performed through the commissions and Palika assemblies as shown in Figure XX. The MoHP still needs to address these issues by better aligning its policy priority and actual expenditures with budgets. Some of the challenges that still persist with planning and budgeting in the health sector include:



- Aligning or harmonising exclusive functions of Federal, Provincial and Local Governments;
- Defining concurrent planning and budgeting functions in terms of system, organisation and people;
- Developing and harmonising health policy and priorities at all levels of government;
- Re-aligning the health strategy, plan and budget across Federal, Provincial and Local Governments;
- Developing and harmonising a consistent health planning cycle at all spheres of government;
- Standardising the Medium-term Expenditure Framework (MTEF) applicable to all levels of government;
- Determining the health budget and programmes that are consistent with national and international commitments at all levels of government;
- Enhancing the capacity of officials engaged in planning at all levels of government; and
- Standardising the budget and expenditure tracking system at federal, provincial and local levels.

CHAPTER 3: ANALYSIS OF MACRO INDICATORS FOR HEALTH SECTOR (FY 2020/21)

This section provides a snapshot of the country's macroeconomic status and investment in the health sector through the analysis of share of GDP in health, government health expenditure, per capita national health expenditure, and budget directly reaching the household. For the purpose of clarity, health sector budget is defined as health budget allocated to the MoHP, MoFAGA and other line ministries. The following analysis does not provide definitive reasons for trends, but does try to elucidate potential reasons for some of the findings.

3.1 Trends in Health Budget Allocation and Expenditure against GDP

Table 3.1 shows GDP, National, Provincial and Local budget, and budget for health sector disaggregated, including expenditure for the same from FY 2016/17 to FY 2020/21. Health budget includes the budget for Federal Government (MoHP) and conditional grants to Provincial and Local Governments.

Table 3.1: GDP, Budget, Health Budget and Absorption (NPR Billion)

Categories	2016/17	2017/18	2018/19	2019/20	2020/21*
GDP	2,674.5	3,044.9	3,458.8	3,767.0	4,008.1
Budget					
National	1,048.9	1,279.0	1,315.2	1,533.0	1,474.6
Provincial	NA	7.1	113.4	99.8	99.9
Local	NA	225.1	195.1	213.8	262.8
Health Sector Budget	**49.8**	**56.5**	**65.3**	**78.4**	**115.1**
Health Budget	41.6	46.9	51.7	65.1	90.6
MoHP budget	41.6	31.8	29.4	39.0	60.7
Provincial health budget	NA	NA	4.2	4.9	4.6
Local health budget	NA	15.1	18.2	21.2	25.4
Expenditure					
National	837.2	1,087.3	1,110.5	1,073.4	NA
MoHP budget	39.1	27.4	24.5	31.1	NA
Provincial health budget	NA	NA	3.8	4.2	NA
Local health budget	NA	14.1	17.7	17.5	NA
Absorption Rate (%)					
National	79.8	85.0	84.4	70.0	NA
MoHP	93.9	86.1	83.4	79.7	NA
Provincial health budget	NA	NA	92.0	85.7	NA
Local health budget	NA	93.5	97.5	82.6	NA
Estimated Population	**27,954,441**	**28,331,826**	**28,714,305**	**29,101,948**	**29,494,825**

Source: *GDP for all year from National Accounts 2019/20, Central Bureau of Statistics; for FY 2020/21, GDP estimates taken from Macroeconomic Update, Nepal, Volume 7, No.1, April 2020, Asian Development Bank; Budget: Red Book FY 2016/17-FY 2020/21; Absorption rate: MoHP: TABUCS/FMR, authors' estimate for PG and LG*

In FY 2020/21, the GoN allocated NPR 115.1bn to the health sector, of which the health conditional grant to MoHP makes up NPR 60.7bn, NPR 4.6bn is allocated to PGs and NPR 25.4bn to LGs (NPR 90.7bn in total). NPR 30.7bn is allocated to line ministries other than health. There has been a steady rise in both

health sector and health budget over recent years: in absolute terms, from NPR 37.2bn in FY 2015/16 to NPR 68.8bn in FY 2019/20 (see Table 3.1). However, proportional allocation of health conditional grants to PGs and LGs actually decreased as compared to FY 2019/20, standing at five and 20 per cent respectively (compared to seven and 32 per cent).

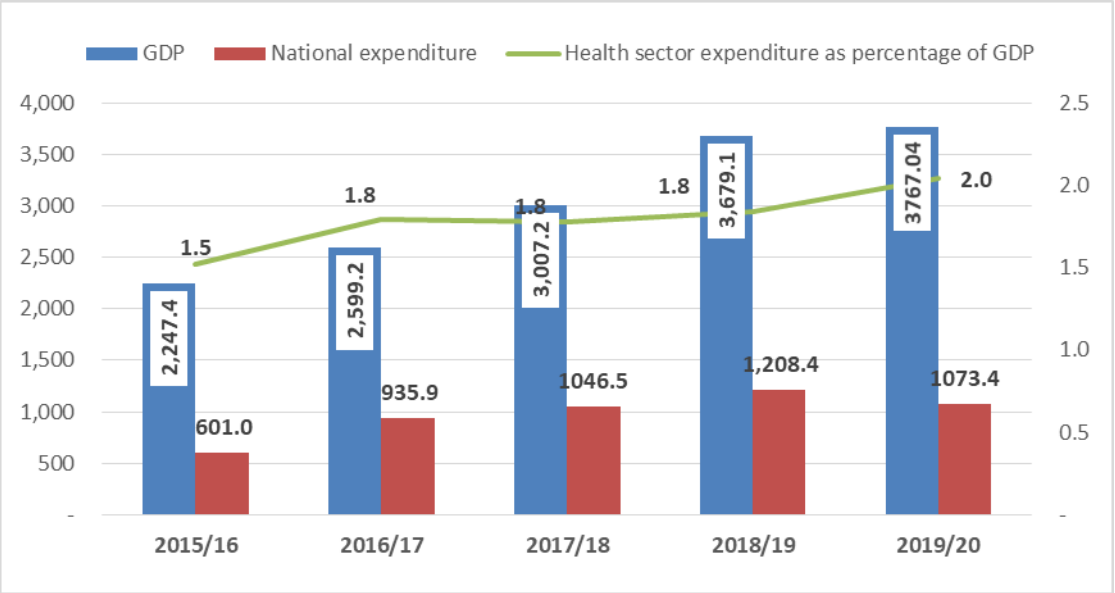
The MoHP absorption rate in FY 2019/20 was observed to be the lowest of the last four FYs, at 79.8 per cent; this is nevertheless higher than the national budget absorption rate of 70 per cent. The actual budget absorption for MoHP is even worse when compared to the initial budget allocation of NPR 42.7bn. MoHP has surrendered some budget to MoF to be rechannelled/reallocated to fund conditional grant activities to SNG and for COVID-19 response. MoHP's weaker absorption could be attributed to the onset of COVID-19 and weak planning and procurement planning. At the same time, both PGs and LGs absorbed 80 to 85 per cent of the conditional grant.

3.2 Trends in Government Health Conditional Grant Expenditure

Figure 3.1 provides an indication of the trend of government health spending as a percentage of GDP. Over the years, government spending on health as a share of GDP has risen from 1.5 per cent in FY 2015/16 to 2 per cent in FY 2019/20. Government spending on health includes budget allocated to MoHP and other line ministries[1].

[1] Other line ministries include the MoF, Ministry of Commerce and Supply, Ministry of Defence, Ministry of Home Affairs, MoFAGA, Ministry of Education, and Ministry of Local Development.

Figure 3.1: Trend on Government Health Spending as a Percentage of GDP (NPR Billion)



Source: Red book FY 2015/16–19/20

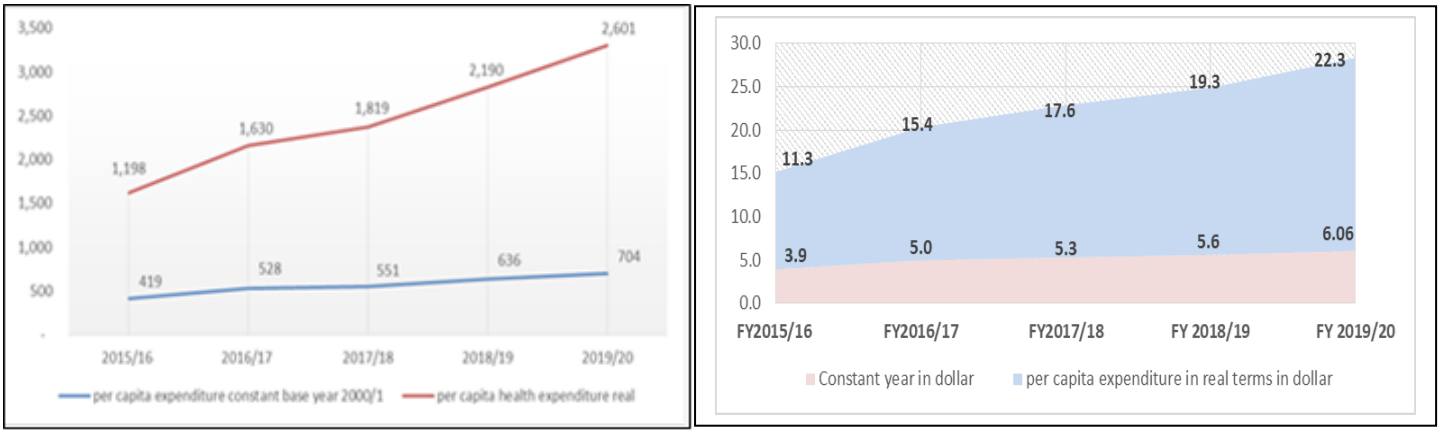
Government health expenditure as a percentage of GDP has remained stagnant for three consecutive FYs, with a sudden jump of 0.2 percentage points in FY 2019/20. There is a 0.6 percentage-point increase compared to the NHSS baseline year (1.4% for FY 2014/15). The Chatham House report issued in 2014 recommended that countries should strive to spend five per cent of their GDP to progress towards Universal Health Coverage (UHC) (Mcintyre, 2014), a figure that is supported by a wide range of evidence and comparisons across countries. The 2010 World Health Report stated that public spending of about six per cent of GDP on health would limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible (WHO, 2010). Government spending on health of more than five per cent of GDP is required to achieve a conservative target of 90 per cent coverage of Maternal and Child Health (MCH) services (Mcintyre *et al*, 2017). This means that Nepal has been investing far less in health as a share of GDP to achieve UHC.

3.3 Per Capita Government Health Expenditure

In real terms, per capita government spending has gradually increased from NPR 1,198 (USD 11.3) in FY 2015/16 to NPR 2,601 (USD 20.2) in FY 2019/20. However, in constant terms (base year fixed to FY 2000/01), within the same time period, per capita government health spending has increased very little, from NPR 419 (USD 4) to NPR 704 (USD 6).

Figure 3.2: Per Capita Health Spending in Real and Constant Terms

(NPR) **(USD)**



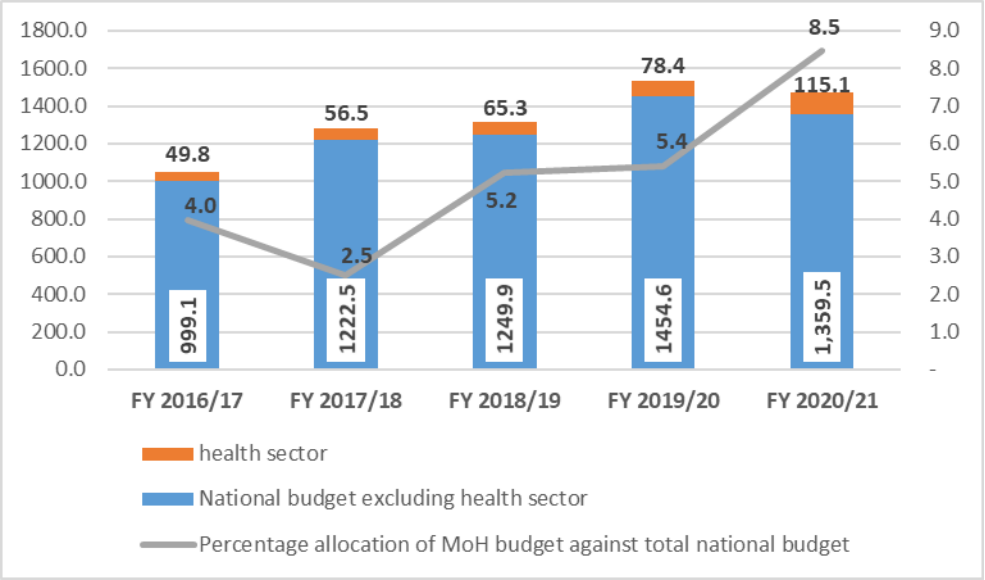
Source: Red book FY 2014/18–18/19, Population projection obtained from Health Management Information System (HMIS)

In FY 2019/20, per capita health expenditure also includes expenditure from PGs' and LGs' own sources in addition to conditional grants. The Chatham House report, including recent evidence, recommends that low-income countries spend USD 86 per capita to promote universal access to primary care services (Mcintyre, 2014). This shows that Nepal is spending far less than the recommended amount to achieve universal access to primary care services.

3.4 Share of Health Sector Budget out of Total Government Budget

Figure 3.3 shows trend in the health sector budget as a percentage of the national budget. As indicated by the figure, the volume of the health sector budget has more than doubled from NPR 49.8bn in FY 2016/17 to NPR 115.1bn in FY 2020/21. Between FY 2017/18 and FY 2020/21, the share of the health sector budget against total national budget has increased by almost six percentage points. In FY 2017/18, a slight decrease was observed in percentage allocation of the health sector budget against national budget compared to FY 2016/17, which was mainly because of reconstruction priorities after the earthquake. The NHSS sets a target of 10 per cent for 2020/21. This means that the health sector has not been able to meet the NHSS target in terms of allocation against the national budget.

Figure 3.3: Percentage of National Budget Allocated as Health Conditional Grant (NPR Billion)



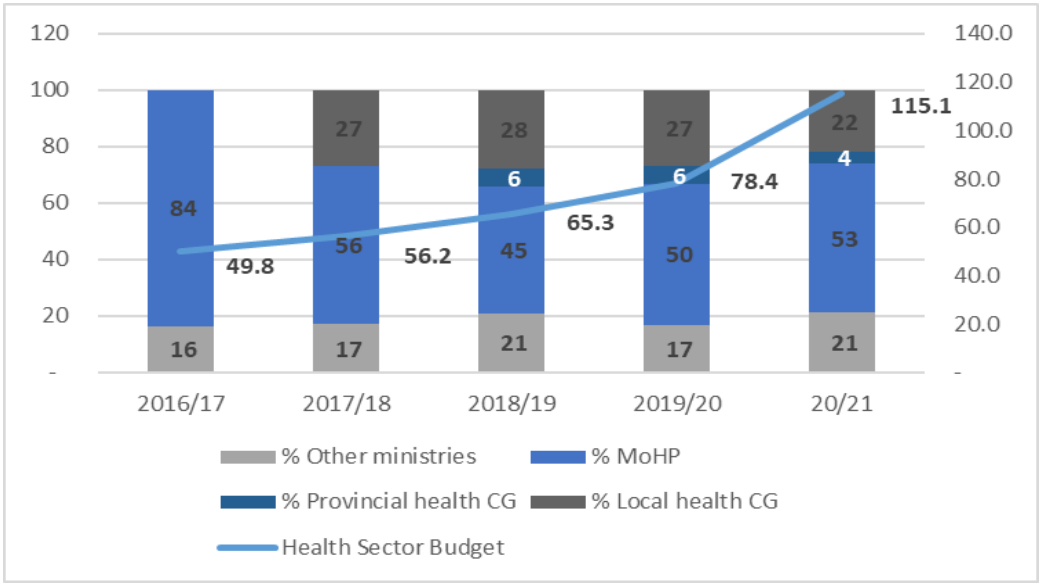
Source: GoN, Red Book, FY 2016/17–2020/21

Note that the health conditional grant includes budget allocated to MoHP, PG, LG and health budget for other line ministries. In the above figure, the total national budget is obtained by adding national budget and health sector budget together.

3.5 Health Sector Budget

Figure 3.4 shows a stacked graph with percentage distribution of the health sector budget across MoHP, other ministries and conditional grants to PGs and LGs from FY 2016/17 to FY 2020/21. The line graph shows health sector budget in absolute figures.

Figure 3.4 Composition of Health Sector Budget (NPR Billion)



Source: GoN, Red Book, FY 2014/15-2018/19

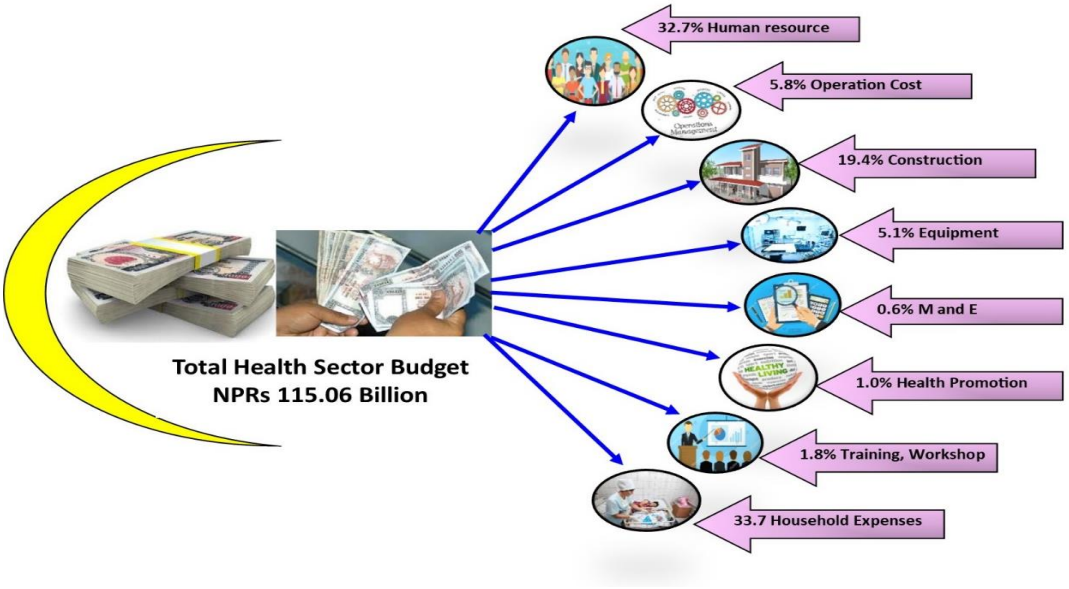
The health sector budget in actual terms has been on a gradual rise, from NPR 49.8bn in FY 2016/17 to NPR 115.1bn in FY 2020/21. This results from the increase in health budget, especially for other ministries, from 16 to 21 per cent. Compared to FY 2019/20, proportional allocation of conditional grants to PGs has

decreased by two percentage points, and LGs by five percentage points, while that allocated to MoHP has increased by three percentage points.

3.6 Distribution of Health Sector Budget by Support Functions and Actual Services (FY 2020/21)

Figure 3.5 provides a breakdown of the health sector budget by support function and actual services. Less than 35 per cent of the budget is actually allocated for services that directly reach the household.

Figure 3.5 Health Sector Budget by Support Function and Actual Service



This section is an attempt to analyse the government spending on health excluding off-budget off-treasury and private sector contributions. Furthermore, this analysis does not take into account local resources allocated to health by PGs and LGs through fiscal transfers and internal revenue.

CHAPTER 4: HEALTH CONDITIONAL GRANT ANALYSIS FOR FY 2020/21

This chapter starts with an analysis of the health conditional grant at federal (MoHP), PG and LG levels. This excludes both the NPR 24.5bn provided to other federal ministries for health and health budget allocation from PGs and LGs using their own resources. The following analysis does not provide definitive reasons for trends but does try to elucidate potential reasons for some of the findings.

4.1 Health Conditional Grant by Capital and Recurrent heading to at Federal, Provincial and Local Government

Health budget to Provincial and Local Governments is provided in the form of conditional grants. Details of health conditional grant activities provided to PGs and LGs can be found at www.mofaga.gov.np. Eighty-three per cent of health budget is allocated under recurrent headings, which also includes conditional grants to SNGs (see Table 4.1). It is important to note that conditional grants allocated to SNGs is accounted as a recurrent expense in the Red Book.

Table 4.1: Capital and Recurrent Health Budget Allocation by Federal, Provincial and Local Government

Budget type	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Recurrent	45,411	4,530	25,411	75,352	83
Capital	15,268	-	-	15,268	17
Total	60,679	4,530	25,411	90,620	100

4.2 Health Conditional Grant by Programme and Administrative Heading at at Federal, Provincial and Local Government

Seventy-five per cent of health budget is allocated under programme headings. Almost 76 per cent of the administrative budget sits with LG and 82 per cent of programme budget still remains at the federal level (see Table 4.2).

Table 4.2: Health Budget Allocation under Administrative and Programme Headings by Federal, Provincial and Local Government

Budget type	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Administrative	5,070	488	17,536	23,094	25
Programme	55,609	4,042	7,875	67,527	75
Total	60,679	**4,530**	**25,411**	**90,620**	**100**

4.3 Health Conditional Grant by Source of Funds (GoN and EDP) at Federal, Provincial and Local Government

Fifty-seven per cent of health budget is funded through government sources. Almost 50 per cent of government budget is spent on funding LG health activities; this budget constitutes almost the sole source of funds to them (see Table 4.3). Almost all EDP budget still sits at the Federal Government.

Table 4.3: GoN and EDP Health Budget Allocation by Federal, Provincial and Local Government

Source of fund	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
GoN	21,470	4,206	25,410	51,086	57
EDP	39,209	324	1	39,534	43
Total	**60,679**	**4,530**	**25,411**	**90,620**	**100**

4.4 Health Conditional Grant by GoN, Bilateral, Multilateral, and I/NGO at Federal, Provincial and Local Government

Fifty-seven per cent of health budget is funded through government sources, followed by 29 per cent through multi-lateral and 13 per cent through International Non-governmental Organisation (I/NGO) sources (see Table 4.4). Only one per cent of the health budget is funded through bilateral sources. Other than the GoN, I/NGOs are the only external source of funding available at the local level.

Table 4.4: GoN, Bilateral, Multilateral and I/NGO Health Budget Allocation by Federal, Provincial and Local Government

Source of fund	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
GoN	22,364	4,206	25,410	51,980	57
Bilateral	724	42	-	766	1
Multilateral	26,147	3	-	26,150	29
I/NGOs	11,444	279	1	11,724	13
Total	**60,679**	**4,530**	**25,411**	**90,620**	**100**

4.5 Health Conditional Grant by Priority at Federal, Provincial and Local Government

Ninety per cent of health budget is allocated to funding priority one programmes. Almost 96 per cent of LG health budget is funded through government sources, followed by 29 per cent from multi-lateral and 13 per cent from I/NGO sources. Only one per cent of the health budget is funded through bilateral sources. Other than GoN, I/NGO's are the only external source of funding available at the local level.

Table 4.5: Health Conditional Grant by Priority at Federal, Provincial and Local Government Levels

Priority	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Priority one	53,446	3,949	24,331	81,726	90
Priority two	7,233	581	1,080	8,894	10
Total	60,679	**4,530**	**25,411**	**90,620**	**100**

4.6 Health Conditional Grant by Contribution to Women at Federal, Provincial and Local Government

Sixty-nine per cent of health budget is allocated to funding programmes that directly contribute to women. Almost 58 per cent of programmes that directly contribute to women sit at the federal level.

Table 4.6: Contribution of Health Budget Allocation to Women by Federal, Provincial and Local Government

Category	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Direct contribution to women	36,015	3,111	23,536	62,661	69
Indirect contribution to women	24,664	1,419	1,876	27,959	31
Total	60,679	**4,530**	**25,411**	**90,620**	**100**

4.7 Allocation of Health Conditional Grant by Line-item at Federal, Provincial and Local Government

Table 4.7 summarises health budget provided to the FG, PGs and LGs. Almost 41 per cent of health budget is comprised of hospital grants, followed by wages and salaries (21%) and capital construction (16%).

Table 4.7: Line-item-wise Allocation of Health Budget by Federal, Provincial and Local Government

Line item (economic code)	Allocated budget (NPR million)				
	Federal	Provincial	Local	Amount	%
Wages and salaries	547	489	18,314	19,349	21.4
Support services	2,189	283	130	2,602	2.9
Capacity building	122	462	112	696	0.8
Programme activities	3,958	1,484	4,038	9,480	10.5
Medicine purchases	4,031	642	986	5,659	6.2
Grants to hospitals	34,565	928	1,650	37,143	41.0
Capital – construction	14,562	60	86	14,709	16.2
Capital – goods	706	182	96	984	1.1
Total	**60,679**	**4,530**	**25,411**	**90,620**	**100**

Programme activity occupied only 10 per cent of the health budget. Ninety-seven per cent of the budget for wages and salaries, 82 per cent for capacity building and 58 per cent for programme activities have been devolved to SNG. At the same time, the majority of the health budget for medicines, hospital grants, capital construction and capital goods remains at the federal level (71%, 93%, 99% and 72% respectively). It is interesting to note that almost 42 per cent of the health budget still sits at the federal level. The key health budget driver for LGs is wages and salaries (72%), followed by programme activity (16%) and grants to hospital (6.5%). Similarly, for PG,s key health budget drivers are programme activities (33%), followed by grants to hospital (20%) and purchasing medicine (14%). Wages and salaries accounted for 11 per cent of

the health budget. At the same time, grants to hospitals (57%), capital construction (24%) and purchasing medicine (6.6%) remain the top three drivers of health budget at the MoHP.

4.8 Cluster-wise Allocation of Health Conditional Grant at Federal, Provincial and Local Government

By cluster-wise allocation, almost 25 per cent of the health budget is spent on physical infrastructure development and improvement followed by 23 per cent on office operation and administrative expenses almost 12 per cent on social health protection services, 11 per cent on MCH services and 10 per cent on communication and infectious disease control services. No health budget under laboratory & diagnostics, health research & survey and population health services.

Table 4.8: Cluster-wise Allocation of Health Budget by Federal, Provincial and Local Government (NPR Million)

Cluster	Federal	Provincial	Local	Total	%
Office operations and administrative expenses	4,621	2	16,580	21,203	23.4
Reproductive and safe motherhood services	1,282	1,187	2,399	4,868	5.4
Immunisation, child treatment and nutrition	3,278	1,026	825	5,128	5.7
Female Community Health Volunteers (FCHVs) and community health	305	187	2,085	2,577	2.8
Communicable and infectious disease control	8,060	486	594	9,139	10.1
Epidemic and disaster management	585	61	3	649	0.7
Non-communicable disease (NCD)	1,760	107	69	1,936	2.1
Human organ transplant and eye health	500	0	0	500	0.6
Social health protection services	10,251	184	11	10,445	11.5
Laboratory and diagnostic services	440	-	-	440	0.5
Human Resources (HR) management	1,102	52	-	1,154	1.3
Health education and information	113	53	177	343	0.4
Ayurveda and alternative medicine	219	488	956	1,663	1.8
Drug-related regulation, purchase and supply	1,958	341	987	3,287	3.6
Health research and surveys	199	-	-	199	0.2
Physical infrastructure development and improvement	22,340	50	20	22,410	24.7
Other health services	12	3	39	54	0.1

Good governance management	229	305	537	1,071	1.2
Academy and hospitals	3,406	-	130	3,536	3.9
Population health services	18	-	-	18	0.0
Total	**60,679**	**4,530**	**25,411**	**90,620**	**100.0**

The majority of the budget under office operation and administrative expenses, FCHVs and community health, reproductive and safe motherhood services, health education and Ayurveda, is allocated to LG. At the same time, the majority of the budget under communicable and infectious disease control, NCDs and epidemic and disaster management is allocated at federal level. Almost all budget under physical infrastructure is allocated to Federal Government, including HR management. The three main cost drivers at LGs are office operation and administrative expenses (65%), followed by MCH (13%) and FCHVs and community health programme (8%). Similarly, the three major cost drivers at PG are MCH (49%), communicable and infectious disease control (11%) and Ayurveda (11%). The three major drivers for MoHP budget are physical infrastructure (37%), followed by social health protection services (17%), and communicable and infectious disease control (13%).

4.9 Drug Procurement from Health Budget at Federal, Provincial and Local Government

Vaccines, diluent and syringes occupy 23 per cent of budget under drug procurement, followed by procurement of COVID-19 medicines (20%) and free care drugs and supplies (19%). MoHP is solely responsible for the purchase of lab kit, rabies, antimalarials, lymphatic filariasis, anti-snake venom, and ophthalmic and COVID-19 drugs. Similarly, the purchase of leprosy drugs is only allocated to PGs. The majority (70%) of procurement of free health drugs and supplies remains at the local level. At the same time, the majority of MCH drugs and supplies (78%) and Integrated Management of Newborn and Childhood Illness (IMNCI) drugs and supplies (60%) remain at the provincial level.

Table 4.9: Drug Procurement from Health Budget by Federal, Provincial and Local Government

Drug-related activities	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Ayurveda and alternative medicine	7	-	-	7	0
Procurement of free drugs and supplies	212	211	986	1,409	19
Vaccines, diluents and syringes	1,720	25	-	1,744	23
MCH drugs and supplies	7	23	-	30	0
Nutritional drugs and supplies	400	250	-	650	9
IMNCI drugs and supplies	40	61	-	101	1
FP commodities	221	18	-	239	3
HIV/AIDS drugs	496	16	-	512	7
Tuberculosis (TB) drugs and supplies	644	1	-	645	9
Leprosy drugs	-	4	-	4	0
Lab kit/reagent/chemicals	230	-	-	230	3

Lymphatic filariasis drugs	21	-	-	21	0
Malaria (rapid diagnostic test kit, antimalarial drugs and supplies)	129	-	-	129	2
Rabies vaccine	160	-	-	160	2
Anti-snake-venom drugs	50	-	-	50	1
Epidemic- and disaster-related drugs	30	33	-	63	1
COVID-19	1,509	-	-	1,509	20
Ophthalmic drugs	8	-	-	8	0
Total	**5,883**	**642**	**986**	**7,511**	**100**

At local level, the only cost driver is free health care drugs and supplies. At provincial level, the major cost drivers are the purchase of nutritional drugs and supplies (39%) followed by free health care drugs (33%). At the federal level, 29 per cent of drug-related health budget is allocated on the purchase of vaccines, diluents and syringes, followed by the purchase of COVID-19 drugs (25.6%) and supplies and TB drugs and supplies (11%).

4.10 Equipment Procured from Health Budget by Federal, Provincial and Local Levels

Table 4.10 presents equipment categories budgeted from health budget at three levels. Ninety-seven per cent of the budget for equipment purchase remains at the federal level, with almost negligible allocations for LG. Almost 47 per cent of the equipment budget is budgeted for procuring medical equipment, followed by equipment required for COVID-19 (29%). At the provincial level, some budget is allocated for the purchase of MCH, TB diagnostics, radiology/imaging and medical equipment. Only medical equipment is purchased at all three spheres of the government. Major cost drivers for Federal Government include medical equipment (47%), COVID-19 equipment (29%) and cold chain equipment (3.9%). At the same time, key drivers for PG include radiology/imaging (66%) and medical equipment (26%).

Table 4.10: Equipment Procured from Health Budget by Federal, Provincial and Local Levels

Equipment categories	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Cold chain	204	-	-	204	3.8
MCH	20	12	-	32	0.6
FP	22	-	-	22	0.4
TB diagnostics	25	3	-	29	0.5
Laboratory	82	-	-	82	1.5
Radiology/imaging	183	120	-	303	5.6
Medical	2,443	47	5	2,495	46.5
Cancer	267	-	-	267	5.0
Cardiac, thoracic and vascular	96	-	-	96	1.8
Human organ transplant	58	-	-	58	1.1

Neuroprosthetics	20	-	-	20	0.4
Ophthalmic and Ear Nose and Throat (ENT)	21	-	-	21	0.4
Trauma	117	-	-	117	2.2
Orthopaedic	10	-	-	10	0.2
Computers/printers/ photocopiers	65	-	-	65	1.2
COVID-19	1,500	-	-	1,500	27.9
Other equipment[2]	49	-	-	49	0.9
Total	**5,182**	**182**	**5**	**5,369**	**100**

4.11 Budget Allocation for Free Care at Federal, Provincial and Local Government

Almost 39 per cent of the health budget allocated under free care/treatment is spent on MCH followed by treatment of target population (36%) and free health care (10%).

Table 4.11: Budget Allocation for Free Care/Treatment at Federal, Provincial and Local Government

Free health care/treatment	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
MCH	390	745	1,623	2,758	38.5
Reproductive Health (RH)	222	-	-	222	3.1
Food for patients	51	4	-	55	0.8
Free health care	557	89	61	707	9.9
Health camp	311	-	-	311	4.3
Eye treatment	16	-	-	16	0.2
Cancer (screening/treatment)	14	-	-	14	0.2
Heart treatment	511	-	-	511	7.1
HIV/AIDS lab test/treatment	-	5	-	5	0.1
TB treatment	1	1	-	2	0.03
Leprosy services	-	10	6	16	0.2
Treatment for target populations	2,548	-	-	-	35.6
Total	**4,621**	**854**	**1,691**	**7,165**	**100**

All budget related to free treatment of heart-, eye-, cancer- and RH-related problems, health camps and treatment of target populations is allocated only at the federal level. At the same time, all of the budget

[2] Other equipment includes generators, laundry machines, transformers, equipment related to Good Manufacturing Practice (GMP) upgrade etc.

related to HIV/AIDS testing and treatment is allocated to PGs. None of the budget under leprosy is allocated to FG. Similarly, no budget for TB treatment is allocated to LG; HIV testing and AIDS treatment is allocated to FG and LGs.

4.12 Health Budget Allocation under Programme Code at Federal, Provincial and Local Government

Table 4.12 provides detailed activities included in the programme code. This table intends to highlight likely errors in programme planning. Activities that are grouped under programmes actually fall under different codes. Almost 76 per cent of programme activities is occupied by COVID-19 allowance, followed by skills development and awareness training (18%) and miscellaneous programme expenses (2.5%).

Table 4.12: Programme Budget by Federal, Provincial and Local Government

Programme activities (22522)	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
COVID-19 allowance	3,000			3,000	75.7
Insurance and renewal	5			5	0.1
Operation and maintenance of machinery and tools	6			6	0.2
General office expenses	7			7	0.2
Newspaper, printing and information publication	19			19	0.5
Consultancy and services contracts	24			24	0.6
Information systems and software operation	2			2	0.1
Contract services fees	1			1	0.01
Skills development and awareness training	279	242	179	700	17.7
Miscellaneous programme expenses	7	3	91	101	2.5
Monitoring and evaluation expenses	15			15	0.4
Travelling expenses	2			2	0.05
Miscellaneous expenses	1			1	0.02
Unconditional social assistance	3			3	0.1
Procurement of drugs and supplies	10			10	0.3
Plant and machinery	64			64	1.6
Furniture and fixtures	1			1	0.01
Procurement and development of software	6			6	0.1
Total	**3,451**	**245**	**270**	**3,966**	**100**

4.13 Unbundling Hospital Grant by line item allocation at Federal, Provincial and Local Government

Table 4.13 provides unbundling of hospital grant by line item. Thirty-six per cent of the hospital grant is allocated as hospital grants, followed by capital goods (21%) and wages and salaries (19%). Nineteen per cent of hospital grants is allocated to SNGs.

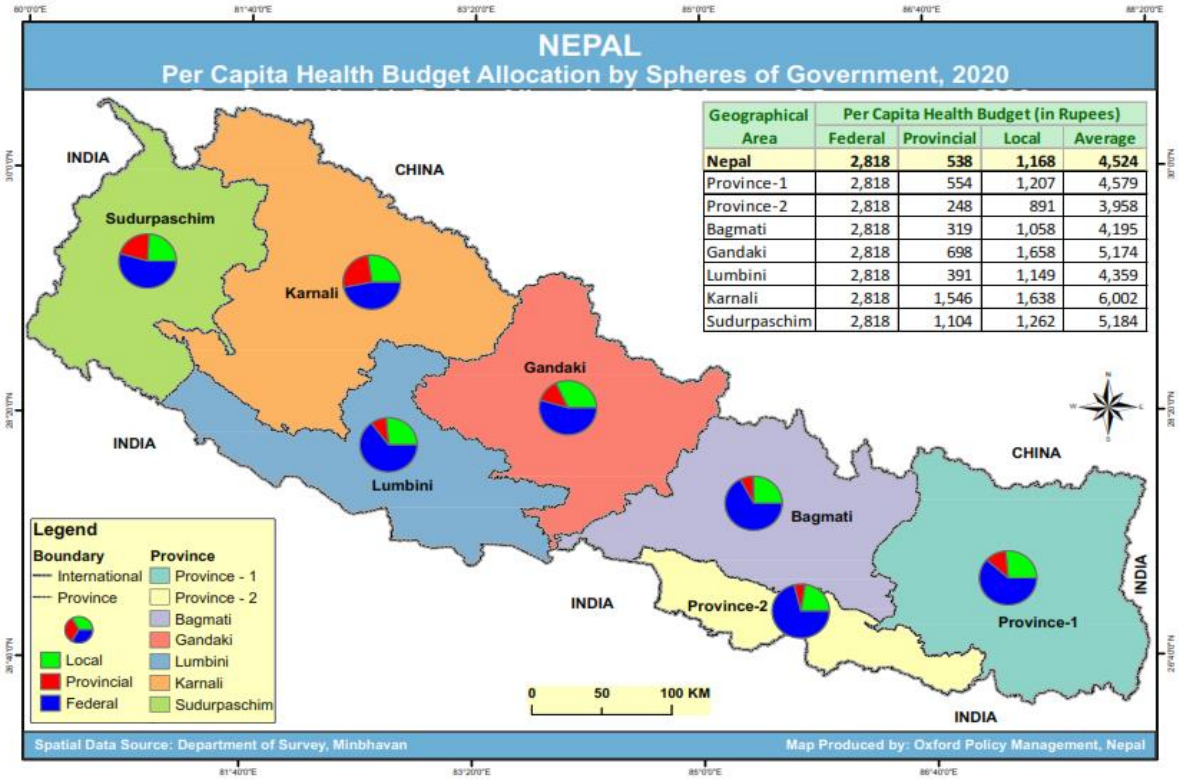
Table 4.13: Hospital Grant by Line Item by Federal, Provincial, and Local Government

Grant to hospitals	Allocated budget (NPR million)				
	Federal	Provincial	Local	Total	%
Wages and salaries	5,867.32			5,867.32	15.80
Support services	1,134.07			1,134.07	3.05
Capacity building	410.82			410.82	1.11
Programme activities	1,916.27			1,916.27	5.16
Medicine purchase	1,851.71			1,851.71	4.99
Grant to hospitals	10,915.60	928.19	1,649.97	13,493.76	36.33
Capital goods	7,738.10			7,738.10	20.83
Capital construction	4,730.71			4,730.71	12.74
Total	**34,564.6**	**928.2**	**1,650.0**	**37,142.8**	**100.0**

4.14 Per capita Budget Allocation at Federal, Provincial and Local Government (FY 2020/21)

Figure 4 provides an overview of the per capita budget allocation at the federal, provincial and local levels for FY 2020/21. The per capita health sector allocation at federal level is NPR 2,818 (excluding conditional grants for PGs and LGs). The PG share in the health sector varies from NPR 248 in Province 2 to NPR 1,546 in Karnali Province. The per capita health budget allocation in Karnali Province may seem high; however, it is to be noted that it has the largest administrative boundary and has difficult topographic terrain with a small population. Similarly, the LG share in the health sector varies from NPR 891 in Province 2 to NPR 1,658 in Gandaki Province. Average per capita allocation is lowest for Province 2 (NPR 3,958) and highest for Karnali Province (NPR 6,002).

Figure 4: Per Capita Budget Allocation at Federal, Provincial and Local Government



Geographical Area	Per Capita Health Budget (in Rupees)			
	Federal	Provincial	Local	Average
Nepal	**2,818**	**538**	**1,168**	**4,524**
Province-1	2,818	554	1,207	4,579
Province-2	2,818	248	891	3,958
Bagmati	2,818	319	1,058	4,195
Gandaki	2,818	698	1,658	5,174
Lumbini	2,818	391	1,149	4,359
Karnali	2,818	1,546	1,638	6,002
Sudurpaschim	2,818	1,104	1,262	5,184

At the same time, the percentage share of per capita health budget for the three spheres of government varies across the provinces. For example, federal sources accounted for 71 per cent of the Province 2 per capita budget, whereas its share for Karnali Province is only 45 per cent. In Province 2 and Bagmati and Lumbini Provinces, the provinces accounted for less than 10 per cent of per capita allocation. At the same time, Karnali Province has the highest share of per capita allocated by PG. Additionally, LG as a source of per capita allocation is highest in Gandaki Province, where it accounts for slightly more than one-third of per capita health budget, and lowest in Province 2, where is it almost a quarter.

CHAPTER 5: ANALYSIS OF MOHP BUDGET FY 2020/21

This chapter provides detailed analysis of the budget allocated for the MoHP (NPR 60.7 billion for FY 2020/21) and excludes analysis of conditional grants provided to PGs and LGs. It captures budget up to FY 2020/21 and expenditure up to FY 2018/19. MoHP's Financial Monitoring Report (FMR), verified with the Financial Comptroller General Office's (FCGO's) Financial Management Information System (FMIS), is the source of expenditure and the final adjusted budget. This chapter also analyses revenue generated by MoHP SUs that has deposited amount in the central treasury and attempts to analyse audit observations from the Office of the Auditor General (OAG).

5.1 MoHP Budget and Expenditure by Capital and Recurrent Classifications

Table 5.1 shows that there was an almost twofold increase in the volume of capital budget from NPR 6.6bn in FY 2016/17 to NPR 15.3bn in FY 2020/21. This increase reflects the GoN's policy commitment to building health infrastructure. The percentage allocation of the capital budget has increased from 16 per cent in FY 2016/17 to 24 per cent in FY 2020/21. At the same time, recurrent budget decreased almost 10 percentage points, from 84 per cent in FY 2016/17 to 74 per cent in FY 2020/21.

Table 5.1: Budget and Percentage Expenditure by Capital and Recurrent (NPR Billion)

Budget type	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Capital	6.6	88.6	7.4	90.8	8.6	68.4	9.3	77.5	15.3
Recurrent	35.0	94.9	26.0	79.6	20.8	89.6	29.7	80.5	45.4
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

The trend data suggest that absorption of the recurrent budget is higher than that of the capital budget, with expenditure as high as 95 per cent in FY 2016/17. One of the reasons for this could be that a significant proportion of the recurrent budget is used for administrative expenditure, including salary and allowances, whereas expenditure of capital budget is subject to procurement delays. However, the opposite obtains in FY 2017/18, with 91 per cent absorption of the capital budget. This is explained by an additional NPR 1 billion for building construction expenditure provided by Ministry of Urban Development to MoHP. In FY 2019/20, the absorption of capital budget improved compared to FY 2018/19, whereas the recurrent budget actually declined: this is mainly because many recurrent activities could not be completed as a result of COVID-19. *It should be noted that the budget mentioned for FY 2019/20 in the last BA report is different from that in this report. This is a result of using the adjusted budget in the BA report. This practice applies across this report.*

5.2 MoHP Budget and Expenditure by GoN and EDPs

The share of government contribution to MoHP's budget remained relatively constant at 77 per cent until FY 2017/18; it then decreased to 66 per cent in FY 2018/19, increasing slightly in FY 2019/20 to 74 per cent. A sharp fall in the government share of MoHP budget was observed in FY 2020/21, to 37 per cent. EDPs' share in the MoHP budget was maintained at 23 per cent until FY 2017/18, increasing to 34 per cent in FY 2018/19, mainly because of the conditionality to fund/reimburse activities implemented solely by MoHP. By FY 2019/20, the EDP share had decreased to 26 per cent; however, in FY 2020/21, more than 63 per cent of the MoHP budget was funded by EDPs.

Table 5.2: Budget and Percentage Expenditure by Source of Fund (NPR Billion)

Budget source	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
GoN	31.9	99.8	25.5	84.5	19.4	88.7	28.8	78.5	22.4
EDP	9.7	74.7	7.8	74.2	9.9	73.1	10.2	83.4	38.3
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

The absorption of government budget in FYs 2016/17–2018/19 remained at or above 85 per cent; in FY 2019/20, absorption was only around 79 per cent. The absorption of the EDP budget for the same period remained between 75 and 73 per cent, with almost 84 per cent absorption in FY 2019/20, which is the highest recorded in Nepal's history. This could be because of improved reporting practices from EDPs, in particular the capture of direct funding.

5.3 MoHP Budget and Expenditure by Administration and Programme

Table 5.3 shows the proportion of MoHP budget allocated under administrative and programme headings. Before FY 2017/18, almost 27 per cent of MoHP budget was allocated under administration. In FY 2017/18, the administrative budget was reduced to 9.6 per cent of MoHP budget, and decreased to four per cent in FY 2018/19. This is mainly because salaries and other administrative expenses have been allocated to PGs and LGs through conditional grants. However, an increase in administrative budget was observed in FY 2019/20 but remained constant at nine per cent in FY 2020/21.

Table 5.3: Budget and Percentage Expenditure by Administrative and Programme (NPR Billion)

Budget source	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Adminis-tration	11.2	113.3	3.2	87.4	1.3	80.6	3.2	65.1	5.1
Programme	30.4	86.8	30.1	81.5	28.1	83.5	35.8	81.1	55.6
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

Expenditure trends suggest that MoHP is better at spending administrative budget than programme budget, sometimes even spending more than is allocated. However, the trend has been decreasing over the years and in FY 2019/20 administrative budget absorption was as low as 65 per cent. This is mainly because of delays in HR adjustment and reduction in filed activities. Programme budget absorption has been maintained above 80 per cent.

5.4 MoHP Budget and Expenditure by Government, Pool Fund, and Direct Funding

The GoN's Red Book mainly covers government funds and contributions from EDPs in the form of direct and pooled funds. Table 5.4 shows that the share of pool and direct funding in the MoHP budget is gradually increasing. Until FY 2019/20, direct funding remained at 10 to 11 per cent of the MoHP budget until a sudden jump to 47 per cent was observed in FY 2020/21. This was primarily caused by an increase in technical assistance funds to multilateral and technical agencies. Pool fund contributions remained at 16 per cent of the MoHP budget for FY 2020/21.

Table 5.4: Budget and Percentage Expenditure by Government, Pool and Direct Funding (NPR Billion)

Budget source	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
GoN	33.8	98.4	25.5	84.5	19.4	88.7	28.8	78.5	22.4
Pool fund	3.4	100.0	4.4	82.1	6.6	83.5	6.1	83.2	9.8
Direct fund	4.4	55.1	3.4	63.8	3.3	51.9	4.1	83.7	28.5
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

It is important to note that expenditure reporting under direct funding, which used to be weak, has improved dramatically over the years. In FY 2018/19, absorption of direct funding appeared to be equivalent to that of pool funding and more than GoN's absorption. This is mainly because of underreporting from direct funding and the fact that the DTCO is yet to record in-kind support to the Treasury Single Account (TSA).

5.5 MoHP Budget and Expenditure by Organisational Level

Until FY 2016/17, the DoHS occupied a major part of the MoHP budget. Since FY 2017/18, budget allocation within MoHP cost centres, such as the DoHS, Department of Drug Administration (DDA), Department of Ayurveda (DoA) and centres, is slowly decreasing, which is mainly because the majority of health activities have been devolved to LGs, and later to PGs.

At the same time, budget to MoHP as a SU seems to have drastically increased from NPR 4.2bn to NPR 34.9bn between FY 2017/18 and FY 2020/21. In FY 2020/21, MoHP as a SU occupied almost 58 per cent of MoHP's budget, followed by insurance (12%) and DoHS (11%). Compared to FY 2019/20, the budget for hospitals and academies has slightly reduced. The budget for the DoA is in decreasing trend, from NPR 1.1bn in FY 2016/17 to NPR 0.2bn in FY 2020/21. This is mainly because the majority of DoA activities have been devolved to LGs.

Table 5.5: Budget and Percentage Expenditure by MoHP Organisations (NPR Billion)

Organisation	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
MoHP	5.0	92.6	4.2	84.9	10.7	75.5	13.9	69.1	34.9
DoHS	26.5	95.5	18.4	80.2	7.3	84.8	7.2	78.5	6.9
DDA	0.1	69.5	0.1	76.4	0.2	71.1	0.2	47.7	0.2
DoA	1.1	87.5	0.6	83.7	0.4	71.8	0.4	74.5	0.2
Centres	2.6	72.8	3.0	67.7	1.7	78.2	1.7	75.6	1.9
Hospitals	2.5	96.5	2.5	94.5	2.4	99.4	3.8	94.2	3.0
Insurance	-	-	1.8	73.5	3.4	82.1	5.2	89.6	7.5
Councils	0.06	100.0	0.11	99.9	0.11	100.0	0.11	83.6	0.20
Academies	3.6	100.8	2.6	99.9	3.2	99.8	6.5	89.9	5.9
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

Over the years, academies, councils and hospitals have sustained between 94 and 101 per cent absorption. However, in FY 2019/20, the absorption rate for councils and academies dropped to 83.6 per cent and 89.9 per cent respectively, while health insurance boards showed improved absorption, increasing to 89.6 per cent. The MoHP organisation with the lowest budget absorption rate in FY 2019/20 was the DDA (48%), followed by MoHP (69%).

5.6 MoHP Allocation and Expenditure by EHCS, Systems Support, and Beyond EHCS

Essential Health Care Services (EHCS) are a priority for MoHP and thus account for the majority of the MoHP's budget. This is in line with the NHSS's recommendations. Over the past years, the percentage allocation of EHCS budget has remained at more than sixty eight per cent of the MoHP's budget; this decreased to 44 per cent in FY 2019/20 and 29 per cent in FY 2020/21. At the same time, allocation to system components[3] in MoHP's budget has fluctuated from nine to 26 per cent.

[3] System components include: decentralised service delivery, private/NGO sector development, sector management, health financing/resource management, logistic management, human resource development and information system management

Table 5.6: MoHP Budget and Percentage Expenditure by EHCS, Beyond EHCS, and Systems Support (NPR Billion)

	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
EHCS	27.9	92.4	20.0	76.6	17.5	86.5	17.3	81.9	17.5
Beyond EHCS	5.9	97.9	6.5	94.0	6.6	78.8	17.9	85.8	27.7
System components	7.8	96.3	6.8	86.6	5.3	78.8	3.9	42.2	15.5
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

Compared to FY 2018/19, budget absorption for system components has dramatically reduced from 79 per cent to 42 per cent in FY 2019/20, while both EHCS and beyond EHCS sustained absorption rates of more than 80 per cent. The reason for this dramatic decrease in system component absorption could be the rechannelling of budget to COVID-19 response.

5.7 MoHP Allocation and Expenditure by Priority Programmes

Table 5.7 shows the MoHP's budget in NPR and the percentage of the budget spent by the different levels of priority programmes. Priority one programmes are programmes with the highest priority assigned by the National Planning Commission (NPC). Over the years, Priority one programmes were allocated almost 80 per cent of MoHP budget. Since FY 2018/19, the GoN decided to exclude P3 from the priority levels.

Table 5.7: MoHP Budget and Percentage Expenditure by Programme Priority (NPR Billion)

Priority	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Priority 1	33.5	92.9	26.6	79.2	22.9	79.7	30.3	76.0	53.5
Priority 2	7.6	98.3	6.0	94.9	6.5	96.5	8.7	92.9	7.2
Priority 3	0.6	96.2	0.7	79.8	-	-	-	-	-
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

Source: Red Book, FY 2016/17–2020/21

Compared to FY 2018/19, the share of P1 programmes in MoHP budget has increased from 77 per cent to 88 per cent in FY 2020/21; absorption decreased from 79 per cent to almost 76 per cent over the same period.

5.8 MoHP Budget and Expenditure by Line Item

Table 5.8 shows the budget allocated and percentage spent by the main budget line items. The data shows that, for the budget allocated between FY 2016/17 and FY 2019/20:

- Grants to hospitals have more than doubled since FY 2016/17, from NPR 15.6bn to NPR 34.6bn in FY 2020/21;
- Budget for capital construction has increased threefold between FY 2016/17 and FY 2020/2,1 from NPR 4.9bn to NPR 14.6bn;

- Budget for wages and salaries, and for capacity building is in decreasing trend since FY 2016/17; and
- Compared to FY 2019/20, budget under support services, programme activities and capital goods increased in FY 2020/21, while in medicine it decreased.

Table 5.8: MoHP Budget Line Budgets and Percentage Expenditure by Line Item (NPR Billion)

Broad line item	FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
Wages and salaries	7.9	121.2	1.6	78.9	0.6	89.0	0.5	97.1	0.5
Support services	1.8	82.8	1.2	73.8	0.5	79.5	0.7	67.6	2.2
Capacity building	0.8	64.4	0.7	74.0	0.2	76.2	0.1	36.0	0.1
Programme activities	4.2	69.8	3.3	61.1	1.0	60.3	1.0	39.6	4.0
Medicine purchases	4.7	82.1	4.5	64.2	3.5	87.0	5.8	77.3	4.0
Grants to hospitals	15.6	95.3	14.6	89.4	14.9	92.8	21.6	83.6	34.6
Capital construction	4.9	89.6	6.2	93.3	7.6	69.8	6.2	72.6	14.6
Capital goods	1.7	85.8	1.2	78.2	0.9	56.1	3.2	87.0	0.7
Total	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**60.7**

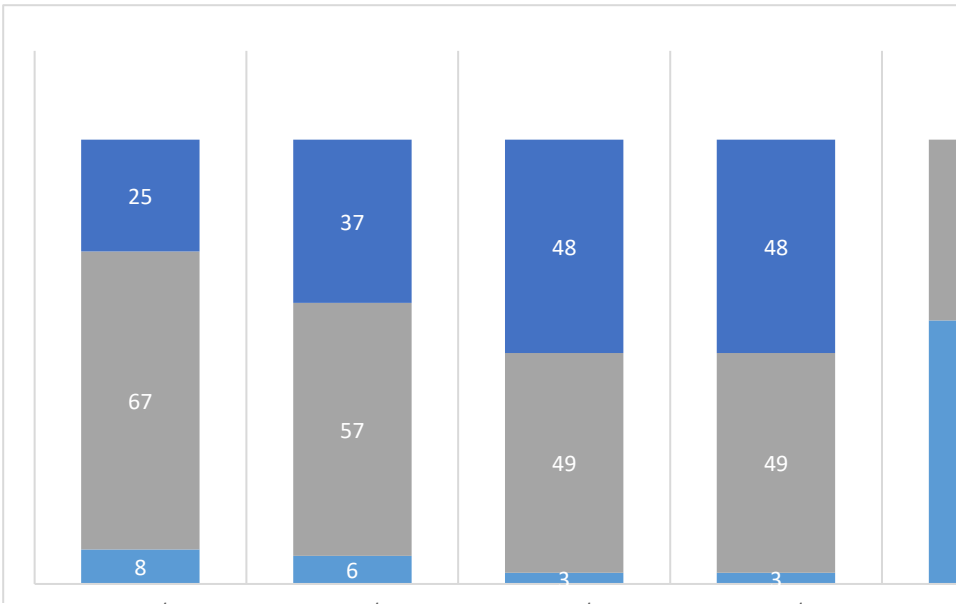
Source: Red Book, FY 2016/17–2020/21

In FY 2019/20, MoHP's overall expenditure performance was 79.8 per cent, lower than in the preceding three FYs. The main reasons for this might include the onset of COVID-19 and HR mobility across all spheres of government. The weakest-performing line items were capacity building and programme activities with less than 40 per cent absorption. This might primarily be explained by the GoN deciding to re-channel unspent budget allocated under training/workshops, service contracts and monitoring for the COVID-19 response. At the same time, hospital grants, which were shown to have good absorption rates, of at least 90 per cent, also declined to 83 per cent. In FY 2019/20, the top performers in terms of expenditure were wages and salaries (97%), capital goods (87%) and grants to hospital (83.6%).

5.9 MoHP Budget Allocation for Women- Focused Activities

The MoHP classifies its activities according to Red Book categories as directly or indirectly contributing to women's health; these are well incorporated into the eAWPB. The largest proportion of the MoHP budget is occupied by programmes indirectly contributing to women's health (Figure 5.1). This is because the MoHP's budget is aimed at both men and women, at people of all ages and those living in different geographies. The MoHP includes budget for curative, disease control, prevention and promotional services. The budget of the Family Welfare Division (FWD) and some others have been considered as programmes directly contributing to women's health. Since FY 2017/18, the MoHP's share of budget directly contributing to women has declined sharply from 6.3 per cent to 2.5 per cent in FY 2019/20; this is mainly because of devolution of basic health services to LGs. The majority of basic health services include programme activities that directly contribute to women's health. In FY 2020/21, the neutral category was no longer valid and the share of budget directly contributing to women increased to 59 per cent.

Figure 5.1: Percentage Allocation of MoHP's Budget by Contribution to Women's Health

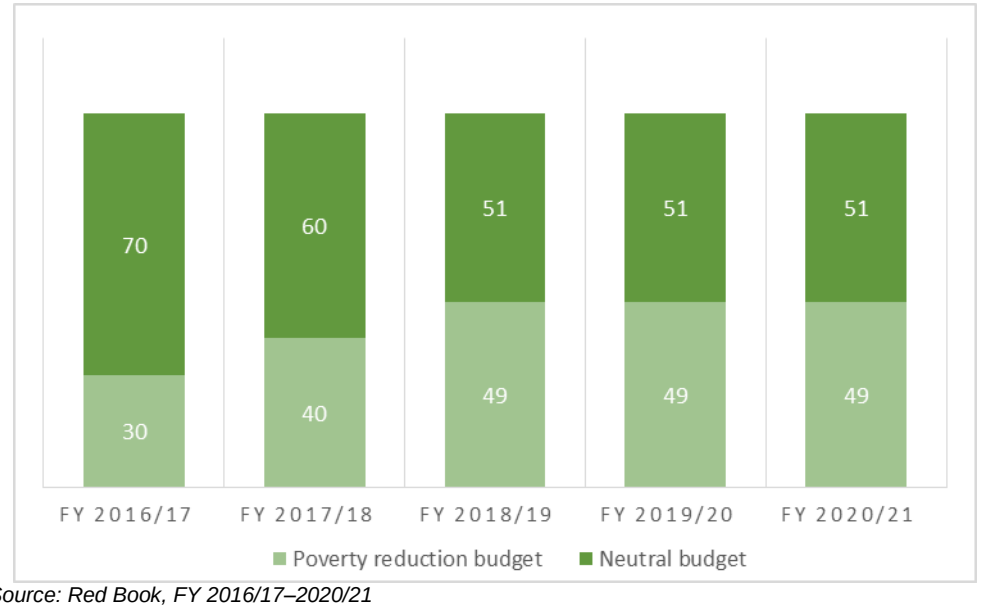


Source: Red Book, FY 2016/17–2020/21

5.10 Budget Allocation by Poverty Reduction

The analysis looked at the MoHP's budget contributing to reducing poverty. The MoHP takes reference from the Red Book for defining activities contributing to reducing poverty. Figure 5.2 suggests that over the years MoHP's poverty reduction budget has increased from one-third in FY 2016/17 to almost half in FY 2020/21. It should be noted that these figures just offer an indication of the share of the MoHP's budget that contributes to reducing poverty and that further work is required to accurately define this proportion.

Figure 5.2: Percentage Allocation of MoHP Budget by Contribution to Poverty Reduction

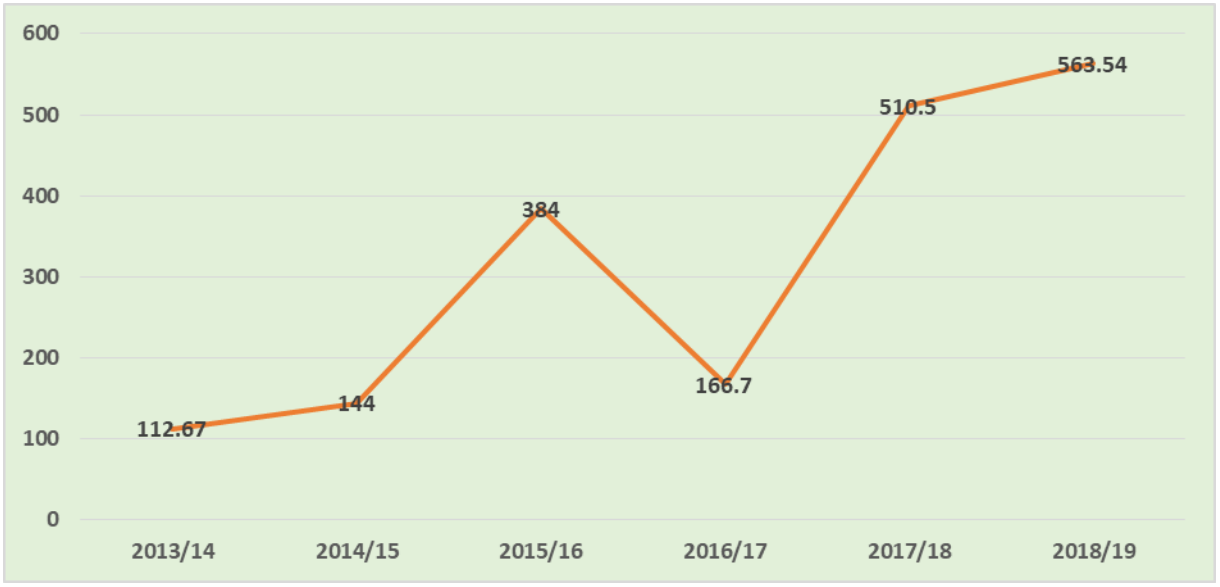


Source: Red Book, FY 2016/17–2020/21

5.11 Reported revenue by MoHP

MoHP earns revenue from various sources. Figure 5.3 covers the total annual revenue of MoHP deposited by SUs in the central treasury.

Figure: 5.3 Annual Revenue Collected from MoHP SUs in Central Treasury (NPR Million)



Source: OAG, 2013/14–2018/19

The data from FY 2013/14 to 2017/18 are taken from OAG annual reports from the respective years (the data represents the audited amount of revenue by the OAG) and data for FY 2018/19 is taken from the MoHP Central Financial Statement. There has been an increasing trend in disclosing and depositing revenue in the central treasury. This is a good indicator of improving governance and transparency. The above figure does not capture revenue collected from user fees, which would amount to more than NPR 563 million. Revenue data for FY 2019/20 is yet to be compiled.

5.12 Audit and Clearance

Table 5.9 presents audit queries against the total audited amount under MoHP. It does not cover autonomous hospitals, or PG- and LG-level analysis of audit queries. Audit queries against audited expenditure are in decreasing trend, from 13.8 per cent in FY 2012/13 to 4.8 per cent in FY 2017/18. However, in FY 2018/19 the proportion has increased, which is explained by staff mobility, ambiguity in budget implementation guidelines and not enough clarity in procurement planning.

Table 5.9: Audit Queries against Audited Expenditure (NPR 1000s)

SN	Audit of Year	Audited Amount	Audit Queries	
			Amount	%
1	2012/13	17,874,272	2,464,659	13.79
2	2013/14	20,833,612	2,397,137	11.51
3	2014/15	23,683,400	2,236,386	9.44
4	2015/16	30,324,700	1,183,108	3.90
5	2016/17	37,674,000	2,642,206	7.01
6	2017/18	31,323,000	1,494,412	4.77
7	2018/19	19,637,600	1,321,766	6.73
7	2019/20	Audit ongoing		

Source: OAG Annual reports

The audit for FY 2019/20 is currently being conducted which will be finalised by Mid-April 2021.

5.13 Cumulative Audit Queries and Clearance

Table 5.10 represents the total audit queries and their clearances over the years, focusing solely on the MoHP's audit queries and clearances. The table shows that cumulative audit query clearance was in increasing trend, from 36.9 per cent in FY 2012/13 to 51.5 per cent in FY 2015/16.

Table 5.10: Cumulative Audit Queries and Clearance (NPR 1000s)

SN	Up to FY (FY)	Cumulative audit queries	Clearance		
			FY	Amount	%
1	2012 Mid July	2,498,288	2012/13	921,253	36.88
2	2013 Mid July	3,077,463	2013/14	1,203,114	39.09
3	2014 Mid July	4,339,008	2014/15	1,960,272	45.18
4	2015 Mid July	4,775,873	2015/16	2,460,141	51.51
5	2016 Mid July	4,552,118	2016/17	2,095,538	46.03
6	2017 Mid July	3,639,688	2017/18	1,508,562	41.45
7	2018 Mid July	4,773,332	2018/19	1,985,658	41.60
8	2019 Mid July	4,282,086	2019/20	473,423	11.65
9	2020 Mid July	5,130,429	2020/21	Audit queries clearance ongoing	

Source: Audit Queries Clearance Evaluation and Monitoring Committee Annual reports

However, audit clearance has decreased since FY 2016/17. This could be because of structural changes, functions of the different governments, and transfer of account officers and office chiefs. This decline should be noted and special attention given to clear the cumulative audit backlog that was observed following structural transition. In FY 2019/20 audit clearance has been very low, which is mainly because of the effects of COVID-19.

This analysis shows that MoHP has received an increased budget compared to the last FY. Additionally, because of low absorptive capacity, MoHP has surrendered budget to MoF for COVID-19 response and redistribution to SNGs for conditional grant activities. The budget allocation pattern shows an increasing trend in capital budget. Further analysis is required to determine the need for infrastructure budget in the health sector.

CHAPTER 6: BUDGET ALLOCATED TO PROVINCIAL AND LOCAL GOVERNMENT

This chapter analyses total budget and health budget including conditional grants allocated to Provincial and Local Governments for FY 2020/21. A brief background is provided, which focuses on the resource pool at the provincial and local level, as well as the budget allocation and reporting mechanisms, followed by the actual budget analysis of SNGs for FY 2020/21. Note that the intention of this analysis is to provide an indicative snapshot of budget preparation practices as this analysis only covers data from 641 Palikas (out of 753). Data sources includes the Red Book and SuTRA. Macroanalysis gives a complete picture and micro-level analysis provides indicative information on health budget. ***Note that data on segregated health budget allocation for PG could not be obtained for FY 2020/21.***

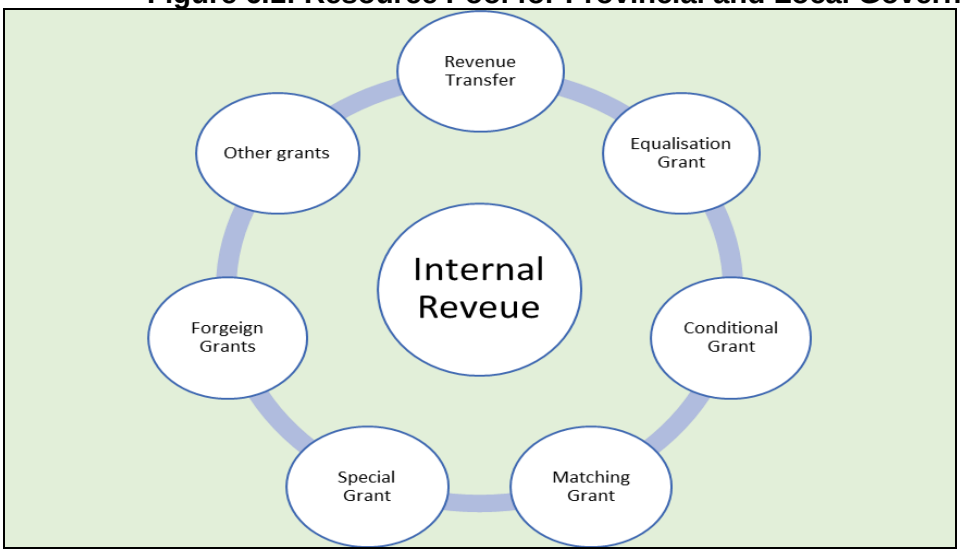
6.1 Background

Nepal started practising decentralisation in the year 2017/18. Equalisation funds and conditional grants were the initial forms of fiscal transfers made by the GoN. By FY 2018/19 all other forms of fiscal transfers, viz. revenue transfer, special and matching funds, came into practice. As devolution progresses, planning, budgeting, expenditure, and reporting mechanisms are evolving and improving over time. In FY 2019/20, it was made mandatory to report on both budget and expenditure in SuTRA; however, not all LGs could comply. This analysis only covers the indicative budget in the form of grants received by LGs for FY 2020/21. FY 2020/21 is the third year that PGs, and the fourth year that LGs, have practised devolution. SNGs are still facing problems regarding basic infrastructure and trained HR with knowledge in health-related activities, including staff adjustment.

6.2 Resource Pool at PGs and LGs Level from Fiscal Transfers

The resource pool at SNGs can be broadly categorised into internal and external sources. Internal sources derive from revenue collected/generated from tax levies by SNGs. External sources consist of different forms of intergovernmental fiscal transfers, funds from EDPs and philanthropy. In FY 2020/21, PGs have been allocated NPR 4.6bn, and LGs NPR 25.4bn, as health conditional grants. In addition to the conditional grant for health, PGs and LGs can allocate resources to the health sector from following resource pool.

Figure 6.1: Resource Pool for Provincial and Local Government



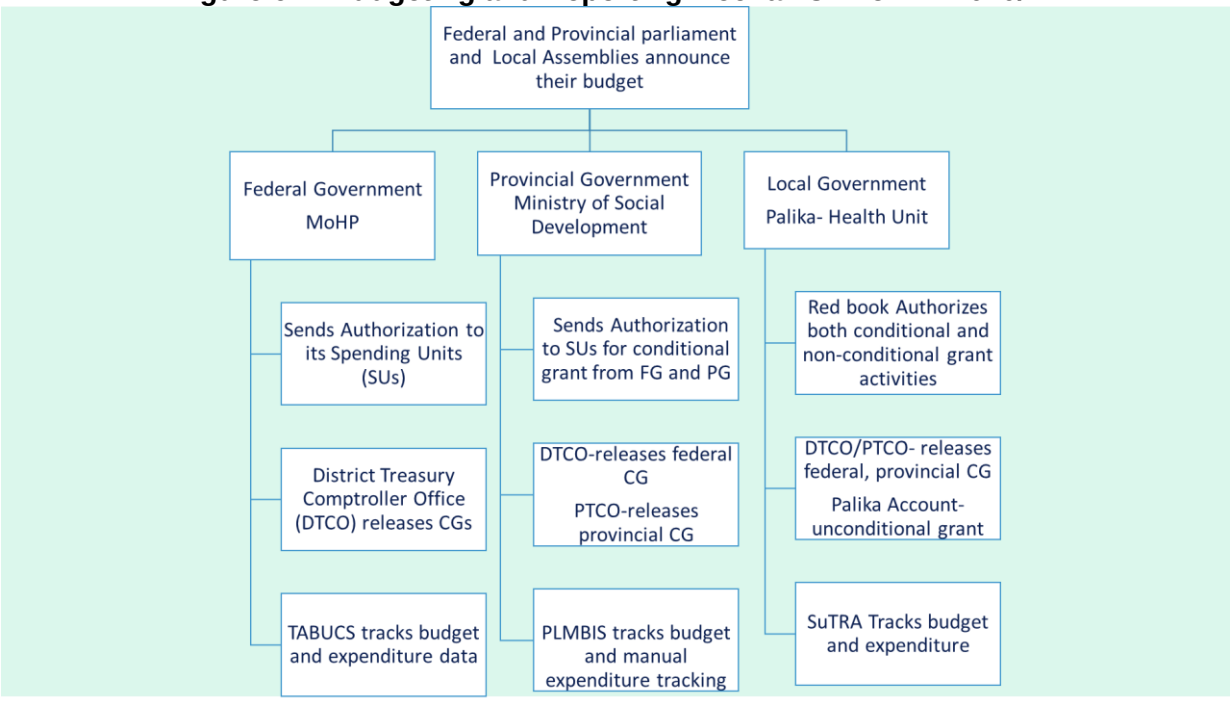
Source: Created by authors

At this point in time, there is no standard electronic mechanism to report/analyse the total amount allocated to PGs and LGs. The expenditures of last year's health conditional grants provided to LGs is captured through SuTRA and the report of the OAG.

6.3 Budgeting and Reporting Mechanism in FY 2020/21

At the federal level, the planning and budgeting process starts at the beginning of January. The operational planning cycle at Local and Provincial Governments is yet to be developed. The constitution obligates both the Local and Provincial Governments to prepare their AWPB through a standard process. During this fiscal year, PGs and LGs organised planning and budgeting meetings, which have been endorsed by their parliaments and assemblies. The following flow chart shows the budgeting and reporting mechanism for FY 2020/21.

Figure 6.2: Budgeting and Reporting Mechanism for FY 2020/21



Source: Created by authors

TABUCS tracks both the budget and expenditure channelled to MoHP and its SUs. Similarly, the Provincial Line Ministry Budget and Information System (PLMBIS) tracks budget; however, there is no consolidated mechanism to track expenditure. At the same time, SuTRA tracks both budget and expenditure at the LG level. It is important to note that TABUCS can be used both for both PGs and LGs: it can also produce information/data as per the chart of accounts, Government Financial Statistics (GFS) 2014 and at the level of activity. PGs and LGs are still challenged by HR and their limited capacity in terms of skills, equipment and infrastructure. PGs and LGs are mandated to comply with the existing financial rules and regulations and to maintain financial discipline within their jurisdiction. Financial reports are prepared in the forms and formats prescribed by the OAG. In FY 2019/20, it was made mandatory for all LGs to enter their budget in SuTRA in order to be able to receive Federal Government fiscal transfers, a condition that continued this year (FY 2020/21). It is to be noted that PGs still prepare expenditure reports manually as there is no standard, nationally rolled-out electronic system to consolidate and report budget and expenditure at the aggregate level.

6.4 Total Budget of Local Government by Revenue Sources FY 2020/21

Table 6.1 describes the different forms of revenue that make up LGs' budget for FY 2020/21 aggregated at provincial level. Conditional grants (37%) still form the major source of revenue for the LG followed by internal revenue (22%), equalisation grants (20%), and revenue transfer (16%).

Table 6.1: Total Budget of Local Government by Revenue Sources in FY 2020/21 (NPR Billion)

Province	Internal revenue	Revenue transfer	Equalis-ation grant	Conditional grant	Special grant	Matching grant	Foreign grant	Other grant	Total
Province 1	12.97	12.54	16.49	29.12	1.12	1.45	0.04	0.93	74.77
Province 2	14.54	6.73	9.97	16.00	1.90	0.97	0.01	0.45	50.65
Bagmati	37.01	18.72	16.69	28.81	1.25	3.04	0.05	1.95	107.68
Gandaki	9.15	7.10	9.99	20.02	0.93	1.08	-	0.06	48.40
Lumbini	13.45	11.02	14.18	27.24	1.60	1.87	0.23	0.49	70.24
Karnali	3.35	4.91	6.92	12.86	1.04	0.88	0.02	0.29	30.32
Sudur-pashchim	4.08	6.73	8.83	15.81	1.25	1.03	0.01	0.01	37.80
Total	**94.55**	**67.76**	**83.06**	**149.85**	**9.08**	**10.33**	**0.37**	**4.17**	**419.86**

Source: GoN 2020

LGs from Karnali Province receive a very low share of revenue transfer, only seven per cent, whereas Bagmati Province receives 28 per cent. LGs from Karnali and Sudurpashchim Provinces receive the lowest share of all fiscal transfers (only 8% of all grants for Karnali and 11% of all grants for Sudurpashchim) whereas LGs from Province 1 and Bagmati receive the highest share (20% of all grants).

6.5 Health Budget at Local Government by Revenue sources FY 2020/21

Table 6.2 shows the total health budget allocated to LG aggregated at province level. The table indicates that an additional NPR 2.5bn budget has been allocated by LG to health on top of the NPR 25.4bn allocated as a conditional grants by the Federal Government. This allocation comes from different sources of fiscal transfer, from Federal and Provincial Governments, foreign grants and grants in the name of people's participation.

Table 6.2: Health Budget at LG by Revenue Source (NPR Billion)

LGs by Province	Internal revenue	Revenue transfer	Equalis-ation grant	Conditional grant	Special grant	Matching grant	Foreign grant	Other grant	Total
Province 1	409.3	252.5	664.0	3,426.4	38.0	5.0	1.6	10.5	4,807.3
Province 2	304.8	126.2	291.6	2,410.8	6.0	39.1	-	51.4	3,229.9
Bagmati	994.2	652.9	514.6	4,060.2	71.3		-	6.2	6,299.5
Gandaki	137.8	190.6	442.1	2,349.3	98.5		-		3,218.4
Lumbini	543.7	488.3	549.5	3,172.7	95.0	15.9	-	1.8	4,866.9
Karnali	78.7	55.6	358.4	1,541.6	71.5	5.0	4.9	5.0	2,120.6
Sudurpashchim	128.2	157.8	469.3	1,908.9	59.9		1.6		2,725.7
Total	**2,596.8**	**1,924.0**	**3,289.5**	**18,869.9**	**440.2**	**65.0**	**8.1**	**74.9**	**27,268.4**

Sixty-seven per cent of the LG budget for health comes through conditional grants, followed by equalisation grants (12%) and nine per cent from internal revenue. It is interesting to note that the share of conditional grants in the overall health budget has been slowly decreasing, from 98% in FY 2017/18 to 67% in FY 2020/21. At the same time, it is encouraging to note the rising share of internal revenue. Separate analysis is suggested to capture further details.

6.6 Line Item-wise Health Budget Allocation at LG by Revenue Source (FY 2020/21)

Table 6.3 shows total health budget allocated at local government by revenue sources aggregated under major line item headings. Thirty-seven per cent of LG health budget is spent on wages and salaries, followed by 31 per cent on programme activities.

Table 6.3: Major Line Item-wise Health Budget Allocation at LGs by Revenue Source (NPR Million)

Line item	Internal revenue	Revenue transfer	Equalis-ation grant	Conditional grant	Special grant	Matching grant	Foreign grant	Other grant	Total
Wages and salaries	125.28	126.13	202.24	9630.65	5.00		0.00		10,089.29
Support services	220.33	264.34	328.37	1038.61	0.70		0.00		1,852.34
Capacity building	178.06	131.19	221.66	98.47	0.50		0.00	50	679.89
Programme activities	793.56	740.72	1151.38	5786.63	73.44	39.10	8.07	18.39	8,611.30
Medicine purchases	158.47	141.68	367.07	618.32	0.56		0.00	0.5	1,286.61
Subsidy to institutions/ corporations	71.27	77.97	136.28	331.09	22.00		0.00		638.61
Grants to hospitals	100.95	27.00	43.02	179.47			0.00		350.44
Capital construction	664.70	199.67	430.34	494.63	321.69	25.90	0.00	5.5	2,142.43
Capital goods	284.17	214.82	408.98	107.98	16.30		0.00	0.5	1,032.74
Grant to local bodies		0.50	0.20	584.04			0.00		584.74
Total	**2,596.79**	**1,924.02**	**3,289.54**	**18,869.90**	**440.19**	**65.00**	**8.07**	**74.9**	**27,268.40**

Source: GoN 2020

Conditional grants are the major source of funding for almost all line items, except for capacity building and capital goods, which are covered through equalisation grants. The greatest proportion of conditional, equalisation, matching and special grants are allocated under wages and salaries (51%), programme activities (35%), programme activities (60%) and capital construction (73%) respectively. It was both interesting and encouraging to note that the majority of revenue transfer and internal revenue is allocated to programme activities (38% and 30% respectively). All foreign grants were allocated under programme activities.

6.7 Health Budget at LGs by Capital and Recurrent Allocations (FY 2020/21)

Table 6.4 provides disaggregation of the LG health budget by capital and recurrent allocations aggregated at province level. Around three per cent of conditional grants is spent on capital expenditure. On average,

only 12 per cent of LG health budget is allocated under the capital heading; LGs from Bagmati and Lumbini Provinces allocated more, at 18 and 14 per cent respectively. At the same time, LGs from Sudurpashchim Province allocated the smallest proportion of health budget under the capital heading (only 6.5%).

Table 6.4: Capital and Recurrent Budget Allocation by PGs and LGs (NPR Million)

Province	Recurrent		Capital		Total
	NPR	%	NPR	%	
Province 1	4,360.7	90.71	446.6	9.29	4,807.3
Province 2	2,982.2	92.33	247.8	7.67	3,229.9
Bagmati	5,192.2	82.42	1,107.2	17.58	6,299.5
Gandaki	2,918.8	90.69	299.6	9.31	3,218.4
Lumbini	4,172.1	85.72	694.9	14.28	4,866.9
Karnali	1,921.2	90.59	199.5	9.41	2,120.6
Sudurpashchim	2,546.1	93.41	179.7	6.59	2,725.7
Total	**24,093.2**	**88.36**	**3,175.2**	**11.64**	**27,268.4**

Source: GoN 2020

6.8 Health Budget at LGs by Administrative and Programme Allocation (FY 2020/21)

Table 6.5 provides the disaggregation of LG health budget by administrative and programme allocation, aggregated at province level. On average, 53 per cent of the health budget is allocated for administrative purposes while 47 per cent is allocated under the programme heading. LGs from Karnali and Sudurpashchim Provinces have made greater-than-average allocations of around 53 and 50 per cent respectively under the programme heading, whereas LGs from Province 1 have allocated less than average (41%).

Table 6.5: Administrative and Programme Budget Allocation by PGs and LGs (NPR million)

Province	Administrative		Programme		Total
	NPR	%	NPR	%	
Province 1	2612.64	54.35	2194.62	45.65	4807.27
Province 2	1907.54	59.06	1322.39	40.94	3229.93
Bagmati	3439.66	54.60	2859.82	45.40	6299.48
Gandaki	1650.93	51.30	1567.49	48.70	3218.42
Lumbini	2600.45	53.43	2266.48	46.57	4866.94
Karnali	1005.03	47.39	1115.61	52.61	2120.64
Sudurpashchim	1355.90	49.74	1369.83	50.26	2725.73
Total	**1,4572.16**	**53.44**	**12696.24**	**46.56**	**2,7268.40**

Source: GoN 2020

6.9 Conditional Grant and Other Revenue Sources at PGs and LGs (FY 2020/21)

Table 6.6 provides the disaggregation of PG and LG health budget by conditional grant and other revenue sources. In total, NPR 51.5bn is allocated to health at SNG level. NPR 11.7bn has been allocated to health

by PG on top of the health conditional grant of NPR 4.5bn. Sudurpashchim Province made the highest allocation of all (NPR 2.5bn), while Province 2 made the lowest allocation (NPR 0.94bn). Similarly, NPR 9.8bn has been allocated by LG on top of the NPR 25.4bn conditional grant. LGs from Bagmati Province appeared to have contributed a greater amount to health than their counterparts, those from Karnali Province appeared to have contributed less. ***Note that the value for LG in the table above is different to this as it only contains analysis of 641 LGs.***

Table 6.6: Health Budget Allocation Through Conditional and Other Sources by PGs and LGs (NPR Million)

Province	Provincial Government		Local Government		Total
	Conditional grant	Other revenue source	Conditional grant	Other revenue source	
Province 1	698	2,054	4,370	1,622	8,744
Province 2	619	946	4,659	962	7,187
Bagmati	652	1,419	4,237	2,630	8,939
Gandaki	549	1,210	3,160	1,021	5,941
Lumbini	755	1,255	3,911	1,990	7,911
Karnali	573	2,248	2,307	680	5,808
Sudur-pashchim	684	2,576	2,767	960	6,986
Total	**4,530**	**11,709**	**25,411**	**9,866**	**51,516**

Source: Provincial budget document and authors' estimate

CHAPTER 7: COVID-19

This chapter analyses budget and expenditure from MoHP with budget code for COVID-19 response for the year FY 2019/20. MoHP reallocated its unspent budget from initial allocation as no extra budget was provided for COVID-19 response. MoHP's final budget after COVID-19 response was NPR 39bn, which also includes budget for the Ministry of Defence, Ministry of Home Affairs, Ministry of Culture, Tourism and Civil Aviation etc.

7.1 COVID-19 Budget and Expenditure by Capital and Recurrent Heading (FY 2019/20)

A COVID-19 budget of around NPR was allocated in total, of which NPR 3.1bn was allocated for capital expenditure and NPR 2.9bn under the recurrent heading. Almost 81 per cent of budget allocated for COVID-19 was spent. Ninety-six per cent of the capital budget was absorbed, while only around 65 per cent of the recurrent budget could be spent in FY 2020/21.

Table 7.1: COVID-19 Final Budget and Expenditure by Capital and Recurrent Heading (NPR Million)

Budget heading	Final budget	Expenditure	% Expenditure
Recurrent	2,872	1,860	64.7
Capital	3,061	2,938	96.0
Total	5,933	4,798	**80.9**

7.2 COVID-19 Budget and Expenditure by Source of Funding (FY 2019/20)

Around NPR 6bn of the COVID-19 budget was allocated in total, of which NPR 4.3bn was allocated from GoN and NPR 1.6bn from the IDA/loans.

Almost 81 per cent budget allocated for COVID-19 was spent. 85 per cent budget from GoN source was absorbed while only 69 per cent IDA/loan budget could be spent in FY 2020/21.

Table 7.2: COVID-19 Budget and Expenditure by GoN and IDA/Loan (NPR Million)

Source	Final budget	Expenditure	% Expenditure
GoN	4,332	3,690	85.2
IDA/Loan	1,601	1,108	69.2
Total	**5,933**	**4,798**	**80.9**

7.3 COVID-19 Budget and Expenditure by Programme Category (FY 2019/20)

Around NPR 6bn COVID-19 budget was allocated on total out of which NPR 4.3bn was allocated from GoN and NPR 1.6bn from the IDA/loans.

Table 7.3: COVID-19 Budget and Expenditure by Programme Category (NPR Million)

Programme categories	Final budget	Expenditure	% Expenditure
Personnel expenses: salaries and allowance	54	41	75.8
Operation costs	64	64	100.3
Monitoring	12	-	-
Programme costs	1,074	616	57.3
Medicine	1,668	1,139	68.3
Equipment	3,042	2,913	95.8
Construction/renovation	18	25	137.2
Total	**5,933**	**4,798**	80.9

The majority of the COVID-19 budget was allocated for equipment (51%), followed by medicine (28%) and programme costs (18%). At the same time, nine per cent was allocated for monitoring, which could not be spent. Budget outrun was observed under construction/renovation and operation costs, which had absorption rates of 137 and 100.3 per cent respectively. Almost 96 per cent of the budget for equipment was spent, compared to only 57 per cent of that allocated for programme costs.

7.4 COVID-19 Budget and Expenditure for MoHP and Other Ministries (FY 2019/20)

Fifty-four per cent of the COVID-19 budget was actually allocated to the MoHP; the rest went to other line ministries but was accounted for under the MoHP budget code. Other line ministries were more successful at absorbing budget (almost 97%) than the MoHP (67%).

Table 7.4: COVID-19 Budget and Expenditure in MoHP and Other Line Ministries (NPR Million)

Source	Final budget	Expenditure	% Expenditure
MoHP	3,208	2,161	67.4
Other line ministries	2,725	2,637	96.8
Total	**5,933**	**4,798**	**80.9**

7.5 COVID-19 Budget and Expenditure by Province (FY 2019/20)

Ninety-three per cent of the COVID-19 budget was allocated to Bagmati Province, with Province 1 (2.8%) and Gandaki Province (1.4%) receiving the next highest proportions. The main reason for Bagmati Province to have the majority of the COVID-19 budget is because the MoHP and other line ministries are located here. Province 5, Karnali and Sudurpashchim received the lowest allocations at 0.6, 0.3 and 0.5 per cent respectively. Gandaki Province spent the lowest proportion of the COVID-19 budget (21%) compared to other provinces.

Table 7.5: COVID-19 Budget and Expenditure by Programme Category (NPR Million)

Province	Final budget	Expenditure	% Expenditure

Province 1	169	169	100.0
Province 2	61	54	89.6
Bagmati	5,542	4,497	81.1
Gandaki	81	17	20.7
Province-5	33	26	77.7
Karnali	16	10	63.2
Sudurpashchim	31	25	81.1
Total	**5,933**	**4,798**	**80.9**

7.6 COVID-19 Budget (FY 2020/21)

The initial budget allocated for COVID-19 documented in the Red Book is NPR 6.1bn. In addition to this, the MoHP prepared a first response plan (July to October 2020), which came up with a budget of NPR 21.80 billion. The response plan covers transmission prevention (NPR 1 bn), case management (NPR 15 bn), logistics and supplies (NPR 5 bn), risk communication (NPR 45 million) and quality assurance and monitoring (NPR 26 million). The details of the budget can be obtained through the MoHP website.

CHAPTER 8: CONCLUSION AND WAY FORWARD

This chapter provides a summary of the findings in the form of a conclusion, way forward and policy note. The policy note included in this chapter may require further discussion with officials working at Local, Provincial and Federal Governments. This BA suggests that LGs have prioritised health as their priority area. This exercise has highlighted the fact that the volume of budget is not fully aligned with the number of technical HR assigned to different levels of governments.

8.1 Conclusions

Recent evidence in UHC suggests that lower- and middle-income countries should spend at least five per cent of their GDP on health, which translates to USD 86 (NPR 9,630) per capita spending. This analysis confirms that government health spending as a share of GDP is far lower (2% in FY 2019/20) than the desired level. Similarly, health sector budget as a share of national budget falls short by 1.5 per cent of achieving the 2020 NHSS target of 10 per cent. At the same time, it was encouraging to observe that per capita expenditure increased almost 2.2 times, from NPR 1,198 in FY 2014/15 to NPR 2,601 in FY 2019/20. One of the key factors to have contributed to this was additional resource allocation to health from PGs and LGs. This analysis suggests that the current investment in health is not sufficient to achieve UHC and SDGs by 2030.

Since FY 2017/18, a share of health budget has been allocated to LGs. In FY 2018/19, a share of the health budget was also allocated to PGs in addition to LGs. The GoN provided conditional grants of NPR 4.5bn for PGs (5%), NPR 25.4bn to LGs (28%) and NPR 60.9bn remains at the MoHP (67%). Ninety-seven per cent of wages and salaries, and 82 per cent of capacity building and 58 per cent of programme activities have been devolved to SNG. A key driver for health budget at LGs is salary and wages (72%), while for PGs, it is programme activities (33%) and for Federal Government, grants to hospitals (57%). Under procurement of drugs and supplies, almost 20 per cent is allocated to procurement of COVID-19 drugs and supplies, almost all of which is budgeted at the federal level. The main cost driver at LGs is free health care drugs; at PGs it is purchase of nutritional supplements and supplies. Almost 97 per cent of the budget for purchasing equipment remains at the federal level, and almost one quarter of it is spent in purchasing medical equipment. More than 80 per cent of SNGs free health care budget is occupied by MCH services, followed by free health care services. At the federal level, 55 per cent of the free care health budget is allocated for treatment of target populations.

This analysis reveals that SNGs have started allocating budget in the health sector using resources other than conditional grants, such as matching and special grants, revenue transfer and internal revenue. This suggest that the health sector budget is more than NPR 90.7bn. There are no specific policy directives that provide the basis for determining the volume of health conditional grants to SNGs. This led to the issue of both under- and over-allocation. Allocations in conditional grants has improved come from the previous Integrated District Health Programme. The initial analysis and anecdotal evidence suggest that there were some issues in spending conditional grants within the stipulated time. Reasons for this might include the absence of programme implementation guidelines, delays in fund flow, issues with the release of donor budget, and lack of trained HR. Additionally, some Palikas delayed their assemblies and, as a result, the health conditional grant could not be transferred in a timely manner to the respective health facilities.

Nepal has practised a Sector-wide Approach (SWAp) in health since FY 2005/06. One of the intentions of SWAp is to improve the budgetary commitment from the government. It was observed that the GoN has been increasing the share of the health budget over the years; however, in FY 2020/21 the GoN contribution has been reduced, primarily because of low revenue generated following COVID-19. In general, the absorptive capacity of the MoHP has improved over the years but it declined in FY 2019/20 as a result of COVID-19. Nevertheless, absorption was still on the better side (79.8%) compared to the national absorption rate (70%). The actual budget absorption for MoHP has been weak given that the MoHP surrendered some budget that was further reallocated to fund conditional grant activities at SNGs for

COVID-19 response. At an organisational level, MoHP as a cost centre holds the major share of the MoHP budget (58%). Similarly, at the economic code level, the majority of MoHP budget is allocated to hospital grants. This analysis indicates the trend of increasing grants to hospitals every year. At the same time, hospitals are the only MoHP entities with absorptive capacity as high as almost 84 per cent. Only 29 per cent of the MoHP's budget is allocated for EHCS, primarily because the majority of budget allocated to SNGs is a part of EHCS. There has been an increasing trend in disclosing and depositing revenue in the central treasury, which is a good sign of improving governance and transparency. MoHP's audit queries against audited expenditure is in decreasing trend, from 13.7 per cent in FY 2012/13 to 4.7 per cent in FY 2017/18, while a slight increment was noted in FY 2018/19 at 6.7 per cent. Similarly, cumulative audit query clearance was in increasing trend, from 36.8 per cent in FY 2012/13 to 41 per cent in FY 2017/18, but also declined to 11.6 per cent in FY 2019/20 as a result of COVID-19.

This BA as a case tried to capture budgeting practice at provincial and local levels. An additional NPR 11.7bn budget has been allocated by PGs on top of the NPR 4.5bn conditional grant to health allocated by the Federal Government. Similarly, an additional NPR 9.8bn budget has been allocated by LG to health on top of the NPR 25.4bn conditional grant to health allocated by the Federal Government This analysis suggest that the health sector budget is greater than the budget reflected in the Red Book. Conditional funds make up a major source of funding for programmes, salaries and wages at the LG level.

This analysis raises an important question regarding capacity around allocative efficiency. The budget for programmes and procurement remains high at federal level, whereas a significant portion of PGs' and LGs' budget is allocated for HR. It is also important to note that most of the procurement budget for free drugs is provided to SNGs. This analysis found that a small proportion of EDP budget is allocated to SNGs. The policies and programmes of Federal, Provincial and Local Government are not sufficiently translated into budget.

8.2 Way Forward

This analysis has brought up some important questions that need to be addressed by the MoHP. The current challenge for the health sector is to sustain the progress made in achieving health outcomes and refining policies that will facilitate the process of bringing health services closer to underserved populations. Evidence-based AWPBs at all levels of government needs to be harmonised through a comprehensive policy framework that is acceptable to Federal, Provincial and Local Governments. This is important because the Constitution of Nepal mandated specific 'concurrent rights' to all governments. The following points comprise some specific recommendations on the way forward:

1. Revise the existing Health Sector Strategy by outlining specific systems and programme-level targets at all levels. It is anticipated that each government has the authority to formulate their own health policy and strategy, which need to be harmonised under the wider policy and strategy umbrella.

2. A costed HF strategy that is applicable to all levels of government needs to be formulated. This should enable the GoN to develop a roadmap for securing at least USD 86 per capita for improving access to primary care or to secure ten per cent of the national budget for the health sector.

3. The MoHP should initiate the process of preparing the health sector transitional plan, which will lend support in securing and distributing the required resources. It should be noted that PGs and LGs with higher levels of revenue can allocate additional resources for health, which may not be possible for Palikas and provinces with lower levels of revenue. This may bring some level of disparity in health care delivery.

4. Development of comprehensive federal, provincial and local Health Accounts (HAs) is required to capture the public and private sector budget and expenditure in health sector. This may require a localised framework to prepare respective HAs. This will also contribute to PGs and LGs preparing their periodic and annual health plans.

5. The practice of delayed approval of annual health budgets and delays in sending budget to SUs (especially in the Provinces) remains a key challenge in the devolved context. As a result, there is a risk of failing to maintain financial discipline and to provide timely health services to people. MoHP should assure the complete implementation of TABUCS in all SUs.

6. Prepare and implement the annual budget calendars, which should address the issue of spending budget during the third trimester.

7. Capture health spending at all levels of government, including resources for health beyond the conditional grant. Update TABUCS to capture budget and expenditure in the devolved context. Build the capacity of hospitals to capture local revenue in TABUCs to give a more comprehensive picture of income and expenditure.

8. The MoHP needs to develop a better understanding of the efficiency of its different programmes and increase allocations towards cost-effective interventions. The use of performance-based grant agreements with hospitals should also be scaled up.

9. The Gender Equality and Social Inclusion (GESI) focal persons of all divisions and centres need to ensure that activities for reaching underserved areas and unreached groups are identified and costed. The GoN needs to ensure that GESI is well addressed in all health sector plans and programmes at all levels.

8.3 Policy Brief

The Constitution of Nepal mandates health as a fundamental right of the people (GoN, 2015) and the National Health Policy, 2014 aims to carry out these rights by ensuring equitable access to high-quality

health care services for all (GoN, 2014). The evidence of other countries suggests that institutionalising the budget formulation process alone is not enough to respond to health needs. It should be coordinated with other important elements of overall PFM reform including use of MTEFs, budget tracking systems, cash management, financial information and progress reporting systems. The classification and organisation of a budget are centrally important issues when preparing sector budget. Budget classifications serve to present and categorise public expenditure in finance law and thereby structure the budget presentation. They provide a normative framework for both policy development and accountability. While budget execution rules influence how money flows to the health system, the choice of budget classifications often pre-empts the underlying rules for budget implementation and thereby plays a pivotal role in actual spending. This BA suggests some important policy options that might be useful in federal context. Following are the major policy areas that could be further discussed at all level of government. To start with, the MoHP can take the lead role.

1. GoN needs to take the initiative to develop a national health policy framework to be utilised by federal, provincial and local levels. This will help in fostering coherent policies, reduce duplications in resource allocation and improve health outcomes. During this process, a clear set of outcome, output and input indicators need to be defined. These indicators should inform one another and be compatible across the levels of government. A financing mechanism that assures the funding for all levels of indicators should also be defined in both health policy and strategy. This requires the assurance of budget inclusion against each of the indicators while finalising respective AWPBs.

2. A new national health sector strategy needs to be developed based on the comprehensive analysis of the policies, guidelines and Standard Operating Procedures (SOPs) across the health sector. The clear outcome and output indicators related to disaster response, epidemic management, PFM and public procurement should be reflected in the new NHSS.

3. A national health sector roadmap for the “new normal” in terms of service delivery needs to be prepared, finalised and implemented.

4. A costed Health Financing (HF) strategy would support MoHP in rationalising the importance of allocating five per cent of GDP to the health sector and USD 86 per capita to ensure universal access to primary care services. The HF strategy should also provide frameworks like MTEF, which will inform GoN to allocate multi-year budgets. The Steering and Technical Committees would be required to standardise scope, methodology and process while developing the HF Strategy. The HF guideline developed by the World Health Organization (WHO) can be used as a reference while developing and finalising Nepal’s HF strategy.

5. A health care transition plan should be prepared so as to sustain achievements and prevent widening disparity in health care delivery. This can be achieved through the provision of special grants to identified PGs and LGs. A policy for determining special grants needs to be developed and endorsed by the MoHP. The MoHP need to identify special units with skilled HR to develop the policy and monitor progress.

6. A policy framework and SOPs that would support in preparing HAs that are acceptable and applicable to all levels of government need to be developed and endorsed. The Steering and Technical Committees would be required to evolve standardised methodology, process, indicators and tools. A specific institution with clear Terms of Reference at MoHP would help in initiating and institutionalising the process. In the future, this practice can be harmonised at provincial and local level. The evidence from HAs needs to be developed as an integral part of the planning and budgeting process.

7. It is essential that an electronic FMIS that is able to track health budget and expenditure at all levels of government be established. This type of system is important to capture actual government

spending in health and also to ascertain total health expenditure. For this, an already existing FMIS tool, such as TABUCS, can be updated to capture income, budget and expenditure at all levels of government. As TABUCS has successfully been implemented by MoHP, NRA, MoUD and their entities, and by some PGs, efforts will be required to build capacity at the PG and LG level. A policy and guideline related to the use of TABUCS would help in capturing total health expenditure.

8. The MoHP needs to shift from incremental line-item-based budgeting to more of a goal-oriented performance-based or programme-based budgeting system. An immediate important step for this would be to institutionalise the existing Performance-Based Grant Agreement (PBGA) being piloted by the MoHP in seven NGO hospitals. A PBGA policy should be developed that has a monitoring framework applicable across all government hospitals. The Steering and Technical Committees would help to monitor the process of PBGA implementation and also determine the scope of scalability in both public and private hospitals. They would also standardise methodology, process, indicators and agreements.

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Annex 1 Macroeconomic Indicators (NPR Million)

Fiscal Year	Gross Domestic Product at Producer Price	Population	GDP Deflator (Base Year 2000/01=103.9)	Dollar: NPR Exchange Rate	MoHP Budget	MoHP Expenditure
2018/19						
2017/18	3,007,246.2	29,024,614	329.99	103	31,781	24,420
2016/17	2,642,595.3	28,621,706	308.80	106.1	40,563	39,113
2015/16	2,253,163.1	28,624,296	285.93	106.4	36,730	29,230
2014/15	2,130,150.0	27,723,373	272.41	99.5	33,517	24,531