Budget Analysis of Ministry of Health and Population FY 2018/19

Federal Ministry of Health and Population
Policy Planning and Monitoring Division
Government of Nepal
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Study Team
September 2018

EXECUTIVE SUMMARY

The budget analysis of the Federal Ministry of Health and Population (FMoHP) for FY 2018/19 intends to enable the FMoHP, DoHS, policy makers, planners, programme managers, and External Development Partners (EDPs) to understand the trend of budget and expenditure for the five year period from financial year (FY) 2014/15 to FY 2018/19. The expenditure of FY 2018/19 has not been included in the analysis. Expenditure of FY 2017/18 is actual expenditure as of 30th July 2018 (14th Shrawan, 2075). Since last fiscal year, the Government of Nepal (GoN) has devolved a portion of the health budget to the Local Governments (LGs) in the form of conditional grants. This FY additional allocation of the health budget has been made to the Provincial Governments (PGs) in addition to the LGs. Thus, the health budget is distributed across all three levels of government viz: the federal, provincial, and local. A brief overview on the pattern of health budget allocation using conditional grants and other forms of grants at the provincial and local level is also included in this report. For comparability purposes, macro level indicators have also been reported on since 2014. The analysis is done using the electronic annual work plans and budgets (eAWPBs), the GoN's Red Book (from FY 2014/15 to FY 2018/19), financial monitoring reports (FMRs), TABUCS, and conditional grants provided to LGs. The adjusted budgets of consecutive fiscal years have been used to capture the final expenditures. Due to this, some minor changes compared to the previous budget analysis report are possible. For FY 2018/19, the initial budget is used in the analysis.

Findings

The government spending on health as a share of the Gross Domestic Product (GDP) has slowly increased from 1.4 percent in FY 2014/15 to 1.9 percent in FY 2017/18. Evidence suggests that countries should strive to spend five percent of their GDP for progressing towards Universal Health Coverage (UHC) (Mcintyre *et al,* 2017). The health sector budget (FMoHP and other ministries*) is gradually increasing over the years from NPR 37.8bn in FY 2014/15 to NPR 65.3bn in FY 2018/19. **Between FY 2013/14 and FY 2017/18, the per capita government spending gradually increased from NPR 966 to NPR 1819 (USD 9.8 to 17.7) in real terms.** However, in constant terms (base year fixed to FY 2000/01), within the same time, the share of government spending has increased very little from NPR 373 (USD 3.8) to NPR 551 (USD 5.4). It is to be noted that Chatham house recommends low-income countries to spend USD 86 per capita to ensure universal access to primary care services (Mcintyre, 2014).

In this fiscal year (FY 2018/19), the GoN has provided NPR 56.41bn to the FMOHP out of which NPR 4.2bn (7.4%) was allocated to provincial governments and NPR 18.15bn (32.2%) allocated to LGs and NPR 34.08bn (60.4%) remains at the FMoHP or the federal level. Almost 38 percent of the health budget is allocated as hospital grants followed by 25 percent of the health budget in wages and salaries. Capital construction accounts for 14 percent of the total health budget. The majority of the health budget under wages and salaries, support services, capacity building, and programme activities have been devolved to LGs. At the same time, the majority of the health budget for medicines, grants to hospital, capital construction, and capital goods remain at the federal level. It is to be noted that 93 percent of the budget for equipment remains at the federal level, and the

* In FY2018/19 health sector allocation is NPR 65bn. Ministry of Defence, Ministry of Federal Affairs and general administration, Ministry of Finance Staff for Retirement funds, Ministry of Home Affairs and Ministry of Education

majority of this is allocated to purchase cancer equipment. Almost 37 percent of the budget allocated under free care is allocated to maternal and child health followed by free health care (26 percent) and free treatment of target population (23 percent).

The FMoHP budget rose gradually each year for the last three fiscal years until FY 2016/17 when it suddenly dropped. This is simply because, from FY 2017/18, the GoN has provided NPR 15.08bn directly to LGs as a conditional grant for health provided through Red Book. In the last three years, the volume of the FMoHP budget increased in absolute terms from NPR 32.2bn in FY 2014/15 to NPR 41.6bn in FY 2016/17. However, the proportion of the FMoHP budget against the national budget has decreased over the same period from 5.2 percent to 4 percent respectively. The volume of budget allocated for both administration and programmes is gradually rising. However, since FY 2017/18, there has been a sudden fall in the administration budget (only 10 percent of the FMoHP budget compared to 27 percent in FY 2016/17. In FY2018/19 this has further been reduced to 5 percent which is mainly because most of the salaries for district-and-below- level facilities are provided to PGs and LGs. The FMoHP has prioritised the Essential Health Care Services (EHCS) budget as it has accounted for the majority of the FMoHP's budget, which is in line with the Nepal Health Sector Strategy (NHSS). Over the past five years, the allocation towards the EHCS as remained above 60 percent of the FMoHP budget. This analysis reveals 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. 65.34bn. There exist no policy directives that provide the basis for determining the volume of health-conditional grants to PGs and LGs. The initial analysis and anecdotal evidences suggest that some Palikas delayed their assemblies and, as a result, the health-conditional grant could not be transferred in a timely manner to the health facilities. The analysis raises important questions around allocative efficiency. A sizeable budget under programme 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. This analysis found that a small proportion of pooled funds in child health activities is allocated to the LGs.

Health is an important development agenda and so it must 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 the priority in budget allocation. The evidence-based annual work planning and budgeting at all levels 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 budget analysis of PGs and LGs, a separate exercise is recommended. The FMoHP must initiate the process of preparing a health sector transition plan, which will support in securing the required resources and allocating them. In the devolved context, this could be additionally challenged, as the plans of PG and LG may not mandated to be aligned with the GoN/National Planning Commission (NPC) priority areas. A costed health financing 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 for improving access to primary care or spending 5 percent of the GDP for progressing towards UHC. Finally, health accounts 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

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
ARI	acute respiratory infection
AWPB	annual work plan and budget
BA	budget analysis
Cap	capital budget
DDA	Department of Drug Administration
DFID	Department for International Development
DHO	district health office
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 partners
EHCS	essential health care services
Expend	expenditure
FCGO	Financial Comptroller's General Office
FMIS	Financial Management Information System
FMR	financial monitoring report
FWD	Family Welfare Division
FY	fiscal year
GAVI	Global Alliance for Vaccines and Immunisation
GDP	gross domestic product
GESI	gender equality and social inclusion
GIZ	German Society for International Cooperation (Gesellschaftfür Internationale Zusammenarbei)
GoN	Government of Nepal
GTZ	German Agency for Technical Cooperation
HDI	Human Development Index
HIV	human immunodeficiency virus
HP	health post
HRFMD	Human Resources and Financial Resources Management Division
HRI	Health Right International
IDA	International Development Association
ITI	International Trachoma Initiative
JAR	Joint Annual Review
JCM	Joint consultative meeting
JICA	Japan International Cooperation Agency
LG	Local Government
LMBIS	Line Ministry Budget Information System
MCH	maternal and child health
MDG	Millennium Development Goal

MoF	Ministry of Finance
MoFAGA	Ministry of Federal Affairs and General Administration
MoFALD	Ministry of Federal Affairs and Local Development
FMoHP	Federal Ministry of Health and Population
MTEF	Medium Term Expenditure Framework
NA	not applicable
NHEICC	National Health Education Information Communication Centre
NHSP	Nepal Health Sector Plan
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NNRFC	National Natural Resource and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese rupees
NSL	Netherland Support for Leprosy
OAG	Office of the Auditor General
PFM	public financial management
PHCC	primary health care centre
PPMD	Policy, Planning, and International Cooperation Division
PMoSD	Provincial Ministry of Social Development
PNC	Post-natal Care
Recurr	recurrent budget
RHD	regional health directorate
SDC	Swiss Development Cooperation
SDG	Sustainable Development Goals
SOP	standard operating procedure
STD	sexually transmitted disease
SWAp	sector wide approach
TB	tuberculosis
ToR	terms of reference
TSA	Treasury Single Account
TUTH	Tribhuvan University Teaching Hospital
TWG	technical working group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

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

1.1 Background

The Constitution of Nepal 2015 mandates health as a fundamental right of the people (GoN, 2015). The National Health Policy 2014, which comes under the overarching framework of the Constitution, aims to implement this right by ensuring equitable access to quality health care services for all (GoN, 2014). The Nepal Health Sector Strategy (NHSS) 2016-2021 lays out the strategic direction and specific roadmap to implement the constitutional mandate (GoN, 2016). The Federal Ministry of Health and Population (FMoHP) has endorsed the NHSS implementation plan, which provides the budgetary framework to ensure Nepal's commitment to achieve Universal Health Coverage and Sustainable Development Goals by 2030. The FMoHP has the opportunity to ensure the fiscal space in the health sector by including priority interventions in forthcoming Nepal's 15th Five Year National Development Plan.

The FMoHP aims to continue to improve its financial management and, in particular, the timely disbursement of funds to spending units. The Financial Management Improvement Plan (FMIP) (2016/17-2021/22), and Procurement Improvement Plan (PIP) (2017/18-2022/23) have been developed and subsequently implemented. Its implementation has also improved the efficiency of resource allocation in the sector. Financial planning and budgeting provides a foundation for effective and efficient service delivery. The annual budget reflects the policy and resource allocation decisions that determine the activities, programmes, and services to be implemented by the FMoHP. The integration of the 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 FMoHP's cost centres making it easily available. The FMoHP is experiencing problems with the timely authorisation of funds, low budget absorption, fragmented fund flow modalities (i.e. off budget and off-programme funding), and weak forecasting of financial contributions by external development partners (EDPs). Since last fiscal year (FY), the GoN has devolved some of the health budget to the local governments (LGs). This year is a first fiscal year to provide the health budget across federal, provincial and local level. This brings up the important question of how to track the budget and expenditure patterns at provincial government (PG) and LG level. There are some initiatives to capture the budget and expenditure which are still in their primitive stage. This analysis primarily captures the budget channelled towards the FMoHP spending units and conditional grants provided to provincial and local levels. An attempt has been also made to capture the budget at PG and LG level on a case study basis.

1.2 Objectives of the Analysis

The purpose of this budget analysis (BA) is to enable the FMoHP, Provincial Ministry of Social Development (PMoSD), LGs EDPs, policy makers, and planners by providing disaggregated information on health budget FY 2018/19. It also aims to provide the reader with a synthesis of the main features of budget allocations and comparisons with actual spending from last three fiscal years of NHSS implementation by source, programme, and disbursement level.

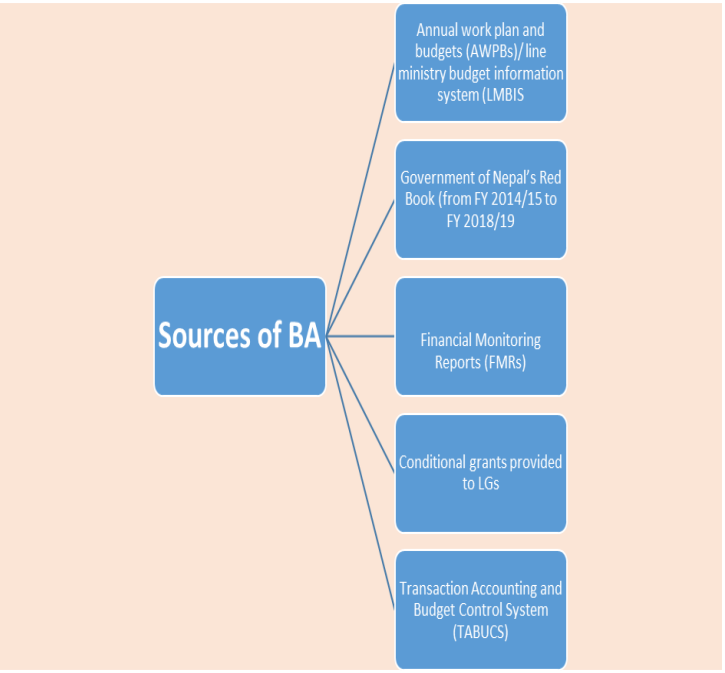
The specific objective of this task is as follows:

1. Analyse the FMoHP budget allocation for FY 2018/19
2. Analyse the budget allocated under conditional grant to 7 provinces, and local governments for FY 2018/19
3. Compare budget allocation and expenditure for first three years of NHSS implementation
4. Report budget allocated under selected outcome, output and input indicators of NHSS for FY2018/19
5. Prepare a case study on budget allocation and expenditure in all provinces and 7 Palikas for FY 2018/19
6. Prepare a case study on Aama Programme budget allocation, distribution and absorption in all Palikas from 7 selected districts
7. Prepare a policy recommendation based on the budget analysis

This can be used as a reference materials while analysing the budget and expenditure in respective governments.

1.3 Methodology

This BA primarily covers the analysis of the budget and expenditure pattern for the period from FY 2014/15 to FY 2018/19. For comparability purposes, macro level indicators have also been reported since FY 2013/14. Analysis is done using secondary sources of data, which include the following sources as outlined in the figure.



The adjusted budgets of the consecutive fiscal years have been used to reflect the final expenditures. Some minor changes in amount is possible when readers refer to the previous BA report. However, the total budget remains same. For FY 2018/19, the initial budget is used in the analysis. The analysis of conditional grants was carried out by collecting information from 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 FMoHP's planning section and discussions with the FMoHP and the Department of Health Service's (DoHS) planning and financial officials also provided useful comments, which have been incorporated into this report.

In order to analyse the budget allocation trend during the NHSS implementation period, this BA the first three years of NHSS implementation (FY 2016/17-FY 2018/19). Because the expenditure of FY 2018/19 has not begun, this analysis includes the first two years FY 2016/17 (complete expenditure) and FY2017/18 (as of 30th July). The case study on BA at provincial and local level includes analysis of the FY 2018/19 budget. The Aama programme case study is based on the analysis of budget and expenditure in FY 2017/18. It is to be noted that budget and its execution started at provincial level began in FY 2018/19 and at the local level in FY 2017/18. For the purpose of this analysis, we analysed the total budget and health budget at federal, provincial, and local level. This analysis made an attempt to analyse the budget against the selected output, and outcome level indicators from the NHSS.

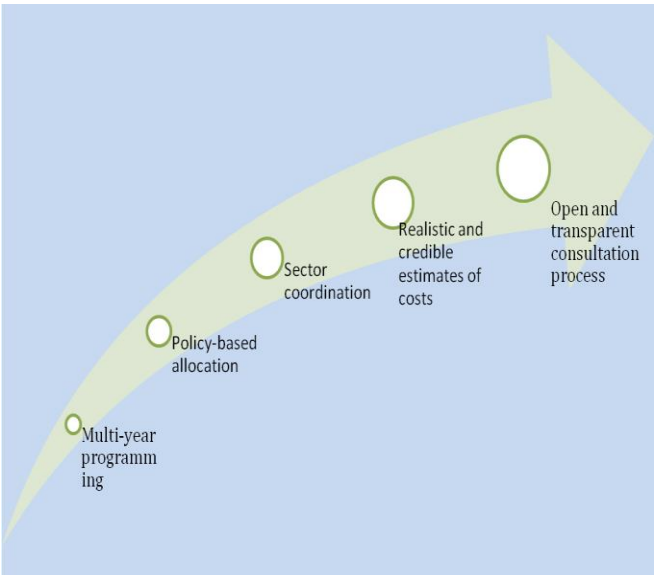
CHAPTER 2: PLANNING, BUDGETING, AND EXPENDITURE PATTERN

This chapter provides some theoretical background on budget characteristics, budget planning, and the preparation process at the 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 are important to ensure the proper implementation of fundamental rights, legal provisions, strategic plans, and international commitments. In the public sector, the budget is a primary instrument for strategic resource allocation. The way budget allocations are presented, organised, and classified in policy and programme has a direct impact on actual spending and ultimately on the performance of the health sector. Health budgets formulated and executed based on goal-oriented programmes (rather than a list of inputs) 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 of the FMoHP, related authorities, and to other Ministries involved in the delivery of health-related expenditures. A clear understanding of core principles of health budgeting therefore includes standardised processes, guidelines, systems, structure, and professional planners. Nepal's commitments to achieving universal health coverage (UHC) and the sustainable development goals 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 the UHC and Sustainable Development Goals (SDG) in the absence of well-functioning planning and budgeting systems. Nepal’s Ministry of Health and Population adopts a mix of three budget classification system viz economic, administrative and programme.

2.2 Budget Preparation Process in FY 2018/19

2.2.1 Planning in FY 2018/19 at the Federal level

The FMoHP's Policy Planning, and Monitoring Division (PPMD) is responsible for the entire planning process. Based on the budget ceilings provided by the Ministry of Finance (MoF), it takes lead role in preparing the budget details require for all departments, divisions, centres, and hospitals. The concern department are responsible to prepare the budget of the centres and division function under them. The PPMD's Planning Unit reviews the draft budget from all department, centres, and hospitals.

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 fiscal year and the "Red Book" is a budget authorisation. The provision for giving authorisation to spending units 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 line ministry budget information system (LMBIS). The approval of the budget is also the approval of AWPB in LMBIS, thus does not require further authorisation by line ministries or departments. However, most of the government entities including the FMoHP are still practicing the provision of authorisation. The sequence of events by which national plans are developed by the FMoHP within the framework of central government practice is as follows (see Table 2.1 for annual schedule):

Table 1: Annual calendar related to FMoHP, AWPB

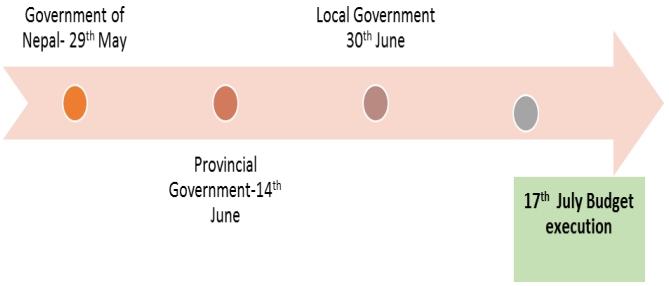
Date	Major activities
January	GoN's National Natural Resource Fiscal Commission (NNRFC) defines the overall budget for the country. This includes the budget for the FMoHP and conditional grants to the PGs and LGs. As per the decision of the NNRFC, the MoF provides budget ceilings and guidelines for sectoral ministries.
January/February	PPMD of the FMoHP allocates the budget ceiling for all departments, divisions, centres, and hospitals based on priority, programme, performance, and actual expenditure. The FMoHP asks for preliminary budgetary commitment from EDPs during the Joint Annual Review (JAR). FMoHP 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 FMoHP at the fourth JCM.
March	The FMoHP'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. FMoHP involves all EDPs and supporting stakeholders
March	The 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

Date	Major activities
	they are not satisfied with. This is a crucial juncture where adjustments may be made to the budget by the MoF. In the last phase, the MoF invites the FMoHP secretary, head of the PPMD, Planning Section, and Finance Section for final hearing and finalisation of the plan and budget. Second and Third JCM with EDPs.
May - June	MoF compile the sectoral budgets and prepares the national budget with policy and programmes. The Red Book is compiled, finalised, and announced by the Parliament by 29th May (15th Jestha). Fourth JCM with EDPs who make their commitments
16th July	Start of the new fiscal year

Source: FMoHP, 2018

2.2.2 Planning in FY 2018/19 at PG

PGs have the authority to plan and budget their health activities. In this FY, 2018/19, the FMoHP provided NPR. 4.18 billion as a conditional grant to PGs. PGs received the conditional grant through the Red Book. The PG budget included in the Red Book does not need any authorisation. The PG announces the budget by 14th June, (31st Jestha). The MoF then sends a circular through its website to all District Treasury and Comptroller Office (DTCO) to release the first quarter budget as per the Red Book irrespective of equalisation or conditional grants. The Provincial Ministry of Social Development (PMoSD) prepares the social sector budget including health budget.



The health budget for PG can include sources such revenue transfer, equalisation, conditional, special, and matching funds from federal government including their own revenue. The budget should be executed by 16th July.

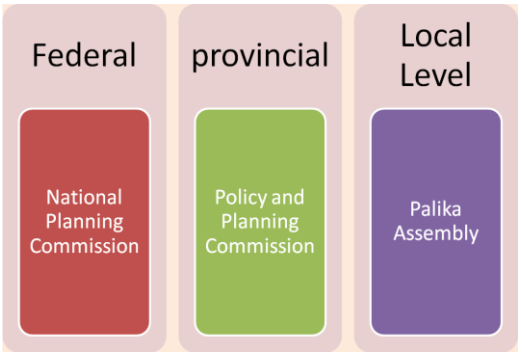
2.2.3 Planning in FY 2018/19 at Local Level

LGs have the authority to plan and budget their health activities. In this FY, 2018/19, the FMoHP have provided NPR. 18.15 billion as a conditional grant to LGs. LGs received the conditional grant through the Red Book. The LG budget included in the Red Book does not need any authorisation. In the second week of July 2018, the MoF sent a circular through its website to all DTCO to release the first quarter budget as per the Red Book, irrespective of equalisation or conditional grants. In September 2017, the GoN increased the number of LGs from 744 to 753, which required further allocation of the budget. The GoN decided to adjust the previously agreed budget to account for the new LGs. During this process, several errors were observed in the Red Book which caused a problem with sending the health budget to some of the LGs. Additionally, 12 LGs have experienced problems with receiving their complete health budget (they received partial budget). These changes

demanded the re-adjustment of the budget in order to correct these errors. The health budget for LG can include sources such revenue transfer, equalisation, and conditional, special, and matching funds from the federal government including their own revenue. The LGs should finalise their budget by 30th June (15th Ashad) and budget execution should start from 16th July.

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 NHSP-1, NHSP-2, and early stages of NHSS implementation. In the changed context, budget preparation and endorsement at different levels of government are done through the commission and Palika assemblies as shown in the figure. The FMoHP still needs to address these issues by better aligning its actual expenditures with budgets. The specific issues include:



- Aligning or harmonising exclusive functions of federal governments, PGs, and LGs
- 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 government
- Developing and harmonising a consistent health planning cycle at all levels of government
- Standardising the Medium Term Expenditure Framework (MTEF) applicable to all levels of government
- Determining a health budget and programme that is consistent with national and international commitments at all levels of government
- Enhancing the capacity of officials engaged in planning at all levels of government
- Standardising the budget and expenditure tracking system at federal, provincial, and local government

2.4 Priority Programmes

Each fiscal year, the GoN/NPC provides a list of priority programmes and planning guidance to sectoral ministries. Based on this, the FMoHP prepares the AWPB for the coming fiscal year. The priority areas from the GoN/NPC normally differ every fiscal year. This is based on the GoN's priorities in the health sector. It is important to note that the changes may still come under the bigger programme areas i.e. national health insurance, child health, maternal health, free healthcare, and disease control. The FMoHP compiles them and prepares a final draft of the AWPB by incorporating actions agreed on at the JAR and included in the aide-mémoire between the GoN and its EDPs.

While analysing the list of priority programmes, it was observed that budget allocations keep changing across programmes based on the change in programme priority. Rather than being uniformly incremental, some of these changes are also influenced by NPC guidance. In the devolved context, this could be additionally challenged, as the plans of PGs and LGs may not be mandated aligned with the GoN/NPCs priority areas. The PGs have also formed their respective planning commissions which have authority to determine their policy and programme. Similarly, the LGs though their assembly have authority to decide their policy and programme. Implementing the JAR aide-mémoire at PG and LG level will pose a challenge. The GoN made decision not to have Priority 3 programmes in all sectors this fiscal year.

CHAPTER 3: REPORT AGAINST NHSS INDICATORS

This section summarises the budget allocated against selected Nepal Health Sector Strategy (NHSS 2016-21) outcomes and output indicators for FY2018/19. The approved activities under the AWPB have been aligned by programme code, budget line item code, and activity code using TABUCS. For this analysis, the activity code is linked to the cluster, NHSS input, output, and outcome indicators. The planners and finance officers responsible for the planning and expenditure of FMoHP budget were involved in aligning activities with indicators. The analysis includes NPR 56bn allocated to health. This raises a question of whether these indicators require the resources or not. This analysis is the first attempt to report on the budget allocation against indicators and not expenditure.

3.1 Budget Allocated in Outcome Indicators

The following table intends to demonstrate the budget allocation across the federal, provincial, and local governments against the NHSS outcome indicators. The table indicates that the outcome indicator named "Improved quality of care at point of delivery" accounts for the largest share of the budget (43 percent) followed by "Equitable utilisation of healthcare" (29%) and "rebuilt and strengthened health systems" (22%).

Table 3.1: Budget Allocation for NHSS Outcome Indicators by Federal, Provincial, and Local Government, FY 2018/19

Amount in NPR Million

NHSS Outcome Indicators	Allocated Budget			Total	
	Federal	Provincial	Local	Amount	%
Rebuilt and strengthened health systems: infrastructure, HRH management, procurement and supply chain management	11,114	463	760	12,337	21.9
Improved quality of care at point-of-delivery	11,364	1,447	11,499	24,310	43.1
Equitable utilisation of healthcare services	9,634	1,625	5,082	16,341	29.0
Improved sector management and governance	7	8	75	90	0.2
Improved sustainability of health sector financing	530	47	78	656	1.2
Improved healthy lifestyles and environment	875	521	409	1,805	3.2
Strengthened management of public health emergencies	335	29	70	434	0.8
Improved availability and use of evidence in decision-making processes at all levels	222	45	179	446	0.8
Total	**34,082**	**4,185**	**18,153**	**56,420**	**100**

In this fiscal year, improved sector management and governance received the lowest budget allocation (0.2%) followed by strengthened management of public health emergencies (0.8%).

3.2 Budget Allocated by Output Indicator

The table below shows that the indicator named "Health services delivered as per standards and protocols" (40.4%) has received the highest budget this fiscal year. It is important to note that there was no budget allocated towards "Improved preparedness for public health emergencies" and "Survey, research and studies conducted in priority areas" at LG level and no budget allocated for "Improved health sector reviews with functional linkage to planning process at provincial and local

government" and "Survey, research and studies conducted in priority areas; and results used" at PG and LG level.

Table 3.2: Budget Allocation for NHSS Output indicators by Federal, Provincial, and Local Government, FY 2018/19

Amount in NPR Million

NHSS Output Level Indicators	Allocated Budget (NPR)			Total	
	Federal	Provincial	Local	Amount	%
Health infrastructure developed as per plan and standards	10309.6	1.8	225.0	10536.4	18.7
Improved management of health infrastructure	79.4	17.9	4.4	101.7	0.2
Improved staff availability at all levels with focus on rural retention and enrolment	21.9	76.0	0.0	97.9	0.2
Improved human resource education and competencies	87.6	87.0	0.0	174.6	0.3
Improved procurement system	282.0	174.1	530.1	986.3	1.7
Improved supply chain management	334.0	105.9	0.0	439.9	0.8
Health services delivered as per standards and protocols	10024.6	1335.9	11440.5	22801.0	40.4
Quality assurance system strengthened	40.3	19.7	13.1	73.1	0.1
Improved infection prevention and health care waste management	1299.4	90.9	45.5	1435.8	2.5
Improved access to health services, especially for unreached population	9625.3	1621.6	4887.0	16133.8	28.6
Health service networks including referral system strengthened	9.1	3.0	195.5	207.6	0.4
Improved governance of private sector	6.5	8.4	75.3	90.2	0.2
Health financing system strengthened	530.5	47.2	78.1	655.8	1.2
Healthy behaviours and practices promoted	874.8	521.2	409.3	1805.3	3.2
Improved preparedness for public health emergencies	2.1	0.0	0.0	2.1	0.004
Strengthened response to public health emergencies	333.1	29.0	70.2	432.3	0.8
Integrated information management approach practiced	195.8	45.0	178.7	419.5	0.7
Survey, research and studies conducted in priority areas and results used	24.0	0.0	0.0	24.0	0.043
Improved health sector reviews with functional linkage to planning process	2.4	0.0	0.0	2.4	0.004
Total	**34,082**	**4,185**	**18,153**	**56,420**	**100**

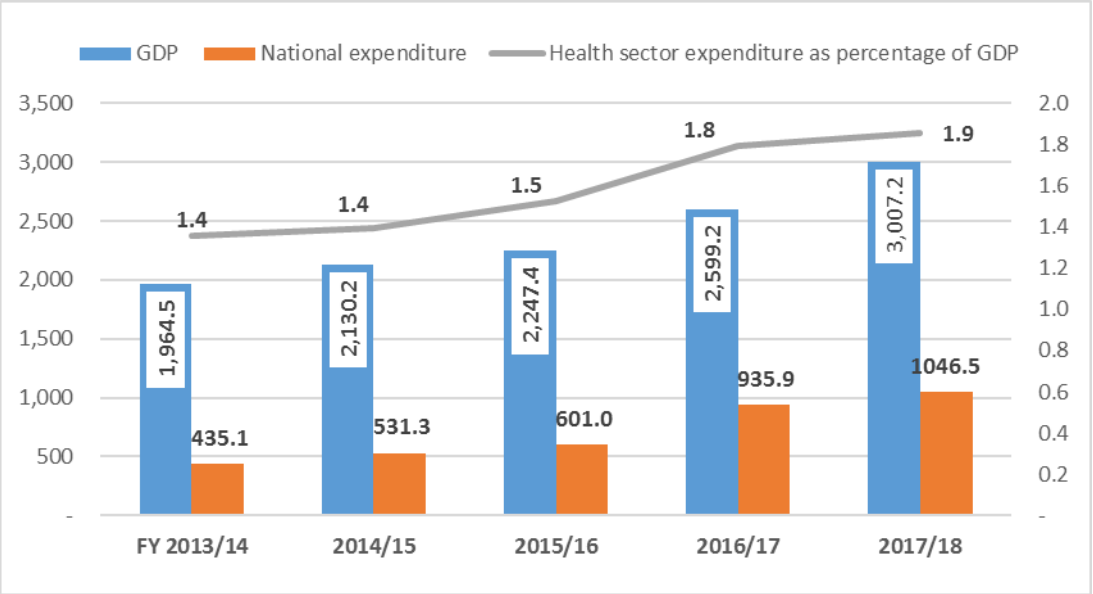
It is important to note that not all NHSS indicators received the budget and distribution across all levels of government. This could be due to insufficient thinking while determining the indicators or not prioritising the indicators while planning and budgeting.

3.3 Trends in Government Health Expenditure

Figure 3.1 provides an indication of the trend of government health spending as a percentage of the gross domestic product (GDP). Over the years, government spending on health as a share of the GDP is slowly increasing. The government spending on health includes budget allocated to the FMoHP

and other line ministries. Other line ministries include the MoF, Commerce and Supply, Defence, Home Affairs, General Administration, Education, and Federal Affairs and Local Development.

Figure 3.1: Trends in government health spending as a percentage of GDP (NPR billion)



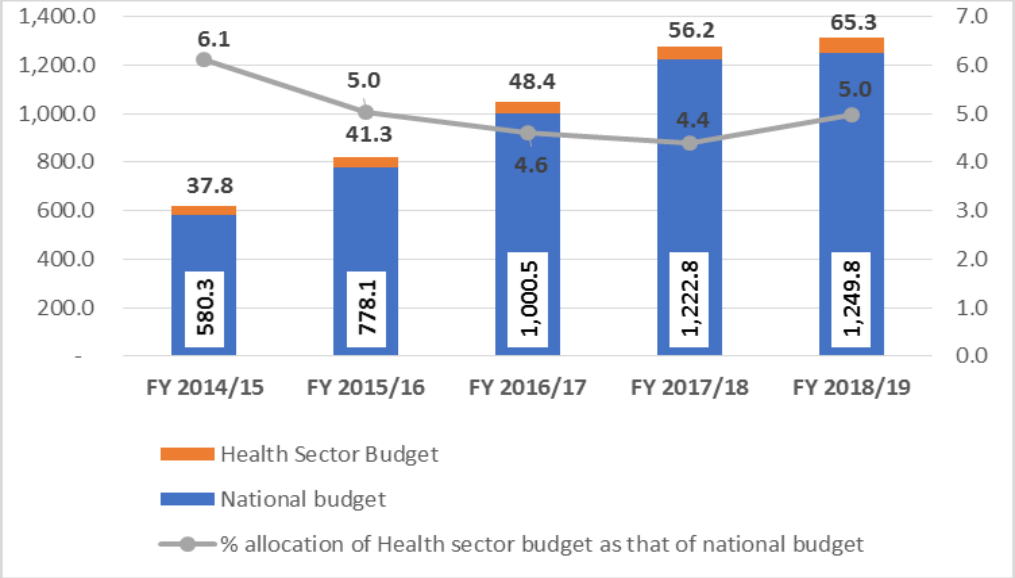
Source: Red book FY 2013/14-17/18

Government health expenditure as a percentage of the GDP for FY 2018/19 is 1.9 percent. There is a 0.5 percentage increase compared to the baseline year (1.4% for 2013/14) and 0.3 percent increase compared to the target (1.6% for 2016/17). The Chatham House report issued in 2014 recommended that countries should strive to spend 5 percent of their GDP for progressing towards UHC (Mcintyre, 2014). There is a wide range of evidence and comparisons across countries that support this target of at least 5 percent or more of the GDP. The 2010 World Health Report stated that public spending of about 6 percent of the GDP on health will 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 5 percent of the GDP is required to achieve a conservative target of 90 percent coverage of maternal and child health services (Mcintyre *et al*, 2017). Detailed progress on other NHSS indicators such as incidence of catastrophic health expenditure, percentage of OOPE as total health expenditure are included the JAR meeting report.

3.4 Share of Health Sector Budget out of Total Government Budget

Figure 3.2 below shows trend in the health sector budget as a percentage of the national budget. As indicated by the figure, the volume of health sector budget has increased from NPR 37.8bn in FY 2014/15 to NPR 65.4bn in FY 2018/19. However, the share of health sector budget against the total national budget has decreased from 6.1 percent in FY 2014/15 to 4.4 percent in FY 2017/18. In FY 2018/19 the health sector shared 5 percent of the national budget. The NHSS set a target of 8.5 percent for 2018. This means that the health sector has not been able to meet the NHSS target in terms of allocation against the national budget.

Figure 3.2: Percentage of national budget allocated to health sector (NPR billion)



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

Note that health sector budget includes budget allocated to the FMoHP as well as the 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.

This section made an attempt to report the budget allocated for federal, provincial, and local level government against NHSS indicators. It also provides analysis of government spending on health excluding the off budget off treasury, and the private sector contribution. Furthermore, this analysis does not take into account the local resources allocated to health by provincial and local governments through their revenues.

CHAPTER 4: HEALTH BUDGET ANALYSIS

This section examines the health budget and related expenditure from FY 2014/15 to FY 2018/19 compared with macroeconomic indicators. The section starts with an analysis of the health sector budget followed by a detailed analysis of the health and FMoHP budget. For clarity, health sector budget is defined as the health budget allocated to the FMoHP, MoFAGA, and other line ministries, and health budget is defined as budget at federal FMoHP health budget at the provincial and local government level. The following analysis does not provide definitive reasons for trends but does try to elucidate potential reasons for some of the findings.

4.1 Trends in Health Budget Allocation and Expenditure against GDP

Table 4.1 shows the GDP, National, Provincial, and Local budget, and health budget including expenditure from FY 2014/15 to FY 2018/19. Health budget includes the budget for the FMoHP and conditional grants to PGs and LGs.

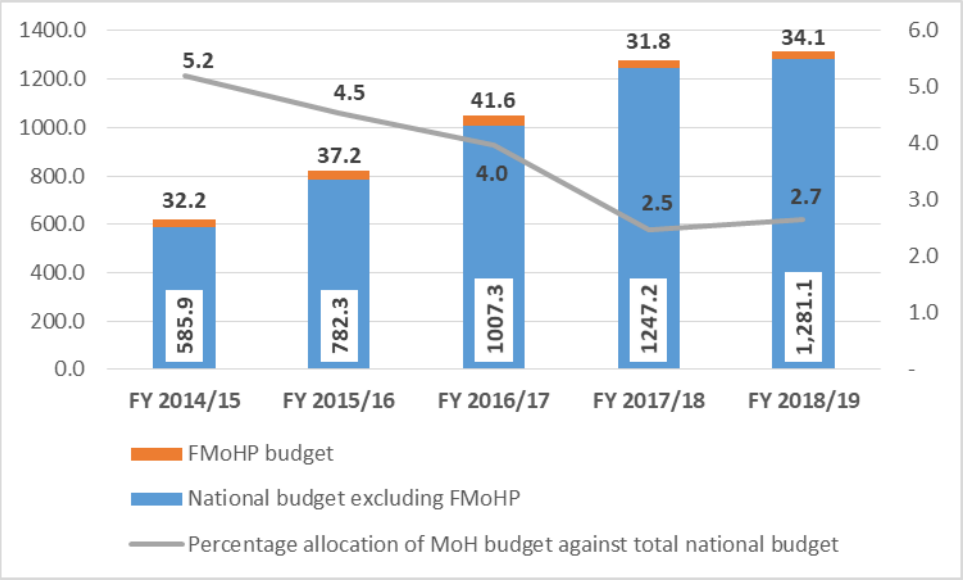
Table 4.1: GDP, National Budget, PGs, LGs, Health Budget, and Absorption (Amount NPR Billion)

Categories	2014/15	2015/16	2016/17	2017/18	2018/19*
GDP	2,130.2	2,253.2	2,642.6	3,007.3	3,154.6
Budget					
National	618.1	819.5	1,048.9	1,279.0	1,315.2
Provincial	NA	NA	NA	7.0	113.4
Local	NA	NA	NA	225.1	195.1
Health Budget	32.2	37.2	41.6	46.9	56.4
FMoHP Budget	32.2	37.2	41.6	31.8	34.1
Local Health Budget	NA	NA	NA	15.1	18.2
Provincial Health Budget	NA	NA	NA	NA	4.2
Absorption Rate (%)					
National	86.0	73.3	79.8	81.8	NA
FMoHP	76.2	78.7	94.0	80.4	NA
Local Health Budget	NA	NA	NA	-	
Provincial Health Budget	NA	NA	NA	NA	

** Forecast from ADB (4.9% projected GDP growth rate) updated April 2018.*
Source: MoF, Economic Survey FY2014/15-18/19; GoN Red Book, FY 2014/15-18/19

In this fiscal year, the GoN has provided NPR 56.4bn to the FMoHP out of which NPR 4.2bn is allocated to PGs and NPR 18.bn to LGs while NPR 34.08bn remains at the FMoHP or the federal level. In the last four years, the health budget has increased in absolute terms from NPR 32.2bn in FY 2014/15 to NPR 56.41bn in FY 2018/19 (see table above). The FMoHP absorption rate in FY 2014/15 was lower than the absorption rate for the national and health sector budget (see Figure 4.1). It is important to note that the FY 2014/15 was considered as an expenditure year meaning that the FMoHP received the amount that it had spent the year before. This practice further highlights the need to improve absorption rates in the FMoHP. In FY 2017/18, the FMoHP absorption capacity was improved to 80 percent. This proportion may increase as the FMoHP is still capturing the final expenditure.

Figure 4.1: Percentage of national budget allocated to FMoHP *Amount in NPR billion*



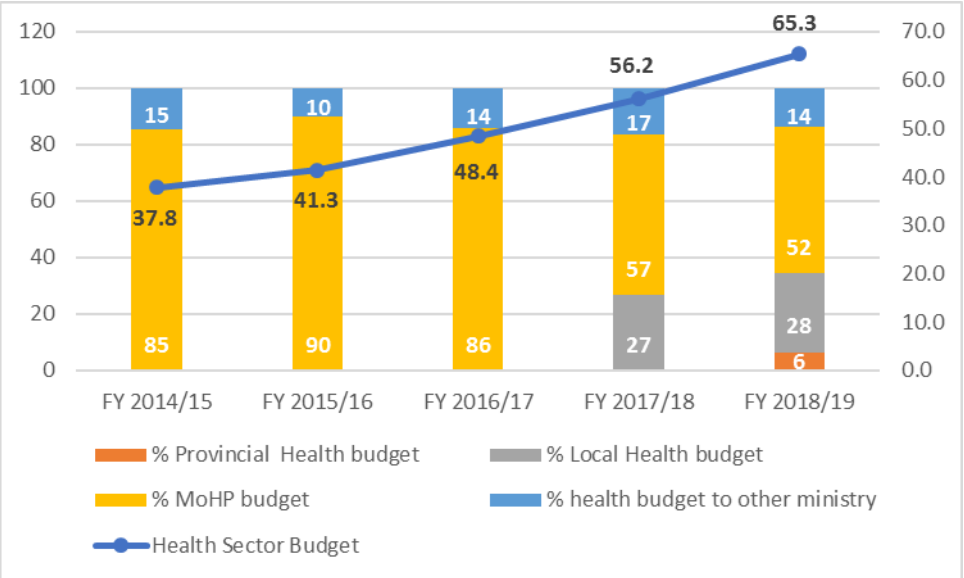
Source: GoN, Red Book, FY 2013/14-2017/18

Since FY 2017/18, a portion of the FMoHP budget was devolved to LGs and in FY 2018/19 to both PGs and LGs in the form of conditional grants though MoFAGA. This indicates that the share of FMoHP budget against the national budget has sharply declined since FY 2017/18 from 5.2 percent to 2.5 percent as shown in the figure. In FY2018/19, the FMoHP budget is 2.7 percent of the national budget.

4.2 Health Sector Budget in FY 2018/19

Figure 4.2 shows the percentage distribution of the health sector budget across the FMoHP, other ministries, PGs, and LGs. The line graph shows that the health sector budget has been gradually increasing over the years from NPR 37.8bn in FY 2014/15 to NPR 65.3bn in FY 2018/19.

Figure 4.2 Composition of Health Sector Budget *Amount in NPR billion*



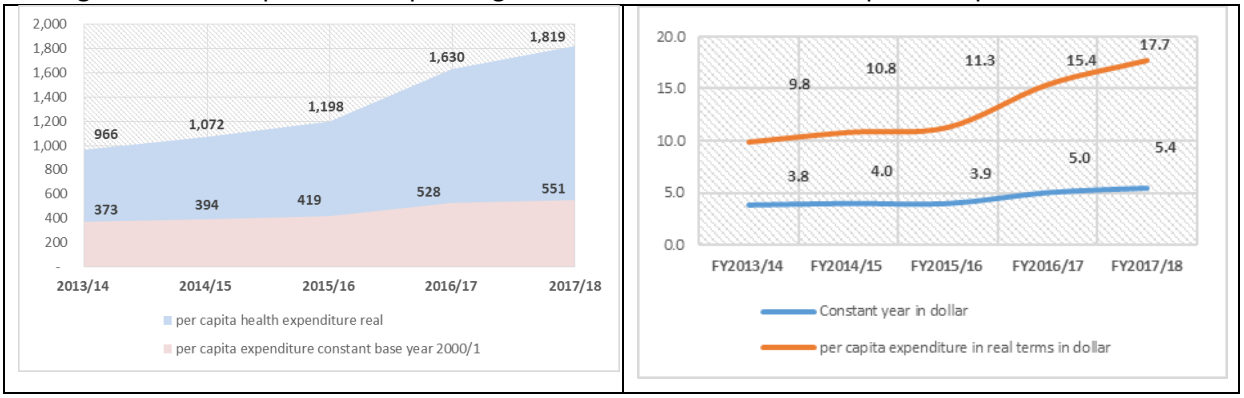
Source: GoN, Red Book, FY 2014/15-2018/19

The health sector budget in actual terms has increased over the review period. This is due to the health budget increase in the FMoHP and other ministries. From this fiscal year onwards, PGs receive conditional grants for health in addition to LGs, which is 34 percent of the total health sector budget for FY 2018/19.

4.3 Per Capita Government Health Expenditure

In FY 2017/18, the per capita government spending has gradually increased from NPR 966 (USD 9.8) to NPR 1819 (USD 17.7) in real terms. However, in constant terms (base year fixed to FY 2000/01), within the same time, the per capita government health spending has increased very little from NPR 373 (USD 3.8) to NPR 551 (USD 5.4). Health sector expenditure for FY 2017/18 is extrapolated based on the absorption rate of FY 2016/17.

Figure 4.3: Per capita health spending in real and constant terms Nepalese rupee and US dollar



Source: Red book FY 2014/18-18/19, Population projection obtained from HMIS

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 behind the recommended amount to achieve universal access to primary care services.

4.4 Allocation of Health Budget by Line-item at Federal, Provincial, and Local levels

The health budget allocated to provincial and local governments is provided in the form of a conditional grant. The details of health programme activities provided to PGs and LGs can be found at www.mofaga.gov.np. The following table summarises the budget provided to the FGs, PGs and LGs.

Table 4.2 Line-item Wise Allocation of Health Budget by Federal, Provincial, and Local Government

Amount in NPR million

Line Item	Allocated Budget				
	Federal	Provincial	Local	Amount (NPR)	%
Wages and Salaries	1,362	1,011	11,459	13,832	24.5
Support Services	527	252	1,312	2,092	3.7
Capacity Building	179	714	760	1,653	2.9
Programme Activities	1,083	394	2,044	3,520	6.2
Medicine Purchases	3,527	786	894	5,207	9.2
Grants to Hospitals	18,833	940	1,211	20,984	37.2
Capital-Construction	7,508	21	315	7,845	13.9
Capital Goods	1,063	67	158	1,288	2.3

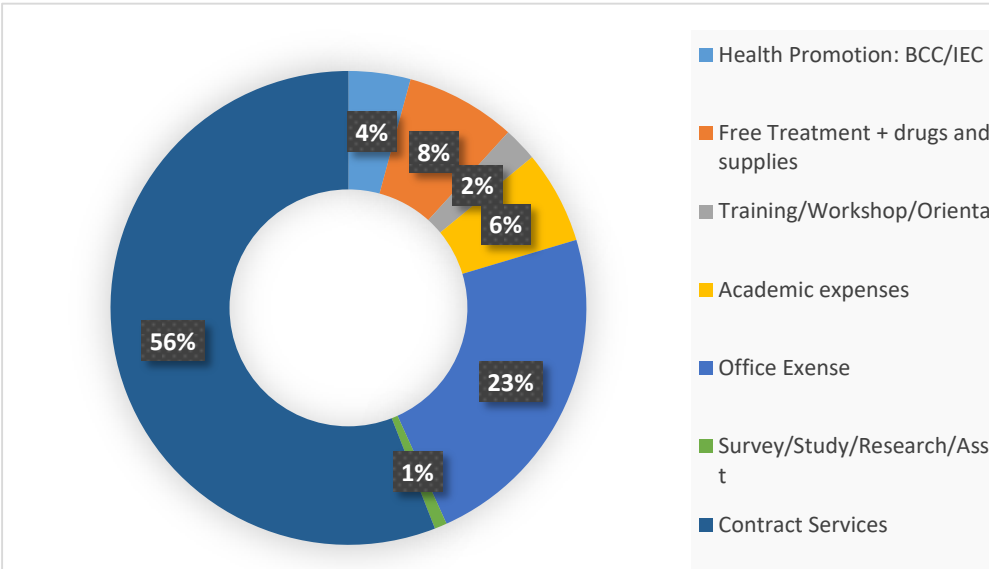
Total	**34,082**	**4,185**	**18,153**	**56,420**	**100**

Almost 38 percent of the health budget is allocated as hospital grants followed by 25 percent in wages and salaries. Capital construction accounts for 14 percent of the total health budget. The majority of the health budget under wages and salaries, support services, capacity building, and programme activities have been devolved to LGs (83%, 46%, and 58% respectively). At the same time, the majority of the health budget for medicines, grants to hospitals, capital construction, and capital goods remains at the federal level (68%, 90%, 96 and 83 respectively). The key health budget driver for LGs is wages and salaries (64%) followed by in programme activity (11%) and in support service (7%). Similarly, for PGs, key health budget drivers are wages and salaries (24%) followed by grant to hospitals (almost 23%), and 19 percent for the purchase of medicines. At the same time, grants to hospitals (55%), capital construction (22%) and medicine purchase (10%) remain the top three drivers of health budget at the FMoHP.

4.5 Disaggregation of Health budget by Recurrent Budget

The FMoHP provides grants in the form of capital and recurrent which is mainly directed to the hospitals. The figure below shows the disaggregation of recurrent grants. Contract services appear to be the major driver of recurrent grant (56%) followed by office expenses (23%). Eight percent of the recurrent grant is spent on free treatment including the purchase of medicines. Six percent of the recurrent grant is spent on academic expenses such as scholarships and operating academic programmes. Around 4 percent of the recurrent grant is spent on health promotion activities.

Figure 4.4: Recurrent grant disaggregation



Almost all of the capital grant budget is allocated to the FMoHP. The majority of the capital grant is spent on building construction and civil works. It is interesting to note that almost 8 percent is spent on purchasing medical equipment.

4.6 Cluster-wise Allocation of Health Budget at Federal, Provincial, and Local levels

By cluster-wise allocation, almost 50 percent of the health budget is spent on general administration and support. Maternal and child health accounted for 16 percent of the total health budget followed

by curative service (12%) and health insurance (11%). Almost all of the health budget for homeopathy/unani, drug management, and health insurance is allocated to the federal level. Similarly, more than half of the health budget is allocated to oral and mental health at the provincial level and the free health care programme (66%) and Ayurvedic services (51%) at the local level.

Table 4.3: Cluster wise allocation of health budget by Federal, Provincial, and Local levels

Amount in NPR million

Cluster	Allocated Budget				
	Federal	Provincial	Local	Amount (NPR)	%
General Administration and Support	13,396	1,148	11,906	26,450	46.9
Curative (Hospital) Services	6,248	105	377	6,730	11.9
Homeopathy/ Unani	16	-	-	16	0.0
Ayurveda	250	31	299	580	1.0
Epidemic Disease Control	539	84	272	895	1.6
TB & Leprosy Control	605	189	222	1,016	1.8
HIV/AIDS and STDs	551	159	44	754	1.3
Drugs Management	168	-	-	168	0.3
Laboratory Service	199	3	-	202	0.4
Oral and Mental Health	19	20	-	39	0.1
Maternal and Child Health	3,458	2,021	3,417	8,896	15.8
Health Education and Training	621	17	-	638	1.1
Health Promotion	95	97	159	351	0.6
MIS/ Survey/ Surveillance/ Research	319	65	179	562	1.0
Free Health Programme	459	201	1,279	1,939	3.4
Impoverished Citizen Treatment	1,141	44	-	1,185	2.1
Health Insurance	6,000	-	-	6,000	10.6
Total	**34,082**	**4,185**	**18,153**	**56,420**	**100**

No health budget is allocated under treatment of impoverished citizen, health education and training, laboratory service, oral and mental health at the local level. The three main cost drivers at the local level are general administrative and support (66%), followed by maternal and child health (19%) and free health programmes (7%). Similarly, at the provincial level the three major cost drivers are maternal and child health (48%), general administration and support (27%) and free health programmes (5%). At the federal level general administration and support (39%), curative service (18%), and health insurance (17.6%) are the key budget drivers. The general administration and support covers administration and support services at hospitals.

4.7 Drug Procurement from Health Budget by Federal, Provincial, and Local levels

Almost 30 percent of the budget under drug procurement is spent on purchasing vaccines, diluent, and syringes followed by free health care (27%) and HIV/AIDS and sexually transmitted disease (STD) drugs (9%). The entire allocation for the purchase of rabies, ant-malarias, kala-azar, lymphatic filariasis, anti-snake venom, and homeopathic drugs is allocated to the federal level (though it does not account for a large share of the total budget for drug related activities). Similarly, all obstetric, general, and specialised drugs are purchased at the provincial level. At the same time more than 80

percent of homeopathic drugs and nutritional drugs and supplements are allocated to the provincial level. 85 percent of Ayurvedic drugs and 56 percent of free health drugs are allocated at local level.

Table 4.4: Drug procurement from health budget by Federal, Provincial, and Local Government

Amount in NPR million

Drug Related Activities	Allocated Budget in NPR				
	Federal	Provincial	Local	Amount	%
Vaccine, Diluent, and Syringe	1,524	36	-	1,560	29.96
Free Health Drugs	450	170	805	1,425	27.36
HIV/AIDS and STD Drugs	413	32	2	448	8.60
TB Drugs and Supplies	365	9	-	374	7.18
FP Commodities	272	5	-	277	5.31
Emergency Preparedness Drugs	113	14	-	127	2.43
Lab Kits/Reagents/Chemicals	102	-	-	102	1.96
Nutritional Drugs & Supplements	86	331	-	417	8.00
Rabies Vaccine	70	-	-	70	1.34
Antimalarial Drugs & Supplies	47	-	-	47	0.89
Kala-azar Drugs & Supplies	28	-	-	28	0.53
Anti-Snake Venom (ASV) Drugs	20	-	-	20	0.38
Lymphatic Filariasis Drugs	20	-	-	20	0.38
IMNCI Drugs & Supplies	15	120	-	135	2.59
Homeopathic Drugs	4	-	-	4	0.08
Ayurveda Drugs	-	15	87	101	1.95
Obstetric Drugs	-	44	-	44	0.84
General/Specialised Drugs	-	11	-	11	0.20
Total	**3,527**	**786**	**894**	**5,207**	**100**

At the local level, the main cost driver is free health drugs purchase which accounts for 90 percent of the total budget. Similarly, at the provincial level the major cost drivers are the purchase of nutritional drugs and supplements (42%), followed by 22 percent for the purchase of free health drugs. At the federal level, 43 percent of the health budget is spent on the purchase of vaccines, diluent, and syringes followed by free health drugs (13%).

4.8 Equipment Procured from Health Budget by Federal, Provincial and Local levels

Table 4.5 presents equipment categories procured from the health budget at three levels. 93 percent of the budget for equipment purchase remains at the federal level. 5 percent of equipment are purchased at the local level. At the national level, the majority of the equipment budget is spent on purchasing cancer equipment (36), followed by the purchase of medical equipment (33%) and purchase of office equipment (6%).

Table 4.5 Categories of equipment procured from health budget by Federal, Provincial and, Local levels

Amount in NPR Million

Equipment Categories	Allocated Budget				
	Federal	Provincial	Local	Amount (NPR)	%
Cancer Equipment	899	-	-	899	35.7
Medical Equipment	791	36	-	827	32.9
Computer/Photocopy/Printer	70	-	75	145	5.8

Maternal and Child Health Equipment	92	18	21	130	5.2
Cardiac, Thoracic, and Vascular Equipment	127	-	-	127	5.0
Cold Chain Equipment	115	-	-	115	4.6
Tuberculosis Equipment	82	12	-	93	3.7
Human Organ Transplant Equipment	72	-	-	72	2.9
Ayurveda Equipment	28	-	20	48	1.9
Ophthalmic Equipment	31	-	-	31	1.2
Laboratory Equipment	27	-	-	27	1.1
Total	**2,333**	**66**	**116**	**2,515**	**100**

At the local level, the purchase of office equipment is the major cost driver (65%). Similarly, at the provincial level, the purchase of other medical equipment is the major cost driver (55%) and purchase of cancer equipment remains the major cost driver at the federal level (38%).

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

Almost 37 percent of the budget allocated under free care/treatment is spent on maternal and child health followed by free health care (26%), and free treatment of the target population (23%). All of the budget related to free treatment of heart, eye, and cancer is allocated to the federal level. 94 percent of the budget for free treatment of target groups sits at the federal level. 57 percent of the budget for tuberculosis (TB) treatment is allocated to PGs. Similarly, 56 percent of free health care budget is allocated to LGs.

Table 4.6: Budget Allocation for Free Care/Treatment at Federal, Provincial and Local Government

Amount in NPR Million

Free Health Care/Treatment	Allocated Budget				
	Federal	**Provincial**	**Local**	**Amount**	**%**
Free Maternal and Child Health	267	750	1,114	2,130	37.0
Free Health Care (drug+ examination fee +OPD)	451	198	827	1,476	25.6
Free Treatment for Target Population	1,230	7	78	1,315	22.8
Free Heart Treatment	422	-	-	422	7.3
Free Health Camp	93	87	134	314	5.4
Free TB Treatment	3	29	19	51	0.9
Free Eye Treatment	30	-	-	30	0.5
Free Cancer Treatment	15	-	-	15	0.3
Free Leprosy Service	-	7	-	7	0.1
Free HIV/AIDS Lab Test	-	5	-	5	0.1
Total	**2,509**	**1,083**	**2,172**	**5,764**	**100**

More than 50 percent the PGs and LGs free health budget is occupied by maternal and child health followed by free health services. At the federal level, almost 50 percent free health budget is captured by treatment of target population.

4.10 Activities under Programme Budget at Federal, Provincial, and Local Levels

Table 4.7 presents a disaggregation of the programme budget into different activities. It is interesting to note that many activities that should be under different line item codes are included in

the programme code. For example, the training/workshop/ orientation and supervision and monitoring should be included in the different line item code. This indicates inefficiency in budget allocation.

Table 4.7 Activities under programme budget by Federal, Provincial, and Local levels *Amount in NPR Million*

Programme Activities (22522)	Allocated Budget				
	Federal	**Provincial**	**Local**	**Amount**	**%**
Service Provision/Strengthening/Expansion	82	93	953	1,127	32.0
Mass Campaign	-	-	247	247	7.0
Health Promotion: BCC/IEC	88	52	185	324	9.2
Free Health Camp	79	18	104	201	5.7
FCHV Retirement Package	-	-	51	51	1.4
Nutrition/Mental Rehabilitation Programme	4	-	8	12	0.3
Celebrate International/National Day	6	-	30	35	1.0
Programme Planning/Review	27	-	-	27	0.8
Training/Workshop/Orientation	192	4	195	392	11.1
Drugs & Supplies	253	60	22	334	9.5
Supervision/Monitoring/Evaluation	69	7	180	256	7.3
Free Treatment	13	112	53	177	5.0
Survey/Study/Research/Assessment	114	34	10	159	4.5
Office Expanses/ Support Services	122	4	-	126	3.6
Contract Services	34	11	6	51	1.4
Total	**1,083**	**394**	**2,044**	**3,520**	**100**

CHAPTER 5: FMOHP BUDGET ANALYSIS

This chapter describes the budget allocated to the FMoHP. The analysis captures the expenditure up to FY 2017/18. The source of expenditure has been taken from the FMoHP's financial monitoring reports (FMRs) which is verified with the Financial Controller General Office's Financial Management Information System (FMIS) (expenditure for FY 2017/18 is as of July 30, 2018). This analysis excludes the conditional grant provided to PGs and LGs.

5.1 FMoHP Budget and Expenditure by Capital and Recurrent Classifications

Table 5.1, shows that there is increase in the volume of capital budget from NPR 4.3bn in FY 2014/15 to NPR 8.6bn in FY 2018/19. This increase suggests a government priority to rebuild health infrastructure. The percentage allocation of the capital budget has increased from 12 percent in FY2014/15 to 25 percent FY 2018/19, which is highest for all years. At the same time, the percentage allocation of recurrent budget is decreasing.

Table 5.1: Budget and Percentage Expenditure by Capital and Recurrent *Amount in NPR Billion*

Expenditure Type	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
Capital	4.3	71.1	4.6	74.2	6.6	88.6	7.0	95.7	8.6	NA
Recurrent	27.9	76.9	32.6	79.3	35.0	94.9	26.0	76.3	25.5	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

The absorption of the recurrent budget is better than the capital budget and as much as 95 percent in FY 2016/17. One of the reasons to this could be because a significant proportion of the recurrent budget is used for administrative expenditure including salary and allowances and capital budget are subjected to procurement delays. However, the trend appears opposite in FY2017/18 with 96 percent absorption in capital budget. This is due to additional NPR 1 billion building construction expenditure provided by the Federal Ministry of Urban Development to the FMoHP.

5.2 FMoHP Budget and Expenditure by GoN and EDPs

The government's share in FMoHP budget has fluctuated over the years. The government share has reached as high as 79 percent in FY 2015/16 and has declined ever since to 65 percent in FY 2018/19. Since, FY2017/18, the EDPs channelling their funding through the pooled fund, have agreed only to fund activities implemented by the FMoHP. As a result the share of EDP in FMoHP budget has increased. However, the overall EDP's contribution in health budget NPR. 56.41 is in decreasing trend.

Table 5.2: Budget and Percentage Expenditure by Source of Fund *Amount in NPR Billion*

Budget Source	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
GoN	20.9	89.7	29.4	82.5	31.9	99.8	24.0	90.1	22.3	NA
EDP	11.3	50.9	7.7	64.0	9.7	74.7	8.9	54.6	11.8	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

The absorption of the government budget in the last four years has remained above 80 percent with almost 100 percent absorption in FY 2016/17. The absorption of the EDP budget for the same period is between 50 percent and 75 percent. This could be due to weak or no reporting of EDP direct funding, which is reflected in the Red Book but not captured in government expenditure records.

5.3 FMoHP Budget and Expenditure by Administration and Programme

Table 5.3 shows the FMoHP budget allocated for both administrative use and programmes. Between FY 2014/15 and FY 2016/17, the volume of both administrative and programme budget has risen with an increasing FMoHP budget. Before FY 2016/17, almost 30 percent of the FMoHP budget was allocated to the administrative budget. Since FY 2017/18, the administrative budget has reduced to 11 percent of the FMoHP budget which further reduced to 5 percent in FY 2018/19. This is mainly because salaries and other administrative expenses have been allocated to PGs and LGs through conditional grants.

Table 5.3: Budget and Percentage Expenditure by Administrative and Programme *Amount in NPR Billion*

Budget Type	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
Administrative	8.9	100.9	11.6	79.2	11.2	113.3	3.4	81.8	1.8	NA
Programme	23.3	66.7	25.5	78.4	30.4	86.8	29.5	80.3	32.3	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

The FMoHP has been able to spend almost all of its administrative budget and sometimes more than allocated. At the same time, programme budget absorption has shown some improvement up to FY 2016/17. In FY 2017/18 both administrative and programme budget had more than 80 percent absorption.

5.4 FMoHP 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 has been fluctuating over the years. In FY 2018/17 pooled funds as a share of the FMoHP budget has remained at 25 percent and direct fund at 10 percent.

Table 5.4: Budget and Percentage Expenditure by Government, Pool, and Direct Funding

Amount in NPR Billion

Source of Funds	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
GoN	20.9	89.7	29.4	82.5	31.9	99.8	24.0	90.1	22.3	NA
Pooled Funds	8.1	57.8	0.8	121.2	3.4	139.4	5.0	110.5	8.6	NA
Direct Funds	3.2	33.3	6.9	57.4	6.3	40.1	3.9	26.7	3.3	NA
MoHP Total	**32.2**	**76.2**	**37.2**	**78.7**	**41.6**	**93.9**	**33.0**	**80.4**	**34.1**	**NA**

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

It is important to note that the reporting of expenditure under direct funding has been weak over the years. In FY2017/18, absorption of direct fund appeared to be very low. This is mainly because of

under-reporting from direct funding and the fact that DTCO is yet to record in kind support to the Treasury Single Account (TSA).

5.5 FMoHP Budget and Expenditure by Organisational Level

The Department of Health Services (DoHS) holds a major share of the FMoHP budget. However, between FY 2014/15 and FY 2018/19, percentage allocation of the DoHS budget decreased from 64 percent to 58 percent. At the same time, budget to the FMoHP's spending unit seemed to have increased from 8 percent to 21 percent while the Department of Ayurveda (DoA) budget decreased from 2.9 percent to 0.6 percent. Similarly, allocation to the hospital budget increased from 15 percent in FY 2014/15 to 21 percent in FY 2017/18 but then decreased in FY 2018/19 to 15 percent. This might be because of the hospital budget provided to PGs and LGs.

Table 5.5: Budget (NPR) and percentage expenditure by FMoHP Organisations *Amount in NPR Billion*

Organizations	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
FMoHP	2.6	68.4	3.6	61.3	3.9	90.0	2.8	81.7	7.1	NA
DoHS	20.5	77.4	24.6	82.0	26.6	95.5	19.7	79.4	19.8	NA
DDA	0.1	90.6	0.1	63.4	0.1	69.5	0.1	78.8	0.2	NA
DoA	0.9	80.1	1.1	69.1	1.1	88.4	0.5	82.8	0.2	NA
Centres	3.2	53.4	2.6	44.0	2.6	72.8	3.0	57.2	1.7	NA
Hospitals	4.8	89.2	5.1	94.6	7.3	99.2	6.8	93.0	5.1	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

Until FY2016/17, the overall absorption of the FMoHP and its entities seems to have improved with almost 94 percent absorption. Almost 100 percent absorption was observed in the hospital budget. In FY 2017/18, the overall budget absorption was 80 percent with highest absorption seen in hospital (93 percent) followed by the DoA (83 percent) and the FMoHP (82 percent).

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

Essential health care services (EHCS) is a priority for the FMoHP, thus EHCS accounts for majority of the FMoHP's budget. This is in line with the NHSS's recommendations. Over the past years, the percentage allocation of the EHCS budget has remained more than sixty five percent of the FMoHP's budget which decreased to sixty percent in FY 2017/18 and FY 2018/19. At the same time, the percentage allocation of the FMoHP's budget to beyond EHCS has increased from 12 to 22 percent between FY 2014/15 and FY 2018/19.

Table 5.6: FMoHP budget and percentage expenditure by EHCS, beyond EHCS, and systems support

Amount in NPR Billion

Budget Type	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
EHCS	21.5	74.6	25.5	79.2	27.9	92.4	19.8	75.1	20.3	NA
Beyond EHCS	3.9	88.4	4.4	87.5	5.9	97.9	6.4	92.2	7.6	NA
System Components	6.7	73.8	7.3	71.4	7.8	96.3	6.8	84.9	6.2	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

The budget for system components, which includes decentralised service delivery, private/NGO sector development, sector management, health financing/resource management, logistic management, human resource development, and information system management, has increased over the last four years. Good budget absorptive capacity has been observed across all three areas in the last four FYs, particularly in FY 2016/17 where it was above 90 percent across each area.

5.7 FMoHP Allocation and Expenditure by Priority Programmes

Table 5.7 shows the FMoHP's budget in NPR and the percentage of the budget spent by the different levels of priority programmes. Priority 1 programmes are the programmes with the highest priority assigned by the NPC. The data shows that the FMoHP has gradually increased their budget for Priority 1 programmes from NPR 25.6bn in FY 2013/14 to NPR 33.6bn in FY 2016/17. Over the years, Priority 1 programmes were allocated 80 percent and above of the FMoHP budget. Less than two percent of the budget is allocated for Priority 3 programmes.

Table 5.7: FMoHP budget and percentage expenditure by programme priority *Amount in NPR Billion*

Priority	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
P1	26.5	74.3	31.0	76.7	33.5	92.9	25.0	77.2	28.2	NA
P2	5.2	83.8	5.6	88.9	7.6	98.3	7.3	91.8	5.9	NA
P3	0.5	94.7	0.5	81.9	0.6	96.2	0.7	79.8	-	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

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

The absorption of Priority 1 programmes appears to have improved over the years with more than 77 percent absorption in FY 2017/18. This fiscal year onward GoN decided to exclude P3 from the priority level.

5.8 FMoHP 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 2014/15 to FY 2018/19:

- The grants to hospitals have almost doubled, accounting for 42% of the FMoHP budget in FY 2017/18
- The budget for programme activities, capital goods, and medicine purchasing has decreased
- The capital construction budget is in gradual rise from NPR 2.8bn in FY 2014/18 to NPR 7.5bn in FY2018/19.

Table 5.8: FMoHP Budget Line Budgets and Percentage Expenditure *Amount in NPR Billion*

Broad Line Item	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
Wages and Salaries	7.5	94.4	9.3	77.0	7.9	121.2	1.6	78.9	1.4	NA
Support Services	1.5	72.1	1.9	56.4	1.8	82.8	1.2	73.9	0.5	NA
Capacity Building	0.6	42.4	1.0	59.8	0.8	64.4	0.7	73.0	0.2	NA
Programme Activities	4.8	62.3	3.4	67.2	4.2	69.8	3.3	58.7	1.1	NA

Broad Line Item	2014/15		2015/16		2016/17		2017/18		2018/19	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
Medicine Purchases	3.9	38.5	5.7	73.9	4.7	82.1	4.5	47.1	3.5	NA
Grants to Hospitals	9.5	89.5	11.3	93.2	15.6	95.3	14.6	89.6	18.8	NA
Capital-Construction	2.8	70.1	3.4	80.2	4.9	89.6	5.8	99.3	7.5	NA
Capital Goods	1.6	73.0	1.2	56.8	1.7	85.8	1.2	78.2	1.1	NA
Total	32.2	76.2	37.2	78.7	41.6	93.9	33.0	80.4	34.1	NA

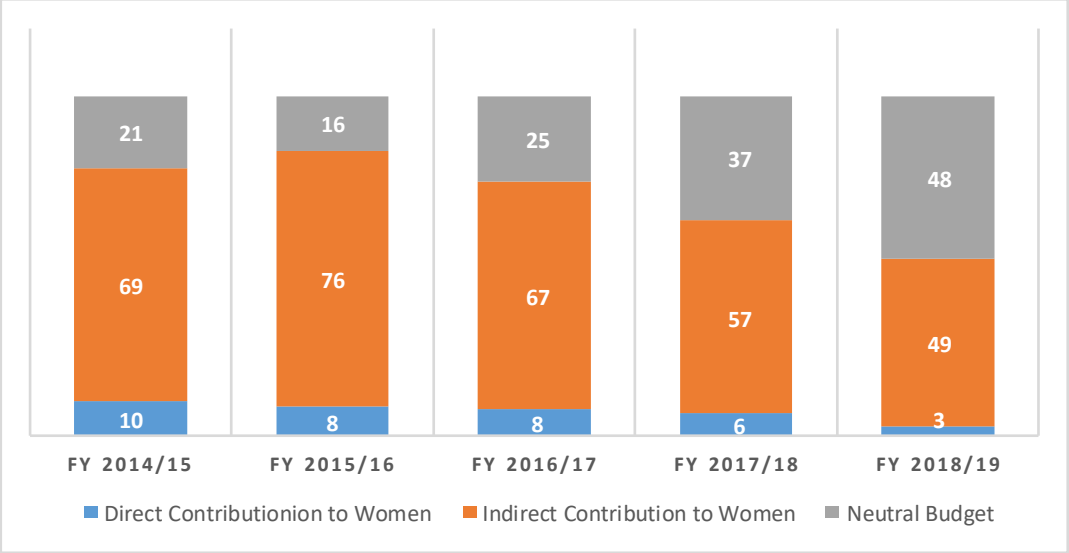
Source: Red Book, FY 2014/15-2018/19

In FY 2018/19, the weakest performance in expenditure is seen in programme activities and medicine purchase. Capital-construction and grants to hospital show good absorption.

5.9 FMoHP Budget Allocation for Women- Focused Activities

The FMoHP classifies its activities according to Red Book categories of directly or indirectly contributing to women's health and these are well incorporated into the eAWPB.

Figure 5.1: Percentage allocation of FMoHP's budget by contribution to women's health



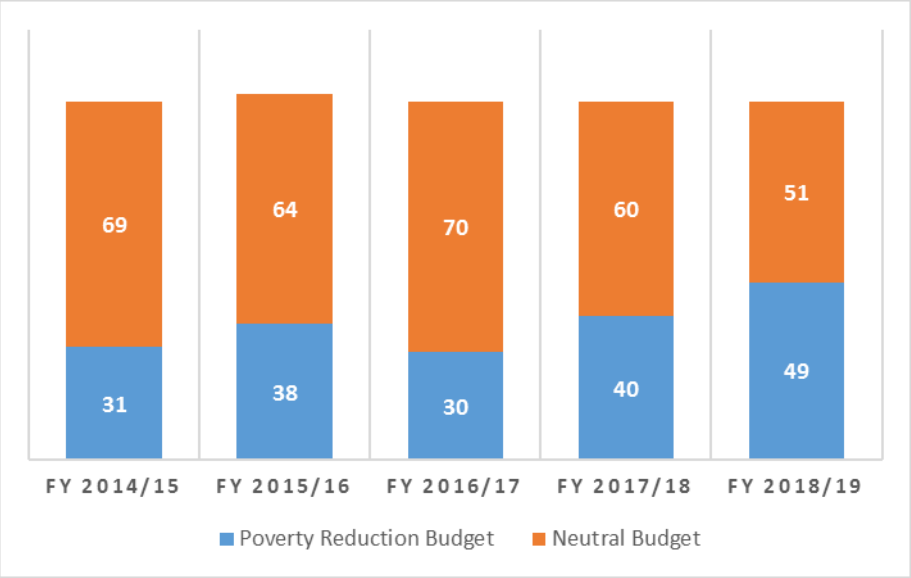
Source: Red Book, FY 2014/15-2018/19

The largest proportion of the FMoHP budget is occupied by programmes 'indirectly contributing to women' (Figure 5.1). This is because the FMoHP's budget is aimed at men, women, and people of all ages and living in different geographies which includes curative, disease control, prevention, and promotional services. The budget of the Family Welfare Division (FWD) and some others have been considered as programmes that directly contribute to women's health.

5.10 Budget Allocation by Poverty Reduction

The analysis looked at the FMoHP's budget contributing to reducing poverty. The FMoHP takes reference from the Red Book for defining the activities contributing to reducing poverty. Figure 5.2 suggests that over the years, the FMoHPs poverty reduction budget has increased from one-third in FY2014/15 to almost half in FY2018/19.

Figure 5.2: Percentage allocation of FMoHP budget by contribution to poverty reduction



Source: Red Book FY2014/15-2018/19

It should be noted that this just gives an indication and further work is needed to accurately define the proportion of the FMoHP's budget that contributes to reducing poverty.

CHAPTER 6: BUDGET ALLOCATED TO PG AND LG

This chapter analyses the total budget ad health budget including conditional grants allocated to the PGs and LGs for FY 2018/19. A brief background is provided at first which focuses on the resource pool at the provincial and local level as well as the budget allocation and reporting mechanism followed by the actual budget analysis of PGs and LGs for FY2018/19. Note that the intention of this analysis is to provide an indicative snapshot of budget preparation practices. A detailed analysis may be required to capture disaggregated budget information and expenditure data.

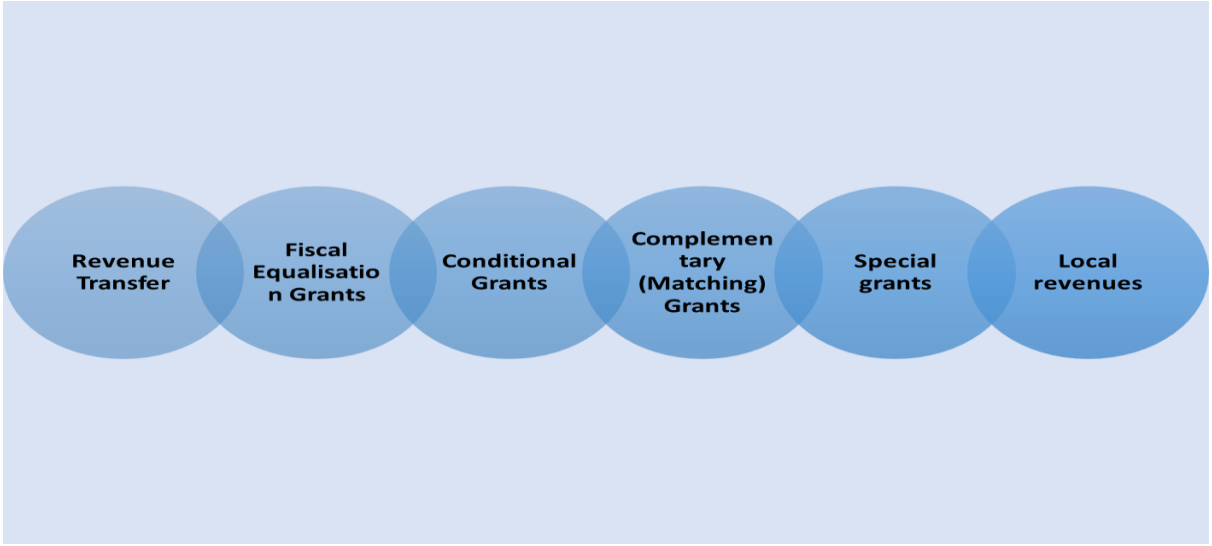
6.1 Background

Since FY 2017/18, the GoN started practising its constitutional mandates through the equalisation funds and conditional grants to the LGs. From this fiscal year (2018/19), the GoN has provided different forms of grants including Revenue transfer, Equalisation, and Conditional, Special, and Matching funds to the PGs and LGs. As devolution progresses, the planning, budgeting, expenditure, and reporting mechanism may evolve over time. This analysis only covers the indicative budget of the grants to PGs and LGs for FY 2018/19. It should be noted that there is no standard nationally rolled-out electronic reporting system in place to capture the expenditure. PGs and LGs are still facing the problem of basic infrastructure and trained human resources with knowledge on health-related activities.

6.2 Resource Pool at PG and LG Levels

The respective governments have their own resources and receive different forms of grants from the federal government. Since FY 2018/19, the GoN has provided Revenue transfer, Equalisation, and Conditional, Special, and Matching funds to the PGs and LGs. In the health sector, NPR.15.08bn conditional grant has been allocated to LGs in FY 2017/18. The amount has been increased to NPR 18.2bn for LGs in FY 2018/19 and NPR 4.2bn health conditional grant to PGs. The PGs and LGs can allocate resources to the health sector from following resource pool.

Figure 6.1: Resource pool for PG and LG



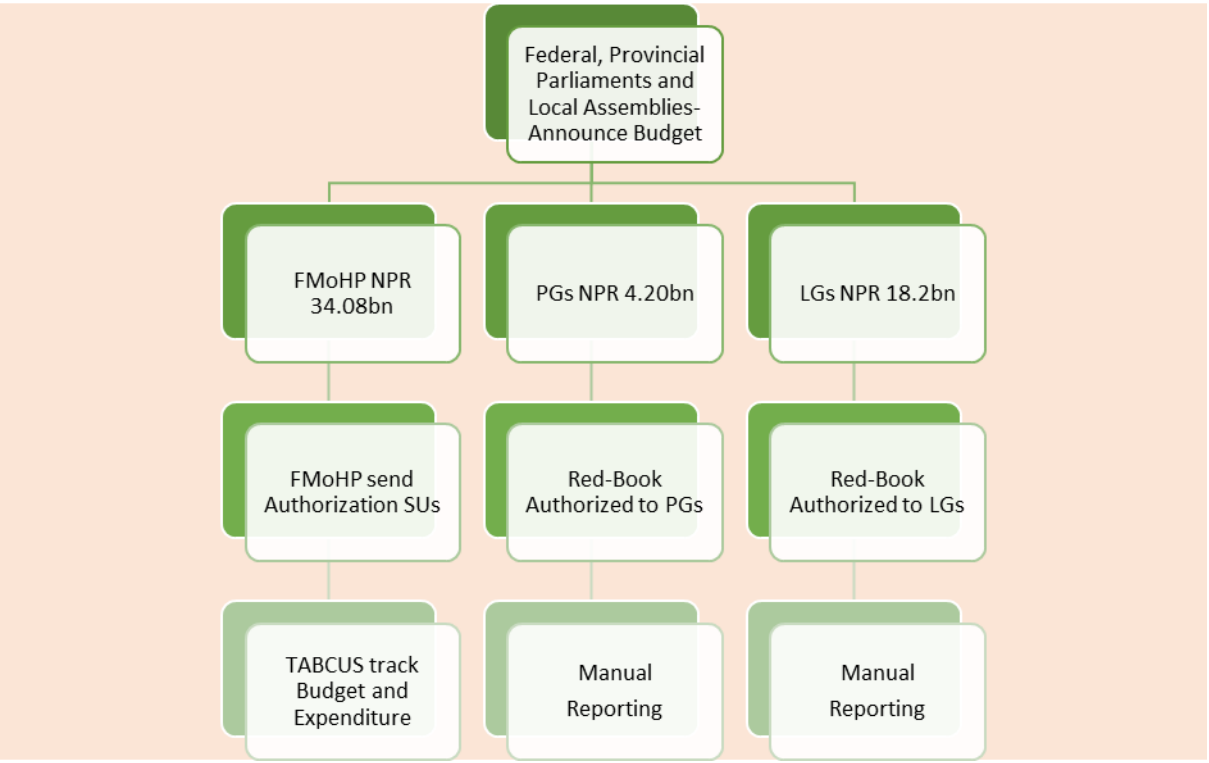
Source: Inter Governmental Fiscal Transfer Act 2017

At this point in time, there is no standard electronic mechanism to report/analyse the total amount allocated to PGs and LGs. The expenditure of last year's health conditional grants provided to LGs has not been reported.

6.3 Budgeting and Reporting Mechanism in FY 2018/19

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 2018/19.

Figure 6.2: Budgeting and Reporting Mechanism for FY 2018/19



The budget channelled to the FMoHP spending units is being tracked through the existing TABUCS. The PGs and LGs can use TABUCS. However, there is a limited capacity in terms of skill, equipment, and infrastructure at the local level. The constitutional obligation of health as a “concurrent right” at all levels also demands clarity on specific roles and responsibilities. The PGs and LGs are mandated to comply with the existing financial rules and regulations and to maintain financial records in their offices. All PGs and LGs prepare reports in the forms and formats prescribed by the Office of the Auditor General (OAG). It is to be noted that repots are prepared manually and there is no standard, nationally rolled out electronic system to track budget and expenditure.

6.4 Total Budget of Provincial Government by Revenue Sources

Table 6.1 describes the different forms of revenue that makeup the budget of the PGs in FY 2018/2019. Revenue Transfer accounts for a major part of the provincial government budget (35%)

followed by conditional grants (30%), and equalisation grants (26%). Internal revenue sources make up 3 percent of the total provincial budget with almost no internal revenue source in province-3 and province-5. All most all revenue sources have made up the budget of PGs.

Table 6.1: Total Budget of Provincial Government by Revenue Sources in FY 2018/19 *Amount in NPR Million*

Province	Revenue Transfer		Equalization Grant		Conditional Grant		Special Grant		Internal Revenue		Matching Grant		Total
	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR
Province-1	12,244	34	6,610	18	13,277	37	1,000	3	806	2	2,000	6	35,936
Province-2	9,179	31	7,716	26	9,181	31	1,000	3	2,311	8	400	1	29,787
Province-3	18,330	52	6,670	19	10,616	30	0	0	0	0	0	0	35,616
Gandaki	8,276	34	6,777	28	6,502	27	355	2	1,400	6	714	3	24,023
Province-5	10,950	39	7,470	27	9,670	34	0	0	0	0	0	0	28,090
Karnali	5,517	20	9,632	34	6,634	24	3,000	11	1,500	5	2,000	7	28,283
Sudurpachim	7,570	30	8,475	34	6,328	25	200	1	493	2	2,000	8	25,066
Total	**72,065**	**35**	**53,349**	**26**	**62,208**	**30**	**5555**	**3**	**6,510**	**3**	**7,114**	**3**	**206,801**

Source: GoN 2018

Karnali province received the lowest amount from revenue distribution however more than 50 percent of province-3 budget comes from revenue distribution. Province-1 and province-3 received the highest amount under the conditional grants. In terms of the equalisation grant, Karnali province and Sudurpachim received highest allocation. Province-1 has the highest volume of budget. The table only provides an indicative picture of budget allocation practices. It is to be noted that the total provincial budget presented in table 4.1 is less than the amount presented in the above table. This is because the table above accounts for the allocation of local revenue and revenue transfer in their health budget.

6.5 Health Budget of Provincial Government by Revenue Sources

Table 6.2 shows the total health budget in respective provinces. An additional 4.8bn budget has been allocated by the PG on top of the 4.2bn conditional grant to health allocated by the federal government as per the table below. This means that health sector budget is more than NPR 65.4bn for FY 2018/19.

Table 6.2: Health Budget of PG by Revenue Sources in FY 2018/19 *Amount in NPR Million*

Province	Revenue Transfer		Equalization Grant		Conditional Grant		Special Grant		Internal Revenue		Matching Grant		Total
	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR
Province-1	261	18	368	26	692	48	108	7	18	1	0	0	1,446
Province-2	926	54	46	3	736	43	0	0	0	0	0	0	1,708
Province-3	412	41	0	0	589	59	0	0	0	0	0	0	1,001
Gandaki	165	11	690	45	471	31	0	0	0	0	210	14	1,536
Province-5	152	13	352	29	703	58	0	0	0	0	0	0	1,208
Karnali	0	0	0	0	415	100	0	0	0	0	0	0	415
Sudurpachim	616	40	348	23	568	37	0	0	0	0	0	0	1,531
Total	**2,532**	**29**	**1,804**	**20**	**4,174**	**47**	**108**	**1**	**18**	**0**	**210**	**2**	**8,845**

Source: GoN 2018

As evident in the table above there are different sources of revenue for the health budget at the provincial level apart from conditional grant. For example internal revenue is also a source of health budget in province-1 as is the matching grant in Gandaki province. A separate analysis is suggested to capture the details.

6.6 Total Budget at LG by Revenue Sources in FY 2018/19

Table 6.3 provides an overview of the revenue sources for the LG budget. The special grant accounts for a major part of the LG budget (72%) followed by conditional grants (11%) and revenue distribution (6%). Internal revenue sources make of 0.2 percent of the total local budget with almost no internal revenue source in province-3, 5, 7, and Gandaki province. LGs have also received money from other sources such as people's participation, EDP and pool fund, including other type of grant.

Table 6.3 Total Budget at Local Government by Revenue Sources (NPR million)

	Revenue Transfer		Equalization Grant		Conditional Grant		Special Grant		Internal Revenue		Matching Grant		Other		Total
Province	**NPR**	**%**	**NPR**	**%**	**NPR**	**%**	**NPR**	**%**	**NPR**	**%**	**NPR**	**%**	**NPR**	**%**	**NPR**
Province-1	2,376	6.5	306	0.77	8637	22	24,035	66	124	0.3	3,391	9	1,125	3	39,995
Province-2	2,597	8.0	18	0.05	6951	19	20,386	63	70	0.2	2,493	8	3,398	10	35,911
Province-3	2,774	7.0	276	0.64	8059	19	27,079	69	0	0	4,238	11	741	2	43,166
Gandaki	492	3.3	17	0.10	2538	15	13,539	91	0	0	245	2	180	1	17,011
Province-5	2,431	7.0	13	0.03	8643	22	24,569	70	0	0	2,547	7	630	2	38,833
Karnali	341	3.0	0	0.00	2190	17	10,049	89	140	1	148	1	122	1	12,992
Sudurpachim	901	5.4	0	0.00	3659	19	14,240	85	0	0	392	2	5	.03	19,197
Total	**11,913**	**6**	**630**	**0.30**	**40,676**	**20**	**133,896**	**72**	**334**	**0.2**	**13,454**	**7**	**6,202**	**3**	**207,105**

Source: GoN 2018 *Includes grant from both the federal and provincial government*

It is to be noted that the total local budget presented in table 4.1 is less than the amount presented in the above table. This is because the table above accounts for the allocation of local revenue, revenue transfer, and other sources in their health budget. A separate analysis is suggested to capture the details.

6.7 Health Budget at Local Government by Revenue Sources

Table 6.4 shows the total health budget allocated to LGs by the province. The table indicates that an additional NPR 3.37bn budget has been allocated to health on top of the NPR 18.15bn conditional grant to health allocated by the federal government. This allocation is done from different sources by both the federal and provincial governments. Almost 97 percent of the local government budget for health is conditional grant followed by equalization grant 1.5 percent and 0.8 percent internal revenue. A separate analysis is suggested to capture the details.

Table 6.4: Health budget at Local Government by Revenue Sources (NPR million)

Province	Revenue Transfer		Equalization Grant		Conditional Grant		Special Grant		Internal Revenue		Other Grant		Total
	NPR	**(%)**	**NPR**	**(%)**	**NPR**	**(%)**	**NPR**	**(%)**	**NPR**	**(%)**	**NPR**	**(%)**	**NPR**
Province-1	22	0.6	80	2.1	3,686	96.4	0	0	35	0.9	0	0	3,822
Province-2	15	0.4	62	1.7	3,450	96.6	0.1	0.002	33	0.9	0	0	3,571

Province-3	33	0.9	57	1.5	3,670	95.8	0	0	70	1.8	0	0	3,831
Gandaki	1	0.0	8	0.4	2,078	99.5	0	0	2	0.1	0	0	2,089
Province-5	75	1.8	99	2.4	3,869	95.0	0	0	14	0.4	14	0.3	4,071
Karnali	3	0.2	22	1.2	1,712	98.5	1E-06	6E-08	0	0.0	1	0.1	1,738
Sudurpachim	6	0.3	27	1.1	2,361	98.2	0	0	11	0.4	0	0	2,404
Total	**154**	0.7	**355**	1.6	**20,826**	96.8	**0.06**	**0.0003**	**165**	**0.8**	**25**	**0.1**	**21,525**

Source: GoN 2018

6.8 Source of Health Conditional Grant at PGs and LGs

The table below provides the disaggregation on the source of health conditional grant at provincial and local level provided by the federal government (NPR 22.3bn). Over 90 percent of health conditional grants at the provincial level come from government sources followed by EDPs (7%) and pooled funds (almost 3%).

Table 6.5: Source of conditional grant at the PGs and LGs (NPR million)

Province	Province Government				Local Government			
	NPR	GoN (%)	EDP (%)	Pool Fund (%)	NPR	GoN (%)	EDP (%)	Pool Fund (%)
Province-1	692.3	91.3	5.9	2.7	3,228.3	95.7	1.2	3.1
Province-2	735.8	87.7	9.8	2.5	3,021.9	93.6	4.4	2.0
Province-3	590.1	91.7	5.1	3.2	2,986.9	97.2	0.4	2.5
Gandaki	470.8	91.1	5.7	3.2	2,235.0	96.9	0.7	2.4
Province-5	703.2	91.8	6.0	2.3	2,857.9	94.5	3.1	2.5
Karnali	425.0	86.1	11.2	2.7	1,664.9	93.6	3.8	2.6
Sudurpachim	567.5	90.9	7.0	2.2	2,157.8	92.0	5.4	2.6
Total	**4,184.7**	**90.2**	**7.1**	**2.7**	**18,152.7**	**94.9**	**2.6**	**2.5**

Source: GoN 2018

At the local level, the GoN accounts for almost 95 percent of the health conditional grant and only 5 percent is contributed by the EDPs and pool fund combined. It is to be noted that pooled fund is only allocated for the child health programme.

6.9 Capital and Recurrent Allocation of Conditional Grant at PGs and LGs

The table below provides the disaggregation of the health conditional grant at provincial and local level. Less than 3 percent of the conditional grant is allocated for capital budget by both the PGs and the LGs.

Table 6.6: Capital and Recurrent Budget Allocation by PGs and LGs (NPR million)

Province	Province Government			Local Government		
	NPR	Capital (%)	Recurrent (%)	NPR	Capital (%)	Recurrent (%)
Province-1	692	2.2	97.8	3,228	3.2	96.8
Province-2	736	1.7	98.3	3,022	2.6	97.4
Province-3	590	1.6	98.4	2,987	2.4	97.6
Gandaki	471	2.1	97.9	2,235	2.3	97.7
Province-5	703	1.6	98.4	2,858	2.5	97.5
Karnali	425	3.3	96.7	1,665	2.6	97.4
Sudurpachim	567	2.8	97.2	2,158	2.6	97.4
Total	**4,185**	**2.1**	**97.9**	**18,153**	**2.6**	**97.4**

Source: GoN 2018

At the provincial level, Karnali province receives highest percentage allocation under capital budget (3.3%) whereas province-1 receives the highest proportion under the capital budget of the LGs budget (3.2%).

6.10 Administrative and Programme Allocation of Health Conditional Grants at PGs and LGs

The table below provides the disaggregation of the health conditional grant at provincial and local level by administrative and programme. On average, 65 percent of the health conditional grant is allocated for administrative purpose at the level while only 24 percent is allocated at the provincial level. Karnali province has the lowest allocation for administration (only 16 percent) whereas Province 7 has the highest the highest allocation (almost 36 percent).

Table 6.7: Administrative and Programme Budget Allocation by PGs and LGs (NPR million)

Province	Province Government			Local Government		
	NPR	Admin (%)	Programme (%)	NPR	Admin (%)	Programme (%)
Province-1	692.3	28.1	71.9	3,228.3	63.4	36.6
Province-2	735.8	23.6	76.4	3,021.9	65.0	35.0
Province-3	590.1	17.6	82.4	2,986.9	66.3	33.7
Gandaki	470.8	15.9	84.1	2,235.0	67.1	32.9
Province-5	703.2	25.8	74.2	2,857.9	63.1	36.9
Karnali	425.0	15.6	84.4	1,664.9	65.5	34.5
Sudurpachim	567.5	35.9	64.1	2,157.8	63.1	36.9
Total	**4,184.7**	**23.9**	**76.1**	**18,152.7**	**64.7**	**35.3**

Source: Red-Book FY 2018/19

6.11 Distribution of Total Budget at Selected Local Government FY 2018/19

The GoN has started providing different forms of grants to LGs since FY 2017/18. This practice continues this fiscal year. As explained earlier, LGs have started using different types of grants while preparing their AWPB. Importantly, different LGs have used different type of grant in health sector. Annex 2 provides a sample of budget allocation practices in selected Palikas from all provinces. This analysis has attempted to capture accurate budget allocations and it is also acknowledged that there can be possibilities of difference in the final amount. The table indicates that almost all conditional grants provided to PGs and LGs are for the recurrent budget.

CHAPTER 7: AAMA PROGRAMME IN THE DEVOLVED CONTEXT

The chapter provides case study on the Aama programme based on the analysis of information provided by Palikas from seven districts, one from each province purposively selected. At first a brief background on the Aama programme budget and implementation in FY 2018/19 is discussed followed by the snapshot of the budget and expenditure in FY 2017/18 and challenges in programme implementation.

7.1 Aama Programme Budget and Implementation in FY 2018/19

In FY 2018/19, the GoN announced the doubling of transport incentives under Aama Programme. A total of NPR. 1.94bn has been allocated for the Aama, Nyano Jhola, and safe abortion programme all under one sub-activity. The current allocation does not sufficiently cover the budget demand for this year including the additional budget required by doubling the transport incentive. Until last year, the Aama programme used to have a separate sub-activity, as did the other two programmes. An important logic behind this was to facilitate flexibility in spending, especially when one programme had surplus budget and others required additional budget. This was also intended to reduce the number of sub-activities for THE FMoHP from 2,300 to 1,400. Out of the total amount, NPR.1.08bn (56%) has been allocated to the LGs, NPR. 0.63bn (33%) to the PGs, and NPR. 0.22bn (11%) still remains at the FMoHP/FWD. The Aama budget allocated at the FMoHP is provided to tertiary hospital (Paropkar Maternity Hospital). PGs are responsible for managing the Aama programme at hospitals functioning at different level viz: district, zonal, regional, and sub-regional. Similarly, LGs are accountable for managing Aama at PHCC, HP hospitals below district level, and Aama implementing private facilities.

7.2 Aama Programme Budget and Expenditure in Selected LGs in FY 2017/18

In FY 2017/18 a total of NPR. 1.37bn has been allocated for the Aama Programme, out of which NPR. 0.69bn (50.4%) has been allocated to LGs and NPR 0.68 (49.6%) remained with the FMoHP/FHD. Aama budget allocated at the FMoHP is distributed to hospitals functioning at zonal, regional, sub-regional, and central level. The Aama conditional grants have been further distributed by LGs to the local level health institutions: the District Hospital, Primary Health Care Centre, and Health Posts.

Palikas were contacted through telephone as there is no system to capture initial budget, additional budget, and expenditure. The following table provides complete information on each Palika with the number of women that delivered, number of women receiving transport and 4ANC incentive, initial and additional budget and expenditure, and surplus budget. For the purpose of simplicity in explanation, the analysis is based on districts and Palika-specific issues are discussed in detail.

Province 1/Terathum:

The total number of deliveries in Terathum was 810 and all women received the transport incentive (100%), while only 594 women received the 4ANC incentive (73%). The initial Aama budget allocated was NPR 2,442,000 and the actual expenditure was of NPR 2,628,700 (108%). An additional budget of NPR 470,000 was sent to Myanglung Palika in two instalments, one for NPR 200,000 and another for NPR 270,000. However, the Palika is still deficit of NPR 125,000. All other Palikas have surplus budget for Aama from initial allocation which totals NPR 409,000. It was also reported that health facilities have not received case specific reimbursement. No additional budget for Aama has been allocated by any Palika in this district.

Province 2 Sarlahi:

A total of 6,836 deliveries were recorded in Sarlahi district, out of which 6,743 received transport incentives (98%), and only 1,813 women received the 4ANC incentive (26%). The initial Aama budget allocated was NPR 13,367,000 and the actual expenditure of NPR 11,813,200 (88%). An additional budget of NPR 5,475,000 was sent to seven Palikas. Hariwon and Ishworpur received an additional Aama budget of NPR 2,000,000 and NPR. 1,500,000 on top of the initial allocation of NPR 1,050,000 and NPR 1,204,000 while their actual expenditure was only NPR 2,177,500 and NPR 1,465,600 respectively. Ishworpur has the highest surplus budget of NPR 1,238,400 from additional Aama budget followed by Hariwon NPR 872,000. Similarly, Bagmati and Haripurba are Palikas having the highest surplus allocation of NPR 938,000 and NPR 819,400 from the initial Aama budget. Palikas such as Barathawa and Godhaita are running deficit by NPR 46,700 and NPR 30,800 even after receiving additional Aama budget. Bagmati Palika has recently established a birthing centre so no births were recorded for the year FY 2017/18. In Sarlahi district alone a total of NPR 7,106,300 remains surplus Aama budget.

Table 7.1: Aama budget and expenditure from selected Palikas under provinces for FY 2017/18

Province/ District	Palika	No of Deliveries	No of Women Getting 4ANC Incentive	No of Women Getting Transport Incentive	Initial Aama Budget	Additional Aama budget	Expenditure Aama Budget	% expenditure	Surplus/Deficit budget
1/Terhathum	Laligurans Municipality	86	36	86	257,000	-	192,000	75	65,000
	Myanglung Municipality	439	393	439	1,167,000	470,000	1,762,700	108	(125,700)
	Aatharai Rural Municipality	79	30	79	274,000	-	198,000	72	76,000
	Chhathar Rural Municipality	86	48	86	257,000	-	191,200	74	65,800
	Fedap Rural Municipality	75	61	75	260,000	-	174,400	67	85,600
	Menchhayayem Rural M	45	26	45	227,000	-	110,400	49	116,600
Total		**810**	**594**	**810**	**2,442,000**	**470,000**	**2,628,700**		**283,300**
2/Sarlahi	Bagmati Municipality	0	0	0	938,000	-	-	-	938,000
	Balara Municipality	251	21	251	1,168,000	-	384,900	33	783,100
	Barahathawa Municipality	981	283	981	1,238,000	300,000	1,584,700	103	(46,700)
	Godaita Municipality	1,100	217	1,100	1,048,000	1,000,000	2,078,800	102	(30,800)
	Haripur Municipality	615	325	615	1,051,000	225,000	1,212,500	95	63,500
	Haripurba Municipality	228	34	228	1,175,000	-	355,600	30	819,400
	Hariwan Municipality	1,421	115	1328	1,050,000	2,000,000	2,177,500	71	872,500
	Ishworpur Municipality	812	244	812	1,204,000	1,500,000	1,465,600	54	1,238,400
	Kabilasi Municipality	480	156	480	809,000	225,000	882,400	85	151,600
	Lalbandi Municipality	316	88	316	1,202,000	-	511,200	43	690,800
	Chakraghatta Rural M	398	280	398	859,000	225,000	767,000	71	317,000
	Chandranagar Rural M	144	45	144	813,000	-	256,000	31	557,000
	Dhankaul Rural Municipality	90	5	90	812,000	-	137,000	17	675,000
	Total	**6,836**	**1,813**	**6,743**	**13,367,000**	**5,475,000**	**11,813,200**		**7,028,800**
3/Dolakha	Bhimeshwor Municipality	848	322	847	1,260,000	1,400,000	2,651,300	100	8,700
	Jiri Municipality	374	146	374	4,128,000	-	1,518,800	37	2,609,200
	Baiteshwor Rural Municipality	95	78	95	367,000	-	268,700	73	98,300
	Bigu Rural Municipality	134	74	134	313,000	200,000	364600	71	148,400
	Gaurishankar Rural Municipality	100	84	100	308,000	50,000	283600	79	74,400
	Kalinchowk Rural Municipality	225	110	225	378,000	375,000	614,500	82	138,500
	Melung rural Municipality	53	49	53	369,000	-	152100	41	216,900
	Shailung Rural Municipality	112	64	112	368,000	100,000	305,600	65	162,400

	Tamakoshi Rural Municipality	110	69	110	314,000	302,600	302600	49	314,000
	Total	**2,051**	**996**	**2,050**	**7,805,000**	**2,427,600**	**6,461,800**		**3,770,800**
Province/ District	**Palika**	**No of Delivery**	**No of Women Getting 4ANC Incentive**	**No of Women Getting Transport Incentive**	**Initial Aama Budget**	**Additional Aama budget**	**Expenditure Aama Budget**	**% expenditure**	**Extra/Deficit budget**
Gandaki/Beni	Beni Municipality	973	450	973	1,714,000	1,400,000	2674000	85.9	440,000
	Annapurna Municipality	48	38	48	545,000	-	111200	20.4	433,800
	Dhaulagiri Rural Municipality	116	58	116	548,000	-	255,200	46.6	292,800
	Malika Rural Municipality	193	96	193	566,000	-	428,400	75.7	137,600
	Mangala Rural Municipality	97	65	97	555,000	-	220,000	39.6	335,000
	Raghuganga Rural M	44	23	44	553,000	-	97,200	17.6	455,800
	Total	**1,471**	**730**	**1,471**	**4,481,000**	**3,786,000**	**3,786,000**		**2,095,000**
5/ Pyuthan	Pyuthan Municipality	1,866		1,866	4,831,000	2,200,000	5,502,000	78.3	1,529,000
	Sworgadwari Municipality	306	178	306	1,105,000	150,000	755,200	60.2	499,800
	Airawoti Rural Municipality	189	152	189	476,000	150,000	458,800	73.3	167,200
	Gaumukhi Rural Municipality	346	235	346	486,000	70,000	786000	141.4	(230,000)
	Jhimruk Rural Municipality	158	98	158	595,000	70,000	359,200	54.0	305,800
	Mallarani Rural Municipality	106	75	106	460,000	-	246,000	53.5	214,000
	Mandabi Rural Municipality	195	153	195	1,054,000	-	459,200	43.6	594,800
	Naubahini Rural Municipality	253	117	253	-	-	568800	0.0	(568,800)
	Sarumarani Rural M	159	104	159	463,000	-	369,600	79.8	93,400
	Total	**3,578**	**1,112**	**3,578**	**9,470,000**	**2,640,000**	**9,504,800**		**2,605,200**
Karnali/Surkhet	Bheriganga Municipality	466	334	466	841,000	200,000	1065600	102.4	(24,600)
	Birendranagar Municipality	160	132	160	2,343,000	-	372,800	15.9	1,970,200
	Gurbhakot Municipality	813	637	813	2,359,000	-	1898800	80.5	460,200
	Lekbesi Municipality	332	251	332	803,000	75,000	764,400	87.1	113,600
	Panchapuri Municipality	679	449	679	810,000	375,000	1635600	138.0	(450,600)
	Barahatal Rural Municipality	177	136	177	491,000	-	408,400	83.2	82,600
	Chaukune Rural Municipality	361	248	361	486,000	375,000	821200	95.4	39,800
	Chinggad Rural Municipality	293	213	293	459,000	150,000	671200	110.2	(62,200)
	Simta Rural Municipality	282	142	282	488,000	130,000	620,800	100.5	(2,800)
	Total	**3,563**	**2,542**	**3,563**	**9,080,000**	**1,305,000**	**8,258,800**		**2,126,200**
Sudurpachim/Darchula	Mahakali Municipality	651	208	651	1,472,000	1,150,000	2,154,700	82.2	467,300
	Shailyashikar Municipality	467	318	467	975,000	150,000	1,294,700	115.1	(169,700)
	Apihimal Rural Municipality	70	70	70	423,000	-	203,000	48.0	220,000
	Byas Rural Municipality	66	44	66	1,550,000	-	182,600	11.8	1,367,400
	Dunhu Rural Municipality	73	62	73	436,000	-	207,300	47.5	228,700
	Lekam Rural Municipality	120	99	120	450,000	80,000	339,600	64.1	190,400
	Malikarjun Rural Municipality	157	124	157	453,000	100,000	442,100	79.9	110,900
	Marma Rural Municipality	214	176	214	451,000	150,000	605,400	100.7	(4,400)
	Naugad Rural Municipality	173	136	173	454,000	100,000	510,900	92.2	43,100
	Total	**1,991**	**1,237**	**1,991**	**6,664,000**	**1,730,000**	**5,940,300**		**2,453,700**

Province 3: Dolakha

A total of 2,051 deliveries were recorded in Dolakha district out of which 2,050 (99%) received transport incentive, one women received a referral incentive, and 996 women received the 4ANC incentive (49%). The initial Aama budget allocated was NPR 7,805,000 and the actual expenditure

out of that was NPR 6,467,800 (83%). An additional budget of NPR 2,125,000 was sent to Bhimeshwor, Bigu, Gauri Shankar, Kalinchowk, and Sailung. The highest additional budget was received by Bhimeshwor municipality of NPR 1,400,000. It was initially allocated NPR 1,260,000 and actual expenditure was NPR 2,657,300. Jiri municipality was allocated NPR 4,128,000 out of which expenditure was only NPR 1,518,800. Jiri alone had surplus Aama budget of NPR 2,609,200 from its initial allocation. Dolakha as a district had surplus Aama budget of NPR 3,462,200. No additional budget for Aama has been allocated by any Palika in this district. Sailung had allocated NPR 50,000 for Post-natal Care (PNC) home visits. Tamakoshi reported that their Aama budget was deficit and they decided to spend from the surplus 4ANC budget specially to cover health facility reimbursement.

Gandaki Province: Myagdi

A total of 1,471 deliveries were recorded in Myagdi and all of them received transport incentives, however only 730 women received the 4ANC incentive (49%). The initial Aama budget allocated was NPR 4,481,000 and actual expenditure NPR 3,786,000 (84%). Beni was the only Palika to receive additional budget of NPR 1,400,000. Beni was initially allocated NPR 1,714,000 and expenditure was NPR 2,674,000. Beni alone had an extra budget of NPR 440,000 from additional allocation. Rahuganga Palika has a surplus budget of NPR 455,800 from the initial allocation of NPR 553,000 and actual expenditure of NPR 97,200. The Palika reported to have used the surplus Aama budget for meeting expenses including the local allowance for the executive officer and local staff. Similarly, Annapurna Palika reported to have not received Aama budget as part of the AWPB. Thus, they have arranged to pay health facility reimbursement from other sources.

Province 5: Pyuthan

A total of 3,578 deliveries were reported and all of them received transport incentive and only 1,891 women received the 4ANC incentive (53%) (no records from Pyuthan Palika). The initial Aama budget allocated was NPR 9,470,000 and actual expenditure was NPR 9,816,400 (103%). An additional budget of NPR 2,200,000 was only send to Pyuthan municipality towards the end of the fiscal year. Pyuthan had an expenditure of NPR 5,813,600 and was initially allocated NPR 4,831,000. The surplus Aama budget from additional allocation in Pyuthan is NPR 1,217,400. Swargadwari Palika was provided additional Aama budget of NPR 150,000 despite being allocated enough money for the expenses incurred (NPR 1,105,000 and actual expenditure NPR 755,200). Mandavi Palika had surplus budget of NPR 594,800 from initial allocation. Gaumukhi Palika only received NPR 70,000 as additional budget of on top of the initial allocation of NPR 486,000 against the actual expenditure of NPR 786,000. Gaumukhi is still deficit of NPR 230,000. This would mean that women have received transport incentives and the health facilities are yet to receive the health facility reimbursement. They were even not aware of the additional Aama budget sent to them. Naubahini was one of the Palikas that did not receive the entire health budget. NPR 6,500,000 has been allocated from the local government for health related activities including opening of birthing centre but no budget for Aama programme was received. NPR 347,200 (253 delivery, 170 4ANC, total delivery) have been spent on Aama programme from DPHO, and payment has been made up to mid-February.

Karanli Province: Surkhet

A total of 3,563 deliveries were reported and all of them received transport incentive (100%), however only 2,542 women the received 4ANC incentive (71%). The initial Aama budget allocated

was NPR 9,080,000 and actual expenditure was of NPR. 8,258,800 (91%). An additional budget of NPR 1,305,000 was sent to Bheriganga, Lekhbesi, Panchapuri, Chaukune, Chingad, and Simta. The highest additional budget was sent to Pachapuri, Chaukune NPR 375,000 and minimum of NPR. 75,000 to Lekhbesi. Birendranagar municipality had an expenditure of NPR 372,800 only and was allocated NPR 2,343,000. The surplus Aama budget in Birendranagar was NPR 1,970,200. This was due to budget allocation for the regional hospital. The regional hospital received their budget separately. Similarly, Gurbakot was allocated NPR 2,359,000 against the expenditure of NPR 1,898,800. Gurbakot had surplus Aama budget from its initial allocation of NPR 460,200. Simta did not know of the additional Aama budget of NPR 138,000 sent to them. They reported to have arranged for the deficit budget from Palika and paid to women and health facilities. Gurbakot and Panchapuri started paying double the transport incentive to women who deliver in their health facility. Gurbakot made allocation of NPR 1,600,000 for Aama out of NPR 8,000,000 allocated to health. Panchapuri later restricted the provision to women from their Palika only. Some of these Palika have stopped paying women additional incentive as they became budget deficit.

Province 7: Darchula

A total of 1,991 deliveries were reported in Darchula and all of them received a transport incentive (100%), however only 1,237 women received 4ANC incentive (62%). The initial Aama budget allocated was NPR 6,664,000 and actual expenditure was NPR. 5,940,300 (89%). In Byas Palika alone, a surplus budget of NPR 1,367,400 is seen from the initial allocation of NPR 1,550,000 against expenditure of NPR 182,600. Additional budget of NPR 1,730,000 was send to Mahakali, Sahileshikar, Lekum, Malikarjun, Marma, Naugad. Highest additional budget was sent to Mahakali NPR 1,150,000 and minimum was sent to Lekum NPR. 80,000. Mahakali municipality had an expenditure of NPR 2,154,700 and was initially allocated NPR 1,472,000. Thus surplus Aama budget from additional allocation in Mahakali is NPR 467,300. At the same time Shaliashikar and Marma are running under deficit budget. Apihimal had relatively less budget for 4ANC which they managed from the Aama budget upon discussion with the Palika. Darchula alone had surplus Aama budget of NPR 2,627,800.

7.3 Challenges in Aama Programme Implementation in FY 2017/18

The following challenges have been observed in implementing the Aama programme in the devolved context.

- Delays in the release of conditional grants from the DTCO to LGs. This is due to the absence of a clear policy directive from the MoF to the DTCO. Despite authorisation through the Red-Book, practical problems were observed by almost all Palikas.
- Different timing of Palika assemblies have caused problems in ensuring timely budget to health. In most of the Palika, the health conditional grant is the single source of revenue which means that they have not allocated local resources to health. This has caused delay in providing transport incentive and free delivery to women.
- Palikas that have no birthing centres also received the Aama budget. The problem now is that there is no system or directives to transfer the budget from one Palika to another and surrender them back to MoFAGA.
- In many places, the budget provided to the LGs were not sufficient for implementing the Aama programme. One of the reasons for this is because the conditional grant has not been determined by considering the caseload in some birthing facilities. Allocation was based on

geographical boundaries and population. At the same time, challenges were also observed with budget re-allocations. For example, there is no policy for inter-governmental transfers at the local level as a result Birendranagar municipality from Surkhet has surplus Aama budget of NPR. 19,720,000 from initial allocation at the same time the district has NPR 540,200 deficit in other Palikas. Additionally, in many Palikas additional Aama budget was sent at the very end of the fiscal year and at the same time some Palikas received more than what was required.

- Some Palikas have announced additional incentives that are beyond the scope of the existing Aama policy guidelines (e.g. Gurbakot and Panchapuri Palika from Surkhet started paying the women double the transport incentive). Additionally, it was observed that there are the practises of using surplus Aama budget in meeting allowances.
- The current Aama guidelines and reporting mechanisms are based on the previous year's centralised requirement. No Palikas have a copy of the current Aama guidelines. As a result, no consolidated Palika-wise Aama reporting is available.
- All budgets under the 4ANC programme has been provided to LGs. There is no mechanism to re-transfer that money to the institutions requiring funds for the 4ANC programme. More specifically, there is no 4ANC fund at the zonal-and-above- level health facilities. This is observed to have caused significant problems for providing incentives to mothers.
- Some Palikas do not have bank accounts, telephones, and other basic infrastructures. This posed an important challenge for channelling the Aama fund within the stipulated time.

The analysis concludes that a coherent Aama policy guideline that is acceptable to all levels of government needs to be developed and implemented. This will help in capturing the number of Aama beneficiaries, building on with the previous year's achievements, and reduce duplication. The FWD has taken some steps towards revision of the Aama programme guideline, forms, and formats for federal, provincial, local governments. This is important because accreditation of health facilities, recording, reporting, and monitoring system needs to be developed and implemented. At the federal level, Aama is a Priority 1 programme. There is not sufficient evidence to document the priority status of the Aama programme at PGs and LGs. In this context, policy and programme level discussions need to be carried out at all levels.

CHAPTER 8: CONCLUSION AND WAY FORWARD

This chapter provides summary of the findings in the form of a conclusion, way forward, and the policy note. The policy note included in this chapter may require further discussions with the officials working at the local, provincial, and federal governments. This BA suggests that all levels of government have prioritised health as their priority area. This exercise pointed that the volume of budget is not fully aligned with the number of technical human resources assigned at different levels of government.

8.1 Conclusion

The recent evidences in UHC suggest that lower and middle-income countries should spend at least 5 percent of their GDP on health, which translates to USD 86 (NPR 9630) per capita spending. This analysis confirms that government health spending as share of the GDP has slightly increased over the years. However, the health sector budget was 6.1 percent of the total government budget in FY 2014/15 which has reduced to 5 percent of the total national budget in FY 2018/19. This could be due to the restructuring of the country having priority in establishing new functions and functionaries in the devolved context. This analysis suggests that the current investment in health is not sufficient to achieve UHC and SDG by 2030.

This BA tried to capture the budget allocated against NHSS outcome and output indicators. The analysis suggest that some indicators have not received a budget allocation. This raises an important question about whether these indicators require investment or not. Additionally, some important interventions like NCD, cancer, and health promotion are not sufficiently included in the output indicators and poorly addressed by the budget. The analysis concludes that there is a lack functional alignment between NHSS indicators and budgeting practise.

Since FY 2017/18, a share of health budget has been allocated to the LGs. In FY 2018/19 a share of the health budget is also allocated to PGs in addition to the LGs. The GoN provided the conditional grant of NPR 4.2bn for PGs (7.5%), NPR 18.2bn to LGs (32%), and NPR 34.1bn remains at the FMoHP (60.5%). Under the economic code, a key driver for health budget at LGs and PGs is salary and wages (which falls under the administrative budget). At the federal level, grants to hospitals and capital construction are the key budget drivers for health. Under procurement of drugs and supplies, the main cost driver at LGs is purchase of free health drugs, at PGs is the purchase of nutritional drugs and supplements and at the federal government is the purchase of vaccines, diluent and syringes. Almost 90 percent of the budget for equipment remains at the federal level, and almost one third of this is spent in purchasing cancer equipment. More than half of the LGs' and PGs' free health budget is occupied by maternal and child health services followed by free health services. At the federal level, almost half of the free health budget is captured by treatment of target population.

This analysis reveals that both PGs and LGs have started allocating budget in the health sector using resources other than conditional grants such as matching, special grants, revenue transfer and internal revenue. This suggests that the health sector budget is more than NPR. 65.34bn. There exist no specific policy directives that provide the basis for determining the volume of health conditional grants to PGs and LGs. This led to both under and over allocation in PGs and LGs. The majority of the conditional grants come from the previous Integrated District Health Programme. The initial analysis and anecdotal evidences suggest that there were some issues in spending the conditional grants within the stipulated time. The reasons for this could be due to absence of programme

implementation guidelines, delay in fund flow, no health budget provided to seven Palikas, and lack of trained human resources. 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 practiced a sector-wide approach (SWAp) in health since FY 2005/06. One of the intensions 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. As a result, flagship programmes such as Aama and reform programmes like TABUCS are now fully owned by the government. In general, the absorptive capacity of the FMoHP has improved over the years. In FY2017/18 the FMoHP absorbed 80 percent of the allocated budget which may rise once the complete expenditure is reported. At an organisational level, the DoHS holds the major share of the FMoHP budget. Similarly, at the economic code level, the majority of the budget is allocated to hospital grants. This analysis indicates that there is a trend of providing increased grants to hospitals. At the same time, hospitals are the only FMoHP entities with more than 90 percent absorptive capacity. The FMoHP has been successful in securing more than 60 percent of its budget towards EHCS. It should be noted that most of the budget allocated to the PGs and LGs fall under EHCS.

This BA tried to capture the budgeting practice at provincial and local level. The analysis shows that revenue transfer accounts for a major part of the PG budget (35%) followed by conditional grant (30%), and equalisation grant (26%). Similarly, at local level, special grant accounts for a major part of their budget (72%) followed by conditional grants (11%), and revenue transfer (6%). The analysis indicates that conditional grants are one of the major sources of revenue for both PGs and LGs. This suggests that the health sector and even national budget is more than the budget reflected in the Red-Book.

The FWD has attempted to capture the Aama budget and expenditure from selected Palikas. During this process, it was learned that Palikas without birthing centres also received an Aama grant. Almost no PGs and Palikas have Aama programme guidelines, the budget for some Palikas is insufficient, some Palikas announced additional incentives to mothers, and there is no mechanism for intergovernmental budget transfer. The recording and reporting forms and formats are based on the previously practiced, centralised system. As a result, Palikas that want to report on their fiscal and physical progress are not able to do so.

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 human resources. It is also important to note that most of the procurement budget for free drugs has been provided to PGs and LGs. This analysis found that a small proportion of pooled fund in child health activities is allocated to the LGs. The policies and programme of federal, provincial, and local governments are not sufficiently translated into the budget.

8.2 Way Forward

This analysis has brought up some important questions that need to be addressed by the FMoHP. 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 service closer to the underserved population. The evidence based AWPB 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. Comprehensive federal, provincial, and local 'Health Accounts' are required to capture the public and private sector budget and expenditure in the health sector. This may require a localised framework to prepare respective Health Accounts. This will also contribute PGs and LGs to prepare their periodic and annual health plan.

2. The FMoHP should initiate the process of preparing the health sector transitional plan which will support in securing required resources and distributing them. 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.

3. 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 at the wider policy and strategy umbrella.

4. A costed health financing 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 percent of the national budget for the health sector.

5. The practice of delayed approval of annual health budgets remains a key challenge in the devolved context. As a result, there is a risk of failing to maintain the financial disciplines and providing timely health services to people. The FMoHP 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 the 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 FMoHP 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 Note

The Constitution of Nepal mandates health as a fundamental rights of the people (GoN, 2015) and the NHP 2014 aims to carry out these rights by ensuring equitable access to 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 response the health needs. It should be coordinated with other important elements of overall public financial management reform including MTEF, budget tracking system, cash management, financial information, and progress reporting systems. The classification and organisation of a budget are centrally important issues when preparing sector budgets. Budget classifications serve to present and categorise public expenditure in the 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 play a pivotal role in actual spending. This BA suggests some important policy options that might be useful in the federal context. The following are the major policy areas that could be further discussed at all levels of government. To start with, FMoHP can take the lead role.

1. The health policy and national health sector strategy need to be updated to address the evolving needs. 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 indicator should also defined in both health policy and strategy. This requires the assurance of budget inclusion against each of the indicators while finalising respective AWPBs.

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

3. A policy framework and standard operating procedures (SOPs) that would support preparing the health account that is acceptable and applicable to all levels of government needs to be developed and endorsed. The steering and technical committees would be required to standardise methodology, process, indicators, and tools. A specific institution with clear terms of reference (ToR) at the FMoHP would help in initiating and institutionalising the process. In the future, this practise can be harmonised at the provincial and local level. The evidence from health accounts need to be developed as an integral part of planning and budgeting process.

4. A costed health financing strategy would support the FMoHP to rationalise the importance of allocating 5 percent of GDP to the health sector, and USD 86 per capita allocation. The HF strategy should also provide the framework like MTEF, which will inform GoN to allocate a multiyear budget. The steering and technical committees would be required to standardised scope, methodology, and process while developing the HF strategy. The HF guideline developed by WHO can be used as a reference while developing and finalising Nepal's Health Financing strategy.

5. An electronic FMIS that is able to track health budget and expenditure at all levels of government must be established. This type of system is important to capture the actual government spending on health and also ascertain the total health expenditure. For this an already existing FMIS tool such as TABUCS can be updated to capture the income, budget, and expenditure at all levels of government. As TABUCS is successfully implemented by the FMoHP, NRA, MoUD and their entities, and some PGs, effort will be required to build capacity at the PGs and LGs level. A policy and guideline related to the use of TABUCS would help in capturing the total health expenditure.

6. The FMoHP needs to shift from the 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 being piloted by the FMoHP in seven NGO hospitals. Develop a PBGA policy with a monitoring framework that is 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 will 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	FMoHP Budget	FMoHP Expenditure
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
2013/14	1,964,540	27,646,053	259.18	98.2	30,432	22,231

ANNEX 2: DISTRIBUTION OF TOTAL BUDGET AT SELECTED DISTRICTS BY PALIKA (NPR THOUSAND)

Province District	PaliKa	Palika	Total		Revenue Distribution (F+P)		Equalization Grant (F+P)		Conditional Grant (F+P)		Special Grant (F+P)		Internal Revenue		Other Grant (F+P)		EDP	
			NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)
Province-1 Terhathum	Total		836,900	100	-	-	24,000	2.9	812,900	97.1	-	-	-	-	-	-	-	-
	Aatharai	Rural	85,100	100		-	-	-	185,100	100.0	-	-	-	-	-	-	-	-
	Fedap	Rural	128,400	100	-	-	-	-	128,400	100.0	-	-	-	-	-	-	-	-
	Menchhayayem	Rural	68,100	100	-	-	-	-	68,100	100.0	-	-	-	-	-	-	-	-
	Myanglung	Urban	155,100	100	-	-	-	-	155,100	100.0	-	-	-	-	-	-	-	-
	Laligurans	Urban	168,100	100	-	-	24,000	14.3	144,100	85.7	-	-	-	-	-	-	-	-
	Chhathar	Rural	132,100	100	-	-	-	-	132,100	100.0	-	-	-	-	-	-	-	-
Province-2 Sarlahi	Total	0	3,245,255	100	94,587	2.9	130,744	4.0	2,846,900	87.7	-	-	17,552	0.5	148,595	4.6	877	0.0
	Lalbandi	Urban	241,900	100	-	-	-	-	241,900	100.0	-	-	-	-	-	-	-	-
	Hariwan	Urban	557,455	100	94,587	17.0	130,744	23.5	159,100	28.5	-	-	17,552	3.1	148,595	26.7	877	0.2
	Bagmati	Urban	95,200	100	-	-	-	-	95,200	100.0	-	-	-	-	-	-	-	-
	Barahathawa	Urban	516,000	100	-	-	-	-	516,000	100.0	-	-	-	-	-	-	-	-
	Haripur	Urban	134,600	100	-	-	-	-	134,600	100.0	-	-	-	-	-	-	-	-
	Ishworpur	Urban	200,100	100	-	-	-	-	200,100	100.0	-	-	-	-	-	-	-	-
	Haripurwa	Urban	84,900	100	-	-	-	-	84,900	100.0	-	-	-	-	-	-	-	-
	Parsa	Rural	60,500	100	-	-	-	-	60,500	100.0	-	-	-	-	-	-	-	-
	Bramhapuri	Rural	45,800	100	-	-	-	-	45,800	100.0	-	-	-	-	-	-	-	-
	Chandranagar	Rural	208,200	100	-	-	-	-	208,200	100.0	-	-	-	-	-	-	-	-
	Kabilasi	Urban	112,600	100	-	-	-	-	112,600	100.0	-	-	-	-	-	-	-	-
	Chakraghatta	Rural	87,300	100	-	-	-	-	87,300	100.0	-	-	-	-	-	-	-	-
	Basbariya	Rural	106,200	100	-	-	-	-	106,200	100.0	-	-	-	-	-	-	-	-
	Dhankaul	Rural	58,000	100	-	-	-	-	58,000	100.0	-	-	-	-	-	-	-	-
	Ramnagar	Rural	76,800	100	-	-	-	-	76,800	100.0	-	-	-	-	-	-	-	-
	Balara	Urban	130,200	100	-	-	-	-	130,200	100.0	-	-	-	-	-	-	-	-
	Godaita	Urban	187,800	100	-	-	-	-	187,800	100.0	-	-	-	-	-	-	-	-

Province District	PaliKa	Palika	Total		Revenue Distribution (F+P)		Equalization Grant (F+P)		Conditional Grant (F+P)		Special Grant (F+P)		Internal Revenue		Other Grant (F+P)		EDP	
			NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)
	Bishnu	Rural	64,100	100	-	-	-	-	64,100	100.0	-	-	-	-	-	-	-	-
	Kaudena	Rural	102,300	100	-	-	-	-	102,300	100.0	-	-	-	-	-	-	-	-
	Malangawa	Urban	175,300	100	-	-	-	-	175,300	100.0	-	-	-	-	-	-	-	-
Province-3 Dolakha	Total	0	1,342,500	100	-	-	-	-	1,342,500	100.0	-	-	-	-	-	-	-	-
	Gaurishankar	Rural	118,700	100	-	-	-	-	118,700	100.0	-	-	-	-	-	-	-	-
	Bigu	Rural	129,900	100	-	-	-	-	129,900	100.0	-	-	-	-	-	-	-	-
	Kalinchowk	Rural	166,600	100	-	-	-	-	166,600	100.0	-	-	-	-	-	-	-	-
	Baiteshwor	Rural	124,500	100	-	-	-	-	124,500	100.0	-	-	-	-	-	-	-	-
	Jiri	Urban	139,000	100	-	-	-	-	139,000	100.0	-	-	-	-	-	-	-	-
	Tamakoshi	Rural	153,700	100	-	-	-	-	153,700	100.0	-	-	-	-	-	-	-	-
	Melung	Rural	154,700	100	-	-	-	-	154,700	100.0	-	-	-	-	-	-	-	-
	Shailung	Rural	116,300	100	-	-	-	-	116,300	100.0	-	-	-	-	-	-	-	-
	Bhimeshwor	Urban	239,100	100	-	-	-	-	239,100	100.0	-	-	-	-	-	-	-	-
Gandaki Myagdi	Total	0	842,000	100	-	-	-	-	842,000	100.0	-	-	-	-	-	-	-	-
	Annapurna	Rural	134,900	100	-	-	-	-	134,900	100.0	-	-	-	-	-	-	-	-
	Raghuganga	Rural	118,300	100	-	-	-	-	118,300	100.0	-	-	-	-	-	-	-	-
	Dhawalagiri	Rural	98,500	100	-	-	-	-	98,500	100.0	-	-	-	-	-	-	-	-
	Malika	Rural	121,900	100	-	-	-	-	121,900	100.0	-	-	-	-	-	-	-	-
	Mangala	Rural	114,100	100	-	-	-	-	114,100	100.0	-	-	-	-	-	-	-	-
	Beni	Urban	254,300	100	-	-	-	-	254,300	100.0	-	-	-	-	-	-	-	-
Province-5 Pyuthan	Total	0	2,478,264	100	350,783	14.2	408,446	16.5	1,578,000	63.7	-	-	76,734	3.1	64,300	2.6	-	-
	Gaumukhi	Rural	115,800	100	-	-	-	-	115,800	100.0	-	-	-	-	-	-	-	-
	Naubahini	Rural	125,300	100	-	-	-	-	125,300	100.0	-	-	-	-	-	-	-	-
	Jhimruk	Rural	1,101,768	100	220,359	20.0	288,609	26.2	555,900	50.5	-	-	36,900	3.3	-	-	-	-
	Pyuthan	Urban	521,101	100	94,764	18.2	119,837	23.0	216,500	41.5	-	-	25,700	4.9	64,300	12.3	-	-

Province District	PaliKa	Palika	Total		Revenue Distribution (F+P)		Equalization Grant (F+P)		Conditional Grant (F+P)		Special Grant (F+P)		Internal Revenue		Other Grant (F+P)		EDP	
			NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)
	Sworgadwari	Urban	160,700	100	-	-	-	-	160,700	100.0	-	-	-	-	-	-	-	-
	Mandavi	Rural	132,695	100	35,660	26.9	-	-	82,900	62.5	-	-	14,135	10.7	-	-	-	-
	Mallarani	Rural	102,600	100	-	-	-	-	102,600	100.0	-	-	-	-	-	-	-	-
	Aairawati	Rural	118,100	100	-	-	-	-	118,100	100.0	-	-	-	-	-	-	-	-
	Sarumarani	Rural	100,200	100	-	-	-	-	100,200	100.0	-	-	-	-	-	-	-	-
Karnali Surkhet	Total	0	2,233,927	100	206,038	9.2	296,676	13.3	1,494,300	66.9	140,298	6.3	94,798	4.2	-	-	1,817	0.1
	Simta	Rural	153,000	100	-	-	-	-	153,000	100.0	-	-	-	-	-	-	-	-
	Chingad	Rural	147,275	100	-	-	43,837	29.8	97,800	66.4	-	-	5,638	3.8	-	-	-	-
	Lekabeshi	Urban	192,569	100	43,869	22.8	-	-	148,400	77.1	-	-	300	0.2	-	-	-	-
	Gurbhakot	Urban	210,300	100	-	-	-	-	210,300	100.0	-	-	-	-	-	-	-	-
	Bheriganga	Urban	159,500	100	-	-	-	-	159,500	100.0	-	-	-	-	-	-	-	-
	Birendranagar	Urban	962,283	100	162,169	16.9	252,839	26.3	316,300	32.9	140,298	14.6	88,860	9.2	-	-	1,817	0.2
	Barahatal	Rural	145,100	100	-	-	-	-	145,100	100.0	-	-	-	-	-	-	-	-
	Panchapuri	Urban	150,700	100	-	-	-	-	150,700	100.0	-	-	-	-	-	-	-	-
	Chaukune	Rural	113,200	100	-	-	-	-	113,200	100.0	-	-	-	-	-	-	-	-
Province-7 Darchula	Total	0	1,193,400	100	-	-	-	-	1,193,400	100.0	-	-	-	-	-	-	-	-
	Byas	Rural	97,400	100	-	-	-	-	97,400	100.0	-	-	-	-	-	-	-	-
	Duhun	Rural	91,500	100	-	-	-	-	91,500	100.0	-	-	-	-	-	-	-	-
	Mahakali	Urban	211,900	100	-	-	-	-	211,900	100.0	-	-	-	-	-	-	-	-
	Naugad	Rural	137,900	100	-	-	-	-	137,900	100.0	-	-	-	-	-	-	-	-
	Apihimal	Rural	77,200	100	-	-	-	-	77,200	100.0	-	-	-	-	-	-	-	-
	Marma	Rural	118,500	100	-	-	-	-	118,500	100.0	-	-	-	-	-	-	-	-
	Shailyashikhar	Urban	174,900	100	-	-	-	-	174,900	100.0	-	-	-	-	-	-	-	-
	Malikarjun	Rural	148,200	100	-	-	-	-	148,200	100.0	-	-	-	-	-	-	-	-
	Lekam	Rural	135,900	100	-	-	-	-	135,900	100.0	-	-	-	-	-	-	-	-