Budget Analysis of Health Sector

Ministry of Health and Population
Policy Planning and Monitoring Division
Government of Nepal
November 2019

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Study Team
December 2019

EXECUTIVE SUMMARY

The Budget Analysis (BA) of the health sector intends to enable the Federal Ministry of Health and Population (MoHP), Department of Health Services (DoHS), policy makers, planners, programme managers and External Development Partners (EDPs) to understand the trend of budget for the five-year period and expenditure for the four years from Fiscal Year (FY) 2015/16 to FY 2019/20. The expenditure of FY 2019/20 has not been included in the analysis. This report also provides analysis of conditional grants provided to Provincial and Local government (PG and LG). The health conditional grant is distributed across all three levels of government: the federal, provincial and local. A brief overview of the pattern of health budget allocation using conditional grants and other forms of grants at the provincial and local levels is also included in this analysis. For comparability purposes, macro-level indicators have also been reported on since 2014. Analysis is performed using the Electronic Annual Work Plans And Budgets (eAWPBs), the Government of Nepal's (GoN's) Red Book (from FY 2015/16 to FY 2019/20), Financial Monitoring Reports (FMRs), the Transaction Accounting and Budget Control System (TABUCS), and conditional grants provided to LGs. The adjusted budgets of consecutive FYs have been used to capture the final expenditures; it is therefore possible that there will be some minor changes compared to the previous BA report. For FY 2019/20, the initial budget is used in the analysis.

Government spending on health as a share of Gross Domestic Product (GDP) has slowly increased from 1.4 percent in FY 2015/16 to 1.8 percent in FY 2018/19. Evidence suggests that countries should strive to spend five percent of their GDP to progress towards Universal Health Coverage (UHC) (Mcintyre *et al,* 2017). The health sector budget (MoHP and other ministries[*]) has been gradually increasing over the years from NPR 37.8bn in FY 2015/16 to NPR 78.4bn in FY 2019/20. **Between FY 2014/15 and FY 2018/19, the per capita government spending gradually increased from NPR 1,072 to NPR 2,295 (USD 10.8 to 20.2) 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 394 (USD 4) to NPR 664 (USD 5.8). It is to be noted that Chatham House recommends that low-income countries to spend USD 86 per capita to ensure universal access to primary care services (Mcintyre, 2014).

In this fiscal year (FY 2019/20), the GoN has provided NPR 68.8bn as health budget, of which the MoHP received NPR 42.7bn (62%), Provincial Governments (PGs) were allocated NPR 4.9bn (7%) and LGs were allocated NPR 21.2bn (30%). Almost 44 percent of the health budget is allocated as hospital grants followed by 23 percent in salaries/wages and 12 percent in capital construction. The majority of the health budget, including wages and salaries, support services, capacity building and programme activities, has been devolved to LGs. 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. It is to be noted that 85 percent of the budget for equipment remains at the federal level, one-third of which is allocated to purchase medical equipment. Almost 44 percent of the budget allocated under free care is allocated to maternal and child health, followed by free health care (37 percent) and free treatment of target populations (10 percent).

The MoHP budget increased by 45 percent from NPR 29.4 billion in FY 2018/19 to NPR 42.6 billion in FY 2019/20. However, MoHP's budget absorption has declined as compared to national absorption and its own over the years. There has been almost a two-fold increase in the volume of capital budget from NPR

[*] In FY 2018/19, 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

4.6bn in FY 2015/16 to NPR 8.2bn in FY 2019/20. Since FY 2017/18, EDPs channelling their funding through the pooled fund have mainly agreed to fund activities implemented solely by MoHP. As a result, the share of EDP funds in the MoHP budget has increased, while the overall government share in health budget is increasing. The MoHP's administrative budget is gradually being reduced, which is mainly because salaries and other administrative expenses have been allocated to PGs and LGs through conditional grants. Over the past five years, the allocation towards Essential Health Care Services (EHCS) has remained above 60 percent of the MoHP's budget; however is slowly being reduced to 50 percent, since a large share of the EHCS budget has been devolved to Sub-national Governments (SNGs).

This analysis supports the fact that both PGs and LGs have started allocating budget towards the health sector using different funding options, which suggests that the health sector budget is more than NPR 78.4bn. There are no clear policy directives that provide the basis for determining the volume of health-conditional grants to PGs and LGs. The initial analysis and anecdotal evidence suggest that some Palikas delayed their assemblies and, as a result, the health conditional grants could not be transferred; new layers of delay have been created at the provincial level in sending the budget to Spending Units (SUs) in a timely manner. The analysis raises important questions around allocative efficiency. A sizeable programme and procurement budget 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.

The GoN realises that health is an important development agenda and is putting initiatives in place to harmonise health in all policies (at all levels of government). A coherent national health policy framework 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 in all spheres of government needs to be harmonised through a comprehensive Health Financing (HF) roadmap that covers the ground reality of the transition. This is important because the Constitution of Nepal has mandated 'concurrent rights' to all spheres of government. In order to have a complete budget analysis of PGs and LGs, a separate comprehensive exercise is recommended. In the devolved context, allocative efficiency could be additionally challenged, as the plans of SNGs may not be aligned with the GoN's/National Planning Commission's (NPC's) priority areas. A costed HF strategy that is applicable to all spheres 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 five percent of the GDP for progressing towards UHC. Finally, health accounts applicable to federal, provincial and local governments would be required to capture total health expenditure in the country. A loose forum, such as the National Health Assembly, might foster better planning, resource allocation and results. Overall, federalisation has initially contributed to increasing fiscal space in the health sector.

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ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AWPB	Annual Work Plan and Budget
BA	Budget Analysis
COFOG	Classification of Functions of Government
DDA	Department of Drug Administration
DFID	Department for International Development
DoA	Department of Ayurveda
DoHS	Department of Health Services
DTCO	District Treasury Comptroller Office
eAWPB	Electronic Annual Work Plan and Budget
EDP	External Development Partner
EHCS	Essential Health Care Services
FCGO	Financial Comptroller General Office
FMIP	Financial Management Improvement Plan
FMIS	Financial Management Information System
FMR	Financial Monitoring Report
FP	Family Planning
FWD	Family Welfare Division
FY	fiscal year
GDP	Gross Domestic Product
GFS	Government Financial Statistics
GoN	Government of Nepal
HF	Health Financing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
LG	Local Government
LMBIS	Line Ministry Budget Information System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MoF	Ministry of Finance
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Federal Ministry of Health and Population
MTEF	Medium-term Expenditure Framework
NHSP	Nepal Health Sector Plan
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NNRFC	National Natural Resource and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese rupees

OAG	Office of the Auditor General
OPD	Outpatient Department
PFM	Public Financial Management
PG	Provincial Government
PLMBIS	Provincial Line Ministry Budget and Information System
PMoSD	Provincial Ministry of Social Development
PPMD	Policy, Planning, and Monitoring Division
SDG	Sustainable Development Goal
SNG	Sub-national Government
SU	Spending Unit
SuTRA	Sub-national Treasury Regulatory Application
SWAp	Sector-wide Approach
TABUCS	Transaction Accounting and Budget Control System
TSA	Treasury Single Account
UHC	Universal Health Coverage
USD	United States Dollars
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

This chapter provides a brief background that describes the current context of Nepal's health systems, the objective of the budget analysis and the methodology used.

1.1 Background

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

All spheres of government aim to continue to improve their financial management and, in particular, the timely disbursement of funds to their Spending Units (SUs). 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 by the Federal Government (FG). Their implementation has also improved the efficiency of resource allocation in the sector. These practices need to be implemented in both Provincial and Local Governments (PGs and LGs). Financial planning and budgeting provide the foundation for effective, efficient and high-quality service delivery. The annual budget reflects the policy and resource allocation decisions that determine the activities, programmes, and services to be implemented by the MoHP. The integration of the Line Ministry Budget Information System (LMBIS) and Electronic Annual Work Plan and Budget (eAWPB) into the Transaction Accounting and Budget Control System (TABUCS) captures the budget and expenditure information of all of the MoHP's cost centres making them easily available. The recent addition of the "*chart of activity*" module in TABUCS also provides the opportunity to capture health sector budget from SNGs. The GoN has allocated conditional grant health budget to LGs for the past three Fiscal Years (FYs) and to PGs for the past two. This year onward, the FG has made it mandatory to use the Sub-national Treasury Regulatory Application (SuTRA) for planning and expenditure tracking at both PGs and LGs. This analysis primarily captures the budget channelled towards the MoHP SUs and conditional grants provided to provincial and local levels. An attempt has been also made to capture the budget at PG and LG levels on a case study basis.

1.2 Objectives of the Analysis

The purpose of this Budget Analysis (BA) is to enable the MoHP, Provincial Ministry of Social Development (PMoSD), LGs, External Development Partners (EDPs), policy makers, and planners by providing disaggregated information on the health sector budget for FY 2019/20. It also aims to provide the reader with a synthesis of the main features of budget allocations and comparisons with actual spending from the last five FYs by source, programme and disbursement level.

The specific objectives of the BA are as follows, to:

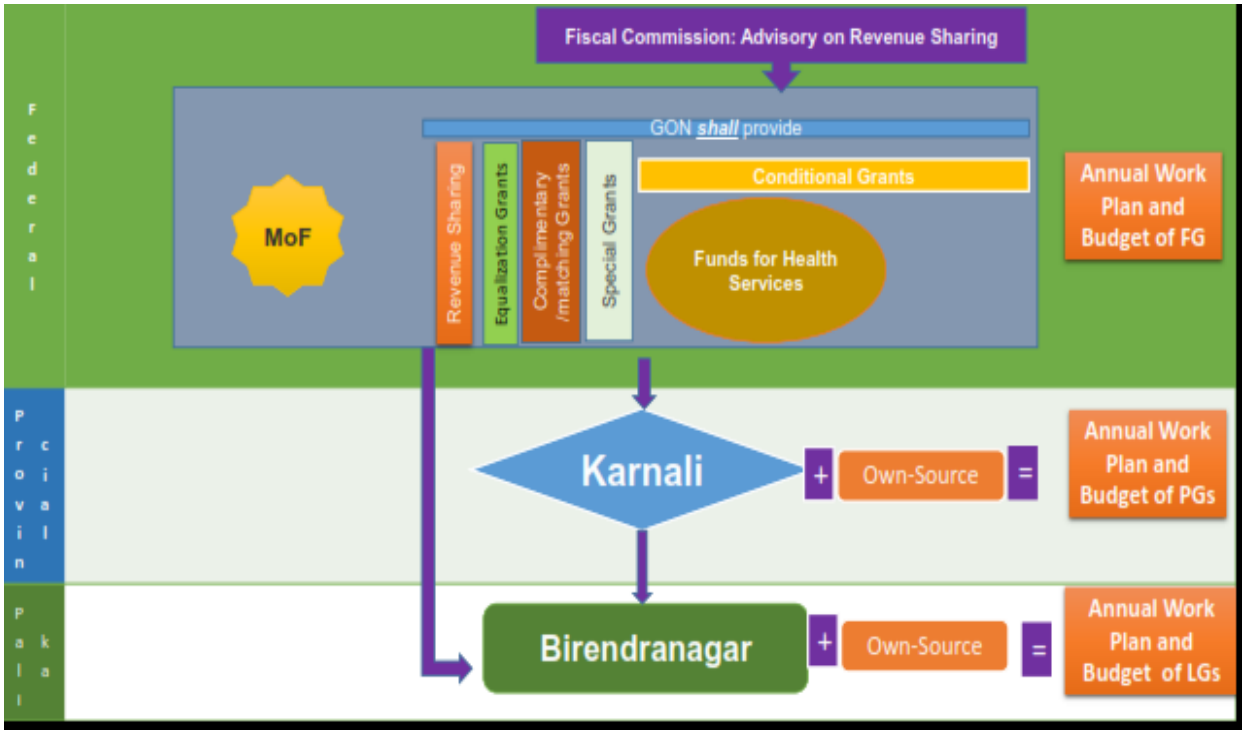
1. analyse the health sector and MoHP budget for FY 2019/20
2. compare budget allocation and expenditure in FY 2018/19, FY 2017/18, FY 2016/17, and FY 2015/16
3. analyse the budget allocated under conditional grants to LGs, PGs and MoHP for FY 2017/18, FY 2018/19 and FY 2019/20
4. analyse the budget allocated in the health sector using the internal sources of PG and LG
5. analyse the revenue generated by MoHP Spending Units (SUs) and audit status; and
6. prepare a policy brief based on the budget analysis.

1.3 Methodology

The analysis of secondary data using the GoNl's LMBIS, eAWPB, TABUCS and SuTRA from FY 2015/16, FY 2016/17, FY 2017/18, FY 2018/19 and FY 2019/20 has been carried out as outlined in Figure 1. For comparability purposes, macro-level indicators have also been reported since FY 2015/16.

The main sources of information were the federal and provincial Red Books and LG budget books. The task was performed in three phases: 1) collect, review, organise and analyse budget and expenditure data; 2) conduct a workshop to validate data; and 3) prepare the policy briefs. This year's BA also includes revenue generated by MoHP SUs and the audit status; further, it attempted to analyse the budget provided to the health sector using different sources in all spheres of government. Figure 1 demonstrates an optimum picture of the possibilities of allocating budget in the health sector.

Figure 1: Example of Sources of Funds Available in all Spheres of Government



The adjusted budgets of the consecutive FYs have been used to reflect the final expenditures. Some minor changes in these amounts are possible when readers refer the previous BA report. However, the total budget remains the same. For FY 2019/20, the initial budget is used in the analysis. The analysis of conditional grants was carried out by collecting information from the Ministry of Federal Affairs and General Administration (MoFAGA). The data was compiled into standard templates, which then provided the platform for analysis. Technical consultations with the MoHP's planning section and discussions with the MoHP and the Department of Health Services' (DoHS') planning and financial officials also provided useful comments, which have been incorporated into this report. It is to be noted that budget and its execution started at PG from FY 2018/19 and LG from FY 2017/18. For the purpose of this analysis, we analysed the total budget and health budget in FG, PGs and LGs.

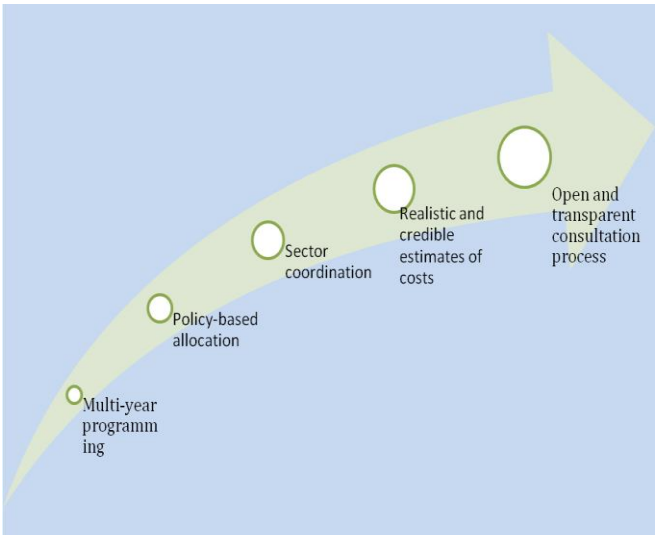
CHAPTER 2: PLANNING, BUDGETING AND EXPENDITURE PATTERN

This chapter provides some theoretical background on budget characteristics, budget planning and the preparation process at the federal, provincial and local levels, and the underlying challenges in the changed context.

2.1 Budget Characteristics

Public sector planning and budgeting processes are important in ensuring 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 in which budget allocations are presented, organised and classified in policy and programmes has a direct impact on actual spending and ultimately on the performance of the health sector. Health budgets 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 from the MoHP, related authorities and other ministries involved in the delivery of health-related expenditure. Thus, to promote a clear understanding of the core principles of health budgeting, it must include standardised processes, guidelines, systems, structures and professional planners. Nepal's commitments to achieving UHC and SDGs by 2030 largely depend on a dominant share of public funds. It is important to note that even increased resources for the health sector will not help achieve UHC and SDGs in the absence of well-functioning planning and budgeting systems.

2.2 Budget Preparation Process in FY 2019/20

2.2.1 Planning in FY 2019/20 at the Federal level

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

The MoF compiles the sectoral budgets and prepares the national budget with policy and programmes; the ministry then announces it publicly through the budget speech and submits the final budget to Parliament

for endorsement. The Parliament endorses the budget of the coming FY; the Red Book constitutes budget authorisation. The provision for giving authorisation to SUs was formally abolished by Parliament in FY 2017/18. Before the budget speech, MoF locks the respective Annual Work Plan and Budget (AWPB) into the LMBIS. The approval of the budget is also the approval of AWPBs in the LMBIS and thus does not require further authorisation by line ministries or departments. The sequence of events by which national plans are developed by the MoHP within the framework of central government practice is as follows (see Table 2.1 for annual schedule):

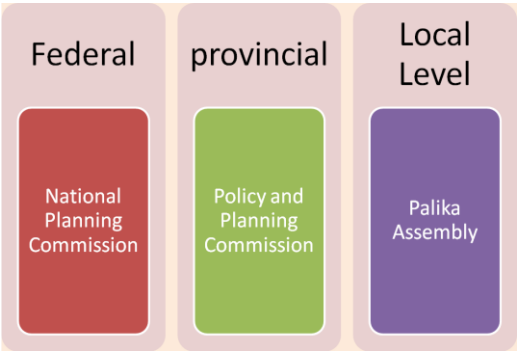
Table 2.1: Annual calendar related to MoHP, AWPB

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

Source: MoHP, 2019

2.2.2 Planning in FY 2019/20 at Provincial Government

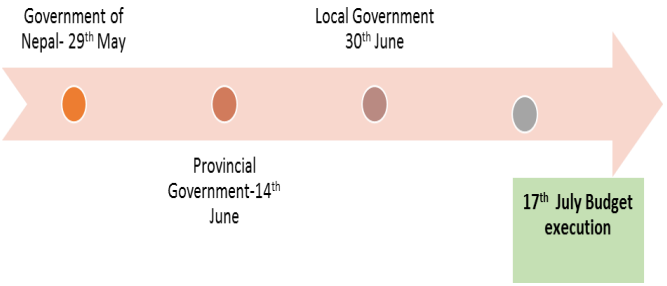
In this FY, 2019/20, the MoHP provided NPR 4.90 billion as a conditional grant to PGs. PGs received the conditional grant through the Red Book. The PG budget included in the Red Book does not need any authorisation. The PG announces the budget by 14 June, (31 Jestha). The MoF sent a circular through its website to all District Treasury Controller 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) prepared the social sector budget, including the health budget.



The health budget for PG can include sources such as revenue transfer, equalisation, conditional, special and matching funds from Federal Government (FG) including their own revenue. The budget should be executed by 16 July (Shrawan 1).

2.2.3 Planning in FY 2019/20 at Local Level

In this FY, 2019/20, the MoHP have provided NPR 21.2 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 District Treasury Comptroller Offices (DTCOs) to release the first quarter budget as per the Red Book, irrespective of equalisation or conditional grants. The health budget for LG can include sources such as revenue transfer, equalisation, conditional, special and matching funds from FG and PGs, including their own revenue. The LGs should finalise their budget by mid-July (end of Ashad) and budget execution should start from 16 July (Shrawan 1).



2.3 Budget Preparation Process and Issues in the Changing Context

Planning and budgeting functions often operate in parallel in the Nepalese context. In practice, planners are only involved in planning while budget implementers (finance officers) are only involved in keeping expenditure records. This separation has been a major issue during the First and Second Nepal Health Sector Plans (NHSP-1 and NHSP-2) and the early stages of NHSS implementation. In the changed context, budget preparation and endorsement at different levels of government are performed through the commission and Palika assemblies as shown in the figure above. The MoHP still needs to address these issues by better aligning its actual expenditures with budgets. The specific issues include:

- Aligning or harmonising exclusive functions of FG, 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 FG, PGs and LGs
- 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 the health budget and programmes that are consistent with national and international commitments at all levels of government
- Enhancing the capacity of officials engaged in planning at all levels of government, and
- Standardising the budget and expenditure tracking system at Federal, Provincial and Local Levels.

CHAPTER 3: ANALYSIS OF MACRO INDICATORS FOR HEALTH SECTOR FY 2019/20

This section summarises government health expenditure, share of Gross Domestic Product (GDP) in health, per capita national health expenditure, and analysis of budget directly going to the household. This section examines the health budget and related expenditure from FY 2015/16 to FY 2019/20. The section starts with an analysis of the health sector budget followed by a detailed analysis of the health and MoHP budget. For clarity purpose health sector budget is defined as health budget allocated to MoHP, MoFAGA and other line ministries. Following analysis does not provide definitive reasons for trends, but does try to elucidate potential reasons for some of the findings.

3.1 Trends in Health Budget Allocation and Expenditure against GDP

Table 3.1 shows the Gross Domestic Product (GDP), National, Provincial and Local budgets and health budgets, including expenditure from FY 2015/16 to FY 2019/20.

Table 3.1: GDP, Budget National, PGs, LGs, Health Budget and Absorption (Amount NPR Billion)

Category	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20*
GDP	2,130.2	2,253.2	2,674.5	3,031.0	3,464.3	3,679.1
Budget						
National	618.1	819.5	1,048.9	1,279.0	1,315.2	1,533.0
Provincial	NA	NA	NA	7.0	113.4	99.8
Local	NA	NA	NA	225.1	195.1	213.8
Health Sector Budget						
Health Sector	**36.7**	**42.1**	**49.8**	**56.5**	**65.3**	**78.4**
Health	**32.2**	**37.2**	**41.6**	**46.9**	**51.7**	**68.8**
MoHP	32.2	37.2	41.6	31.8	29.4	42.7
Provincial Health	NA	NA	NA	NA	4.2	4.9
Local Health	NA	NA	NA	15.1	18.2	21.2
Expenditure						
National	531.3	601.0	837.2	1,087.3	1,208.4	NA
MoHP	24.5	29.2	39.1	27.4	24.5	NA
Provincial Health	NA	NA	NA	NA	3.8	NA
Local Health	NA	NA	NA	14.1	17.7	NA
***Absorption Rate* (%)**						
National	86.0	73.3	79.8	85.0	91.9	NA
MoHP	76.2	78.7	93.9	86.1	83.4	NA
Provincial Health	NA	NA	NA	NA	92.0[2]	NA
Local Health	NA	NA	NA	93.6	97.5[3]	NA
Population	27,954,441	28,331,826	28,714,305	29,101,948	29,494,825	29,609,623

Source: GDP for all year from National Accounts 2018/19, Central Bureau of Statistics, for FY 2019/20 GDP estimates: Macroeconomic Update, Nepal, Volume 7, No.1, April 2019, Asian Development Bank, Budget: Red Book FY 2015/16– 2019/20

The health budget includes the budget for MoHP and conditional grants to PGs and LGs. In FY 2019/20, the GoN has allocated NPR 78.4bn to the health sector, of which the health conditional grant to the MoHP is NPR 42.7bn, NPR 4.9bn is allocated to PGs and NPR 21.2bn to LGs (adding up to NPR 68.8bn). NPR 9.6bn is allocated to line ministries other than health. There has been a steady rise in health budget in absolute

[2] Provincial and local government absorption is obtained from SuTRA data and Authors estimate

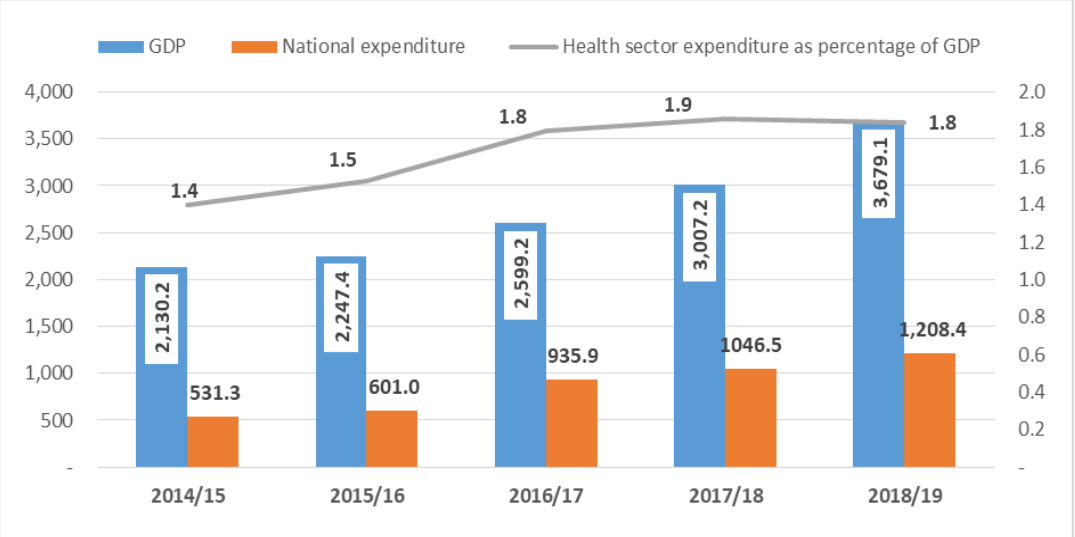
terms from NPR 37.2bn in FY 2015/16 to NPR 68.8bn in FY 2019/20 (see table above). However, the proportional allocation of health conditional grants to PGs and LGs remained almost the same compared to FY 2018/19, at 7 percent and 31 percent respectively.

The MoHP absorption rate in FY 2018/19 is lower (83.4%) than that of the national budget absorption (91.9%). At the same time, MoHP's absorption in FY 2018/19 has reduced compared to FY 2017/18. The actual budget absorption for MoHP is even worse, given that the MoHP has surrendered NPR 4.75bn from its initial budget of NPR 34.08bn to the MoF, which was further reallocated to fund conditional grant activities at PGs and LGs. MoHP's poor absorption could be attributed to weak planning and procurement. At the same time, it is important to note that both PGs and LGs are able to absorb more than 90 percent of their conditional grant.

3.2 Trends in Government Health Conditional Grant Expenditure

Figure 3.1 provides an indication of the trend of government health spending as a percentage of GDP. Over the years, government spending on health as a share of the GDP has slowly been increasing. The government spending on health includes budget allocated to the MoHP and other line ministries. Other line ministries include the Ministries of Finance, Commerce and Supply, Defence, Home Affairs, General Administration, Education, and Federal Affairs and Local Development.

Figure 3.1: Trend on government health spending as a percentage of GDP (NPR billion).



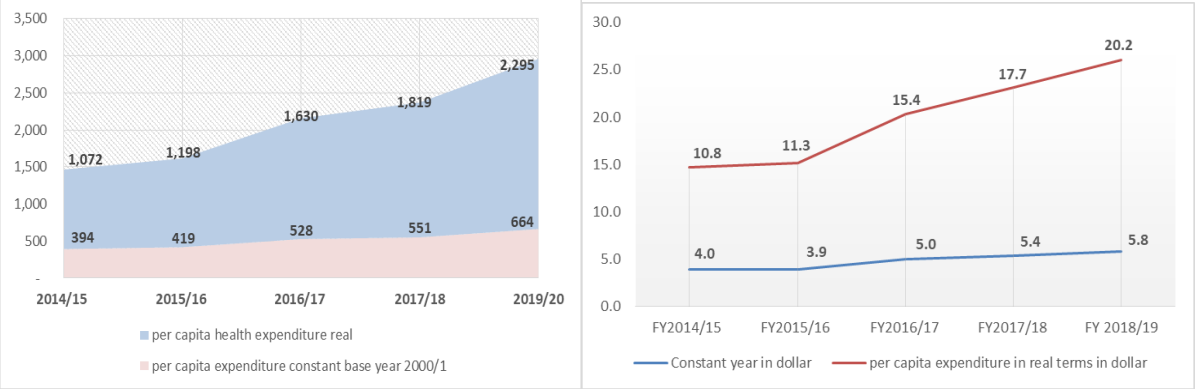
Source: Red book FY 2014/15–18/19

Government health expenditure as a percentage of the GDP for FY 2018/19 is 1.8 percent. There is a 0.4 percentage increase compared to the NHSS baseline year (1.4% for FY 2014/15) and 0.1 percentage decrease compared to FY 2017/18. The Chatham House report issued in 2014 recommended that countries should strive to spend five percent of their GDP to progress towards UHC (Mcintyre, 2014). There is a wide range of evidence across countries supporting this target of at least five percent of GDP. The 2010 World Health Report stated that public spending of about six percent of GDP on health would limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible (World Health Organization, WHO, 2010). Government spending on health of more than five percent of GDP is required to achieve a conservative target of 90 percent coverage of Maternal and Child Health (MCH) services (Mcintyre *et al*, 2017). This means that Nepal has been investing far less in health as a share of GDP than would be necessary to achieve UHC.

3.3 Per Capita Government Health Expenditure

Per capita government spending has gradually increased from NPR 1072 (USD 10.8) in FY 2014/15 to NPR 2295 (USD 20.2) in FY 2018/19 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 394 (USD 4) to NPR 664 (USD 5.8).

Figure 3.2: Per capita health spending in real and constant terms (NPR and USD)



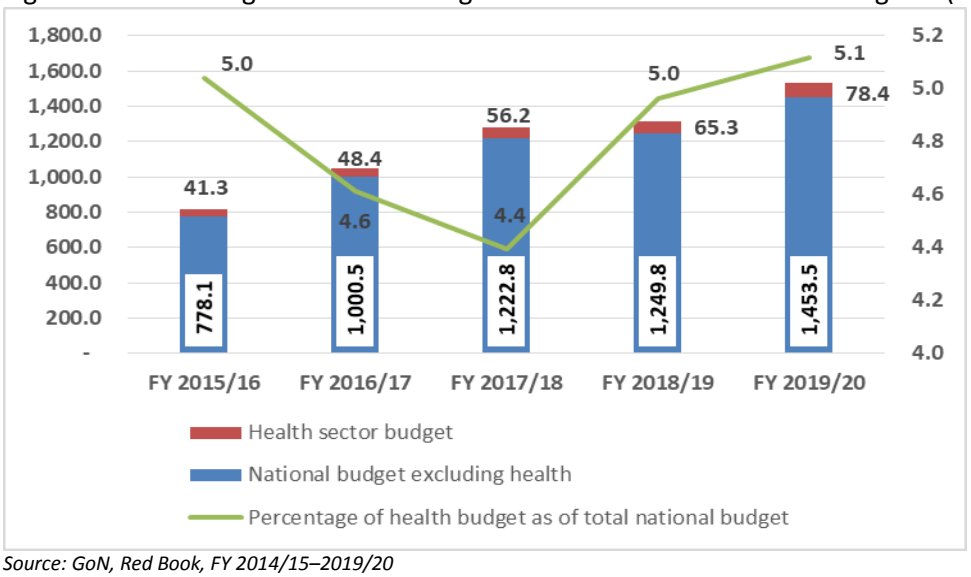
Source: Red book FY 2014/18 –18/19, Population projection obtained from Health Management Information System (HMIS)

In FY 2018/19, per capita health expenditure also includes the expenditure from PGs and LGs own sources in addition to conditional grants. The Chatham House report, including recent evidence, recommends that low-income countries spend USD 86 per capita to promote universal access to primary care services (Mcintyre, 2014). This shows that Nepal's spending is far behind the amount recommended to achieve universal access to primary care services.

3.4 Share of Health Sector Budget out of Total Government Budget

Figure 3.3 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 41.3bn in FY 2015/16 to NPR 78.4bn in FY 2019/20. Between FY 2015/16 and FY 2019/20, the share of health sector budget against total national budget remained stagnant at five percent, given the sharp decline to 4.6 and 4.4 percent in FY 2016/17 and FY 2017/18. One of the reasons for this could be the prioritisation of reconstruction activities after the 2015 earthquake. The NHSS sets a target of nine percent for 2019. This means that the health sector has not been able to meet the NHSS target in terms of allocation against the national budget.

Figure 3.3: Percentage of national budget allocated as health conditional grant (NPR billion)



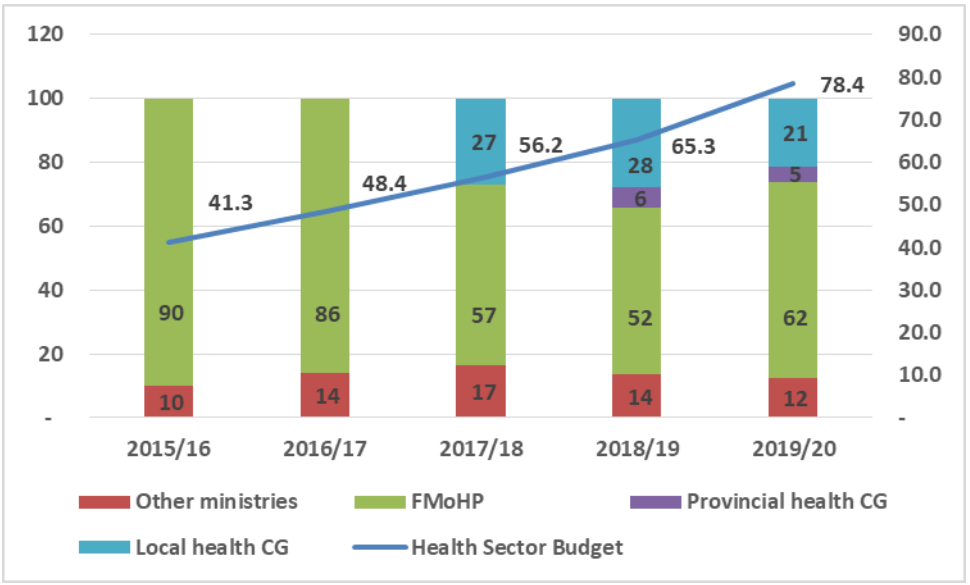
Source: GoN, Red Book, FY 2014/15–2019/20

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

3.5 Health Sector Budget in FY 2019/20

Figure 3.4 shows the stacked graph with percentage distribution of the health sector budget across MoHP, other ministries, and conditional grant to PGs and LGs. The line graph shows the health sector budget in absolute figures.

Figure 3.4 Composition of Health Sector Budget (NPR billion)



Source: GoN, Red Book, FY 2015/16–2019/20

The health sector budget has been on gradual rise in actual terms, from NPR 41.3bn in FY 2015/16 to NPR 78.4bn in FY 2019/20. This is because of the increase in the health budget, especially to the MoHP, where it increased from 52 percent to 62 percent from FY 2018/19 to FY 2019/20. Compared to the last FY, the proportional allocation of conditional grants to PGs and LGs have decreased from 6 percent to 5 percent and 28 percent to 21 percent respectively.

3.6 Allocation of Health Sector Budget by COFOG at Federal, Provincial and Local levels

Table 3.2 presents health sector budget allocation by Classification of Functions of Government (COFOG) at the federal, provincial and local government. Almost 44 percent is spent on public health services, followed by 39 percent on hospital services including Outpatient Department (OPD), and 14 percent on research activities.

Table 3.2 COFOG-wise Allocation of Health Sector Budget by Federal, Provincial and Local Government

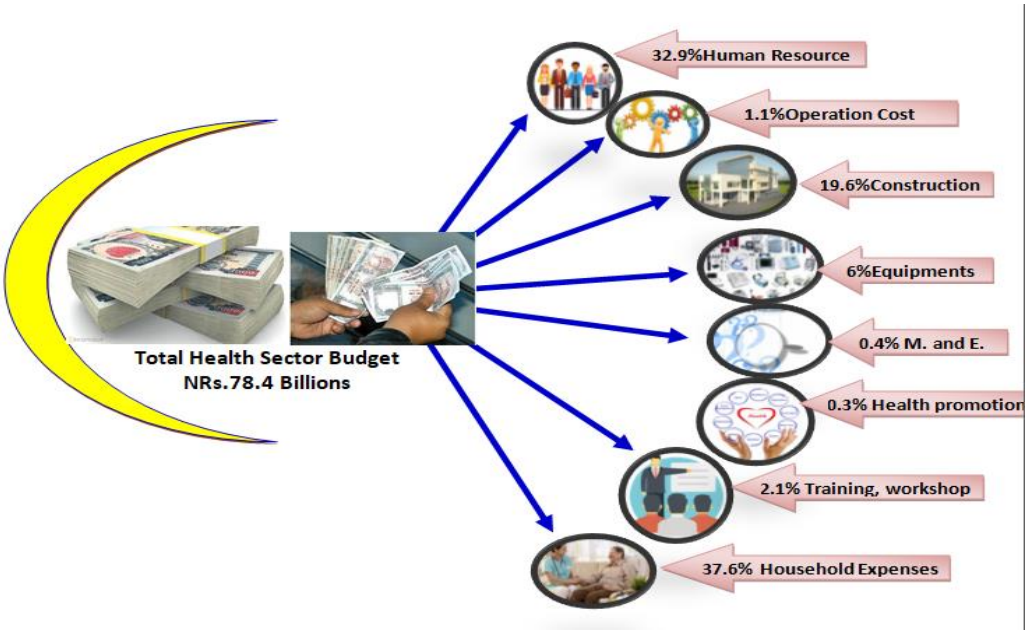
Amount in NPR million

COFOG	Allocated Budget				
	Federal	Provincial	Local	Amount (NPR)	%
Drug production, equipment and tools	436	-	-	436	1
OPD services	5,127	2,138	1,777	9,042	12
Hospital services	16,122	1,351	3,460	20,932	27
Public health services	17,018	1,237	15,869	34,124	44
Research services	10,763	152	124	11,040	14
Health (not classified elsewhere)	2,831	-	-	2,831	4
Total	**52,296**	**4,879**	**21,230**	**78,404**	**100**

3.7 Distribution of Health Sector Budget by Support Functions and Actual Services

Figure 3.5 provides a breakdown of the health sector budget by support function and actual services. Less than 40 percent of the budget is actually allocated for services that directly reach the household. This also indicates that more than 60 percent of the budget is spent on support functions in order to bring services to the household.

Figure 3.5 Health sector budget by support function and actual service



This section attempts to analyse the government spending on health ***excluding off-budget off-treasury*** and ***private sector contributions***. Furthermore, this analysis does not take into account the local resources allocated to health by PGs and LGs through their revenues.

CHAPTER 4: HEALTH CONDITIONAL GRANT ANALYSIS FOR FY 2019/20

This chapter starts with an analysis of the health conditional grant at FG (MoHP), PG and LG. This excludes both the NPR 10bn provided to other federal ministries for health and the health budget allocation from PGs and LGs using their resources. The following analysis does not provide definitive reasons for trends, but does try to elucidate potential reasons for some of the findings.

4.1 Allocation of Health Conditional Grant by Line-item at Federal, PG and LG

Health budget to provincial and local governments is provided in the form of conditional grants. Details of health conditional grant activities provided to PGs and LGs can be found at www.mofaga.gov.np. Table 4.1 summarises health budget provided to the FG, PGs and LGs.

Table 4.1 Line-item-wise Allocation of Health Budget by Federal, Provincial and Local Government

Amount in NPR million

Line Item (Economic Code)	Allocated Budget NPR				
	Federal	Provincial	Local	Amount	%
Wages and Salaries	339	554	14,710	15,603	23
Support Services	708	416	782	1,906	3
Capacity Building	135	918	625	1,678	2
Program Activities	1,037	903	1,788	3,728	5
Medicine Purchases	4,586	825	1,324	6,734	10
Grants to Hospitals	27,687	824	1,471	29,982	44
Capital – Construction	7,480	146	383	8,009	12
Capital Goods	700	292	148	1,141	2
Total	**42,671**	**4,878**	**21,231**	**68,780**	**100**

Almost 44 percent of health budget is allocated to hospital grants, followed by 23 percent on wages and salaries. Capital construction accounted for 12 percent of the total health budget. The majority of the health budget under wages and salaries, support services, capacity building and programme activities has been devolved to SNG (98%, 63%, 92% and 72% respectively). At the same time, the majority of the health budget for medicines, hospital grants, capital construction and capital goods remains at the federal level (68%, 92%, 93% and 61% respectively). The key health budget driver for LGs is wages and salaries (69 percent), followed by in-programme activity (8 percent) and grants to hospitals (7 percent). Similarly, for PGs the key health budget drivers are programme activities and capacity building (17 percent), followed by medicine purchases and grants to hospitals. Wages and salaries accounted for 11 percent. At the same time, grants to hospitals (65 percent), capital construction (18 percent) and medicine purchases (11 percent) remain the top three drivers of health budget at the MoHP.

4.2 Cluster-wise Allocation of Health Conditional Grant at Federal, PG and LG

By cluster-wise allocation, almost 37 percent of the health budget is spent on general administration and support. Maternal and child health accounted for 18 percent of the total health budget followed by curative services (13 percent) and the free health programme (10 percent). Almost all health budget for homeopathy/unani, drug management, and health insurance is allocated to the MoHP. Similarly, more than half of the oral and mental health and MIS/Survey/Surveillance/Research budget is allocated at the provincial level and free health care programme (66 percent) and Ayurvedic services (51 percent) at the local level.

Table 4.3: Cluster-wise Allocation of Health Budget by Federal, Provincial and Local Government

Amount in NPR million

Cluster	Allocated Budget in NPR				
	Federal	Provincial	Local	Total	%
General Administration and Support	11,514	95	14,075	25,684	37.3
Curative (Hospital) Services	8,314	300	-	8,614	12.5
Homeopathy/Unani	17	-	-	17	0.0
Ayurveda	286	116	849	1,251	1.8
Epidemic Disease Control	585	166	482	1,233	1.8
TB and Leprosy Control	724	171	247	1,142	1.7
HIV/AIDS and STDs	549	128	4	681	1.0
Drugs Management	699	-	-	699	1.0
Laboratory Service	282	-	-	282	0.4
Oral and Mental Health	75	68	-	143	0.2
MCH	4,971	3,302	3,807	12,081	17.6
Health Education and Training	1,060	53	143	1,255	1.8
MIS/Survey/Surveillance/Research	158	242	121	520	0.8
Free Health Programme	5,012	231	1,503	6,746	9.8
Impoverished Citizen Treatment	2,200	7	-	2,207	3.2
Health Insurance	6,226	-	-	6,226	9.1
Total	**42,671**	**4,878**	**21,231**	**68,780**	**100.0**

No health budget is allocated under treatment of impoverished citizens, health education and training, laboratory services, and oral and mental health at the local level. The three main cost drivers at LGs are general administrative and support (66 percent), followed by MCH (18 percent) and free health programme (10 percent). Similarly, the three major cost drivers at PG are MCH (68 percent), curative health services (6 percent) and MIS/Survey/Surveillance/Research (5 percent). The three major drivers for MoHP are general administration and support (27 percent), curative service (19 percent) and health insurance (15 percent). It is important to note that from this FY onwards budget under salary and operations for provincial hospitals, provincial health offices, provincial health directorates, provincial training centres, and provincial logistic management centres will be managed from the province equalisation grant. Similarly, the establishment of Department of Drug Administration (DDA) units in various part of the country has contributed to increased budget under drug management.

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

Almost 41 percent of the budget under drug procurement is spent on purchasing vaccines, diluent and syringes, followed by free health care (33 percent) and nutritional drug and supplements (4.5 percent). The MoHP is solely responsible for the purchase of Family Planning (FP) commodities, anti-snake venom and rabies, antimalarial, kala-azar, lymphatic filariasis and homeopathic drugs. Similarly, the purchase of leprosy drugs is devolved to PGs and LGs. All obstetric and Integrated Management of Neonatal and Childhood Illness (IMNCI) drugs are purchased at the provincial level. At the same time, more than 80 percent of homeopathic drugs and nutritional drugs and supplements are purchased at the provincial level. Fifty-two percent of free health drugs are procured at local level, followed by federal (37 percent) and provincial (11 percent).

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	Total	%
Procurement of Free Drugs/Supplies	718	500	1,017	2,235	33.2
Malaria RDT Kit	30			30	0.4
TB Drugs and Supplies	225	12		237	3.5
Lab Kits/Reagents/Chemicals	280			280	4.2
HIV/AIDS Drugs	270			270	4.0
FP Commodities	219			219	3.2
Vaccines, Diluent and Syringes	2,402	65	295	2,761	41.0
IMNCI Drugs and Supplies		123		123	1.8
Nutritional Drugs and Supplements	180	120		300	4.5
Rabies Vaccine	170			170	2.5
Anti Snake Venom (ASV) Drugs	20			20	0.3
Antimalarial Drugs and Supplies	37			37	0.5
Kala-azar Drugs and Supplies	20			20	0.3
Lymphatic Filariasis Drugs	15			15	0.2
Leprosy Drugs		6	11	17	0.3
Total	**4,585**	**825**	**1,324**	**6,733**	**100.00**

At the local level, the main cost driver is the procurement of free health drugs, which accounts for 77 percent of the their total budget. Similarly, at provincial level, the major cost drivers are the purchase of free health drugs (61 percent), followed by 15 on percent nutritional drugs and supplements and IMNCI drugs and supplies. At the federal level, 52 percent of the health budget is spent on the purchase of vaccines, diluent and syringes followed by free health drugs (16 percent). It is important to note that vaccine transport costs are given from Palika (Palika to health office) and province to transport vaccines from provincial logistic management centres to province health offices (vaccine stores).

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

Table 4.5 presents equipment categories procured from health budget at three levels. Eighty-five percent of the budget for equipment purchase remains at the federal level. Ten percent of equipment is purchased by PG and five percent by LG. At the national level, 33 percent of the equipment budget is spent on purchasing medical equipment, followed by purchase of cancer equipment (17 percent) and cardiac, thoracic and vascular equipment (14 percent). The equipment budget for cancer, cardiac, thoracic and vascular, human organ transplant, laboratory, ophthalmic and ENT, trauma, neuroprosthetic, orthopaedic and computer, printer, photocopying equipment is allocated to FG. Interestingly, all budget for the purchase of FP equipment remains at PG. Only medical equipment and equipment for maternal and child health is purchased by all three spheres of the government.

Table 4.5 Categories of Equipment Procured from Health Budget by Federal, Provincial and Local Levels

Amount in NPR Million

Equipment Categories	Allocated Budget in NPR				
	Federal	Provincial	Local	Total	%
Medical	597	232	128	957	33.2
Cancer	500	-	-	500	17.4
Cardiac, Thoracic and Vascular	405	-	-	405	14.0
MCH	306	28	20	354	12.3
Cold Chain	122	11	-	132	4.6
Computer/Printer/Photocopy	124	-	-	124	4.3
Tuberculosis Diagnostic	66	13	-	78	2.7
Human Organ Transplant	46	-	-	46	1.6
Laboratory	40	-	-	40	1.4
Ophthalmic and ENT	191	-	-	191	6.6
Trauma	20	-	-	20	0.7
Neuroprosthetic	15	-	-	15	0.5
Orthopaedic	10	-	-	10	0.3
FP	-	8	-	8	0.3
Total	**2,442**	**291**	**148**	**2,881**	100

Medical equipment is the major cost driver at all three levels of the government: LG (86 percent), PG (80 percent) and federal (24 percent).

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

Forty-three percent of the budget allocated under free care/treatment is spent on MCH, followed by free health care (37 percent) and free nutrition (6 percent). All budget related to free treatment of heart, eye and cancer is allocated to the federal level. At the same time, 80 percent of the budget for free treatment of target groups sits at the federal level. Ninety-eight percent of the budget for TB treatment is allocated to PG. Similarly, 56 percent of the 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

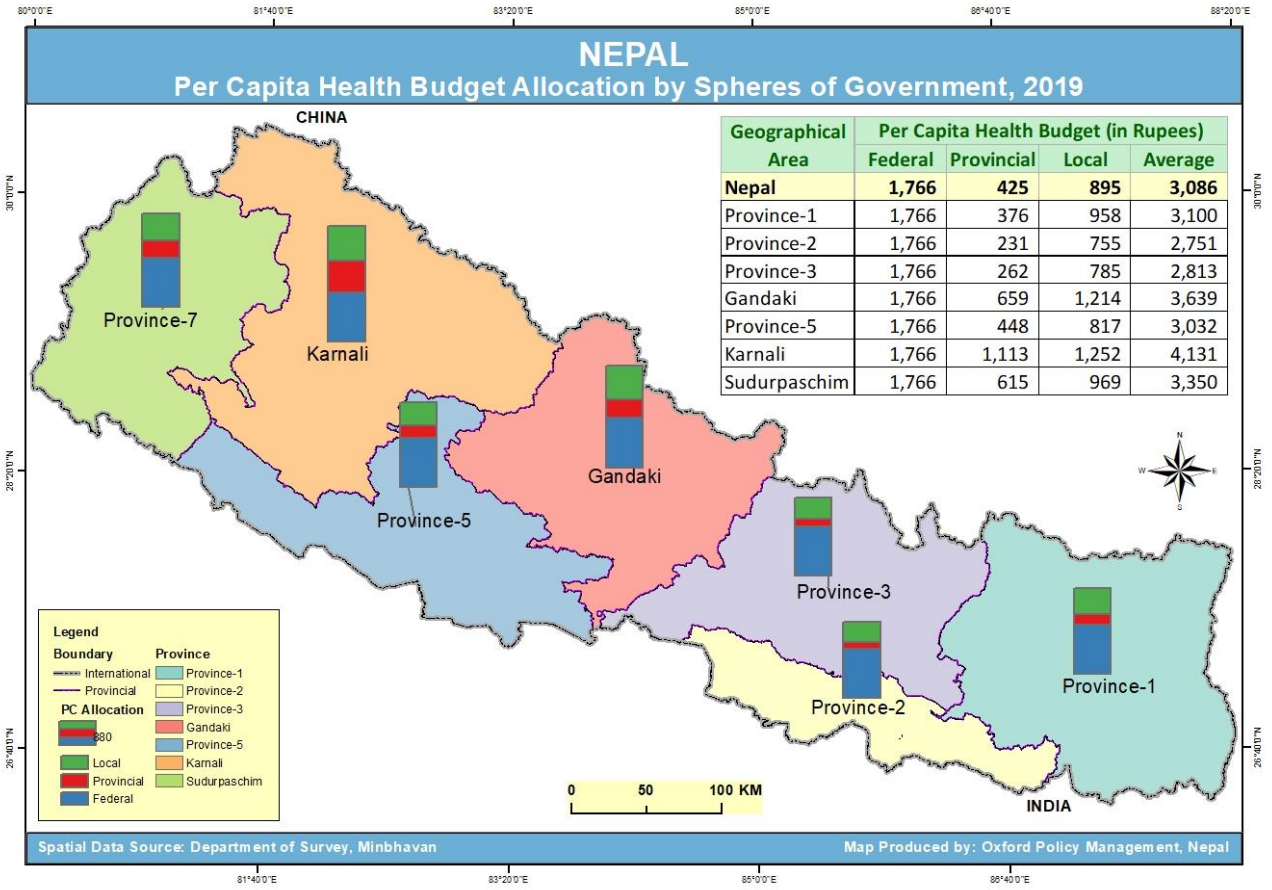
Free Health Care/Treatment	Allocated Budget in NPR				
	Federal	Provincial	Local	Total	%
MCH	345	835	1,445	2,625	43.4
Free Health Care	718	500	1,017	2,235	37.0
Nutrition	213	162	-	375	6.2
Heart Treatment	352	-	-	352	5.8
Treatment for Target Populations	122	30	-	152	2.5
Health Camp	19	-	91	110	1.8
Reproductive Health	30	44	-	73	1.2
TB Treatment	1	44	-	45	0.7
Cancer (Prevention/Screening /Treatment)	40	2	-	42	0.7
Food For Patients	16	-	-	16	0.3
Eye Treatment	11	-	-	11	0.2
Leprosy Service	3	-	-	3	0.0
HIV/AIDS Lab Test	0.6	-	0.8	1.7	0.0
Total	**1,871**	**1,617**	**2,555**	**6,042.7**	**100.0**

More than 50 percent of the PGs' and LGs' free health budget is occupied by maternal and child health followed by free health services (31 percent and 40 percent respectively). At the federal level, almost 50 percent of the free health budget is captured by treatment of target populations.

4.10 Per Capita Budget allocation at Federal, Provincial and Local Government

The figure below provides an overview of the per capita budget allocation at federal, provincial and local levels. The per capita health sector allocation at FG is NPR 1,766 (excluding conditional grants for PGs and LGs). The provincial government per capita share in the health sector varies from NPR 231 in Province 2 to NPR 1,113 in Karnali province. The per capita health budget allocation in Karnali province may seem high; however, it is to be noted that it has the largest administrative boundary and has difficult topographic terrain with a small population. Similarly, the LG per capita share in health sector varies from NPR 755 in Province 2 to NPR 1,252 in Karnali. On average, Province 2 gets NPR 2,751 per capita whereas Karnali province gets NPR 4,131 per capita.

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



Geographical Area	Per Capita Health Budget (in Rupees)			
	Federal	Provincial	Local	Average
Nepal	**1,766**	**425**	**895**	**3,086**
Province-1	1,766	376	958	3,100
Province-2	1,766	231	755	2,751
Province-3	1,766	262	785	2,813
Gandaki	1,766	659	1,214	3,639
Province-5	1,766	448	817	3,032
Karnali	1,766	1,113	1,252	4,131
Sudurpaschim	1,766	615	969	3,350

At the same time, the percentage share of per capita budget allocation from the three spheres of governments varies across the provinces. For example, federal sources accounted for two-thirds of the Province 2 health budget but made up only 45 percent of the Karnali province total. Similarly, provincial government sources account for less than 10 percent in Province 2 whereas more than one-quarter of the health budget in Karnali province comes from provincial allocation. Additionally, LG sources account slightly more than one-quarter in Province 5 whereas one-third of the health budget in Gandaki province comes from local allocation.

CHAPTER 5: ANALYSIS OF MOHP BUDGET FY 2019/20

This chapter provides analysis of the budget allocated for the MoHP. It captures budget until FY 2019/20 (NPR 42.7bn) and expenditure up to FY 2018/19. The source of expenditure has been taken from MoHP's Financial Monitoring Report (FMR), which is verified with the Financial Comptroller General Office's (FCGO's) Financial Management Information System (FMIS). This analysis excludes the conditional grants provided to PGs and LGs. In order to provide the complete picture, this analysis attempts to cover the revenue generated by the MoHP SUs that has been deposited at the central treasury and audit observations from the Office of Auditor General (OAG).

5.1 MoHP Budget and Expenditure by Capital and Recurrent Classifications

Table 5.1 shows that there was almost a two-fold increase in the volume of capital budget from NPR 4.6bn in FY 2015/16 to NPR 8.2bn in FY 2019/20. This increase suggests that the GoN is prioritising rebuilding health infrastructure. The percentage allocation of the capital budget has increased from 12 percent in FY 2015/16 to 19 percent in FY 2019/20. At the same time, the percentage allocation of recurrent budget is decreasing from 87 percent in FY 2015/16 to 80 percent in FY 2019/20.

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

Budget Type	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
Capital	4.6	74.2	6.6	88.6	7.4	90.8	8.6	68.4	8.2
Recurrent	32.6	79.3	35.0	94.9	26.0	79.6	20.8	89.6	34.5
Total	**37.2**	78.7	**41.6**	93.9	**33.3**	82.1	**29.4**	83.4	**42.7**

Source: Red Book, FY 2015/16–2019/20

The trend data suggests that absorption of the recurrent budget is better than the capital budget, attaining as much as 95 percent in FY 2016/17. One reason to explain this could be that a significant proportion of the recurrent budget is used for administrative expenditure, including salaries and allowances, whereas the capital budget is subject to procurement delays. However, the opposite trend appears in FY 2017/18, with 91 percent absorption in capital budget. This is due to an additional NPR 1 billion for building construction expenditure provided by the Ministry of Urban Development to the MoHP. In FY 2018/19, the absorption of capital budget was less than 70 percent, whereas recurrent budget remained at 90 percent. This is mainly due to underspending in building construction. It has to be noted that the budget mentioned for FY 2018/19 in the last BA report differs from that given in this report. This is a result of using the adjusted budget in the BA report. This practice applies across this report.

5.2 MoHP Budget and Expenditure by GoN and EDPs

The government's share of the MoHP budget has fluctuated over the years, reaching as much as 81 percent in FY 2015/16; a similar proportion (79 percent) was recorded in FY 2019/20. Since FY 2017/18, EDPs channeling their funding through the pooled fund have mainly agreed to fund activities implemented solely by MoHP. As a result, the share of EDP expenditure in the MoHP budget has increased. However, the overall contribution of EDPs to the health budget is in decreasing trend.

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

Budget Source	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
GoN	29.4	82.5	31.9	99.8	25.5	84.5	19.4	88.7	33.9
EDP	7.7	64.0	9.7	74.7	7.8	74.2	9.9	73.1	8.8
Total	**37.2**	78.7	**41.6**	93.9	**33.3**	82.1	**29.4**	83.4	**42.7**

Source: Red Book, FY 2015/16–2019/20

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 64 percent and 73 percent. This could be due to weak reporting of EDP direct funding (or lack thereof), which is reflected in the Red Book but not captured in government expenditure records. This could also be due to delay in the timely release (or lack of release) of EDP budget, which ultimately hampers absorption.

5.3 MoHP Budget and Expenditure by Administration and Programme

Table 5.3 shows the MoHP budget allocated for both administrative and programme expenses. Before FY 2016/17, almost 30 percent of the MoHP budget was allocated to the administrative budget. Since FY 2017/18, the administrative budget has reduced to 9.6 percent of the MoHP budget, and further reduced to 4 percent in FY 2018/19. This is mainly because salaries and other administrative expenses have been allocated to PGs and LGs through conditional grants. In FY 2019/20, the administrative budget has increased to 9.7 percent of the MoHP budget and this is mainly.

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

Budget Source	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
Admin	11.6	79	11.2	113	3.2	87	1.3	81	4.2
Program	25.5	78	30.4	87	30.1	81	28.1	84	38.5
Total	**37.2**	78.7	**41.6**	93.9	**33.3**	82.1	**29.4**	83.4	**42.7**

Source: Red Book, FY 2015/16– 2018/19

The MoHP has been able to spend almost all of its administrative budget and has sometimes spent more than has been allocated. Compared to FY 2017/18, programme budget absorption has shown some improvement, from 81 percent to 84 percent, whereas absorption of the administrative budget declined from 87 percent to 81 percent in the same time period.

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

The GoN's Red Book mainly covers government funds and contributions from EDPs in the form of direct and pooled funds. Table 5.4 shows that the share of pool and direct funding has been fluctuating over the years. In FY 2019/20 the pool fund as share of MoHP budget has remained at 25 percent and direct funds at 10 percent.

Table 5.4: Budget and Percentage Expenditure by Government, Pool and Direct Funding *Amount in NPR Billion*

Budget Source	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
GoN	19.3	97.2	29.4	98.4	33.8	98.4	22.2	97.4	19.4
Pool Fund	8.1	57.8	0.8	100.0	3.4	100.0	6.2	0.1	6.6
Direct fund	4.8	22.1	6.9	55.1	4.4	55.1	4.6	127.0	3.3
Total	32.2	76.2	37.2	93.9	41.6	93.9	33.0	83.1	29.4

Source: Red Book, FY 2015/16–2019/20

It is important to note that the reporting of expenditure under direct funding has been weak over the years. In FY 2017/18, absorption of direct funds appeared to be very low. This is mainly because of under-reporting from direct funding and the fact that the DTCO is yet to record in-kind support to the Treasury Single Account (TSA).

5.5 MoHP Budget and Expenditure by Organisational Level

The Department of Health Services (DoHS) holds the major share of the MoHP budget. However, between FY 2015/16 and FY 2019/20, the percentage allocation of DoHS budget decreased from 66 percent to 48 percent. At the same time, budget to the MoHP as SU seemed to have gradually decreased from 4.6 percent to 2.5 percent between FY 2015/16 and FY 2018/19. In FY 2019/20 the share of MoHP as SU increased to almost eight percent. Similarly, allocation to hospital budget increased from 14 percent in FY 2015/16 to almost 19 percent in FY 2018/19, decreasing in FY 2019/20 to almost 17 percent. This might be because many hospitals have been handed over to PGs and LGs. The budget for the Department of Ayurveda (DoA) is in decreasing trend, from 2.9 percent to 0.5 percent over the same period. This is mainly because the majority of DoA activities have been devolved to LGs.

Table 5.5: Budget and Percentage Expenditure by MoHP Organisations *Amount in NPR Billion*

Organizations	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
MoHP	1.7	31.3	0.7	96.8	0.8	82.2	0.7	87.2	3.3
DoHS	24.6	82.0	26.6	95.5	20.4	79.5	17.8	78.4	20.9
DDA	0.1	63.4	0.1	69.5	0.1	76.4	0.2	71.1	0.2
DoA	1.1	69.1	1.1	88.4	0.5	82.4	0.4	72.8	0.2
Centres	4.4	62.9	5.8	81.5	5.0	73.0	4.7	83.5	11.0
Hospitals	5.1	94.6	7.3	99.2	6.5	97.2	5.7	99.6	7.1
Total	**37.2**	**78.7**	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**42.7**

Source: Red Book, FY 2015/16–2019/20

Over the years budget absorption of more than 90 percent has been observed for hospital budget, with almost 100 percent absorption in FY 2018/19. Similarly, budget absorption for DoHS, DDA and DoA reduced from 79, 76 and 82 percent in FY 2017/18 to 78, 71 and 73 percent respectively in FY 2018/19. Compared to FY 2017/18, the overall absorption of MoHP has improved and remained at 83 percent in FY 2018/19.

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

Essential Health Care Services (EHCS) are a priority for the MoHP, thus EHCS accounts for majority of the MoHP's budget. This is in line with the NHSS's recommendations. Over the past years, the percentage allocation to EHCS has remained more than 68 percent of the MoHP's budget, but decreased to 55 percent in FY 2019/20. At the same time, the percentage allocation of MoHP's budget to system components has increased from 12 to 28 percent between FY 2016/17 and FY 2019/20.

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

Amount in NPR Billion

	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
EHCS	25.5	79.2	27.9	92.4	20.0	76.6	17.5	86.5	23.5
Beyond EHCS	7.3	71.4	7.8	96.3	6.8	86.6	5.3	78.8	7.2
System Components	4.4	87.5	5.9	97.9	6.5	94.0	6.6	78.8	12
Total	37.2	78.7	41.6	93.9	33.3	82.1	29.4	83.4	42.7

Source: Red Book, FY 2015/16–2019/20

The budget for system components, which includes decentralised service delivery, private/Non-governmental Organisation (NGO) sector development, sector management, Health Financing (HF)/resource management, logistic management, human resource development and information system management, has increased over the last four years. Compared to FY 2017/18, budget absorption for EHCS has improved by 10 percentage points from 76.6 percent to 86.5 percent, whereas budget absorption for beyond EHCS and system components have decreased to less than 80 percent.

5.7 MoHP Allocation and Expenditure by Priority Programmes

Table 5.7 shows the MoHP's budget in NPR and the percentage of the budget spent by the different levels of priority programmes. Priority 1 programmes are the programmes with the highest priority assigned by the National Planning Commission (NPC). Over the years, Priority 1 programmes were allocated almost 80 percent of the MoHP budget. Since, FY 2018/19 the GoN decided to exclude P3 from the priority level.

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

Priority	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
P1	31.0	76.7	33.5	92.9	25.7	78.4	22.9	79.7	35.9
P2	5.6	88.9	7.6	98.3	7.0	95.9	6.5	96.5	6.8
P3	0.5	81.9	0.6	96.2	0.7	79.8	-	-	-
Total	37.2	78.7	41.6	93.9	33.3	82.1	29.4	83.4	42.7

Source: Red Book, FY 2015/16–2019/20

Compared to FY 2018/19, the allocation to P1 has increased from 74 percent to 84 percent in FY 2019/20; absorption improved from 78 percent to almost 80 percent from FY 2017/18 to FY 2018/19.

5.8 MoHP Budget and Expenditure by Line Item

Table 5.8 shows the budget allocated and percentage spent by the main budget line items. The data shows that for the budget allocated between FY 2015/16 to FY 2019/20:

- Grants to hospitals have almost doubled since FY 2015/16, from 30 percent to almost 65 percent in FY 2019/20
- The budget for support services, programme activities, capital goods and capacity building is in decreasing trend since FY 2017/18
- Compared to FY 2018/19, the budget allocated to purchasing medicine has increased from NPR 3.5bn to NPR 4.6bn
- The capital construction budget is in gradual rise from NPR 3.4bn in FY 2015/16 to NPR 7.5bn in FY 2019/20.

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

Broad Line Item	FY 2015/16		FY 2016/17		FY 2017/18		FY 2018/19		FY 2019/20
	Budget	%	Budget	%	Budget	%	Budget	%	Budget
Wages and Salaries	9.3	77.0	7.9	121.2	1.6	78.9	0.6	89.0	0.3
Support Services	1.9	56.4	1.8	82.8	1.2	73.8	0.5	79.5	0.7
Capacity Building	1.0	59.8	0.8	64.4	0.7	74.0	0.2	76.2	0.1
Programme Activities	3.4	67.2	4.2	69.8	3.3	61.1	1.0	60.3	1.0
Medicine Purchases	5.7	73.9	4.7	82.1	4.5	64.2	3.5	87.0	4.6
Grants to Hospitals	11.3	93.2	15.6	95.3	14.6	89.4	14.9	92.8	27.7
Capital – Construction	3.4	80.2	4.9	89.6	6.2	93.3	7.6	69.8	7.5
Capital Goods	1.2	56.8	1.7	85.8	1.2	78.2	0.9	56.1	0.7
Total	**37.2**	**78.7**	**41.6**	**93.9**	**33.3**	**82.1**	**29.4**	**83.4**	**42.7**

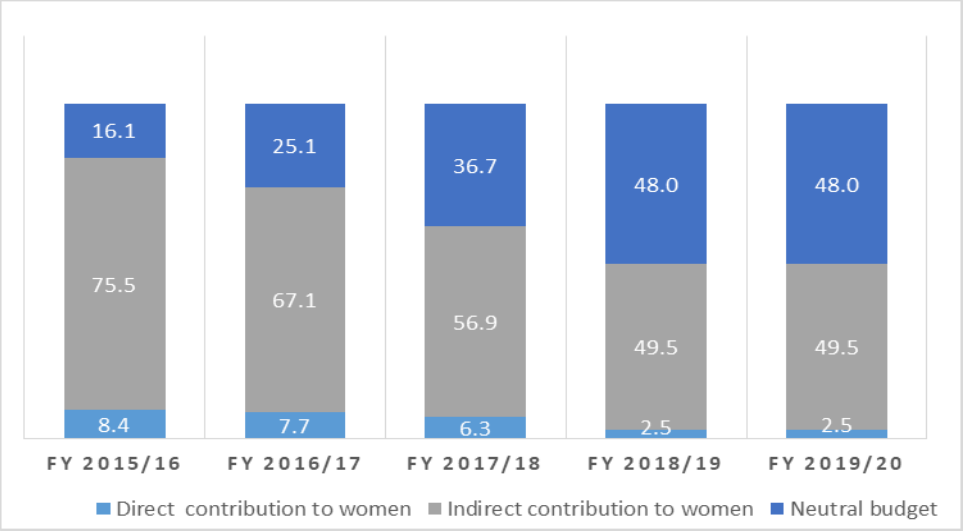
Source: Red Book, FY 2015/16–2019/20

In FY 2018/19, the weakest performance in expenditure was seen in programme activities (60%), purchase of capital goods (56%) and capital – construction (70%). Over the years, hospital grants have been shown to have good absorption, maintained at 89 percent and above. In FY 2018/19, the top performers in terms of expenditure were hospital grants (93%), wages and salaries (89%) and medicine purchases (87%).

5.9 MoHP Budget Allocation for Women-focused Activities

The MoHP 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 MoHP's Budget by Contribution to Women's Health



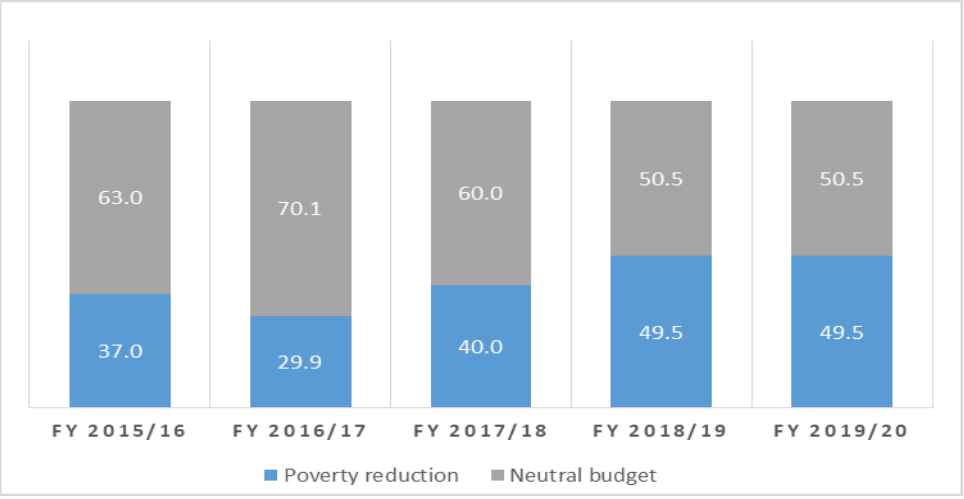
Source: Red Book, FY 2015/16–2019/20

The greatest proportion of the MoHP budget is occupied by programmes 'indirectly contributing to women's(Figure 5.1). This is because the MoHP's budget is aimed at both men and women, people of all ages and those living in different geographies. The MoHP includes budget for curative, disease control, prevention, and promotional services. The budget of the Family Welfare Division (FWD) and some others have been considered as programmes directly contributing to women's health. Since FY 2017/18, MoHP's share of budget directly contributing to women has declined sharply from 6.3 percent to 2.5 percent in FY 2019/20, which is mainly due to the devolution of basic health care services to the LGs. The majority of basic health care services include programme activities that directly contribute to women's health.

5.10 Budget Allocation by Poverty Reduction

The analysis looked at the MoHP's budget contributing to reducing poverty. The MoHP takes reference from the Red Book for defining the activities contributing to reducing poverty. Figure 5.2 suggests that over the years, the MoHP's poverty-reduction budget has increased from one-third in FY 2015/16 to almost half in FY 2019/20.

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



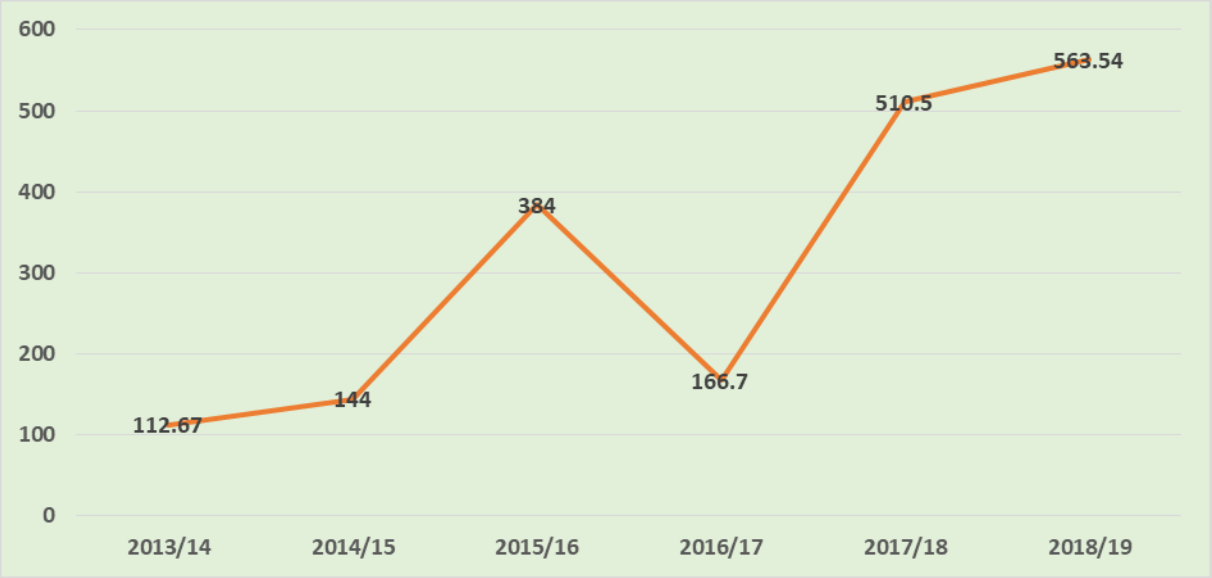
Source: Red Book FY 2015/16–2019/20

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

5.11 Reported Revenue by MoHP

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

Figure: 5.3 Annual Revenue Collected from MoHP Spending Units in Central Treasury *NPR Million*



Source: OAG, 2013/14–2018/19

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

5.12 Audit and Clearance

Table 5.9 presents the audit queries against the total audited amount under MoHP. It does not cover autonomous hospitals, and PG- and LG-level analysis of audit queries. The table shows that the proportion of audit queries against audited expenditure is in decreasing trend, from 14 percent in FY 2012/13 to 5 percent in FY 2017/18.

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

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

Source: OAG Annual reports

The audit for FY 2018/19 is currently being conducted and will be finalised by Mid-April 2020.

5.13 Cumulative Audit Queries and Clearance

Table 5.10 shows the total audit queries and their clearances over the years. It only includes the MoHP's audit queries and clearances. The table shows that the cumulative audit queries clearance was in increasing trend from 37 percent in FY 2012/13 to 52 percent in FY 2015/16.

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

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

Source: Audit Queries Clearance Evaluation and Monitoring Committee Annual reports

However, the audit clearance has been decreased since FY 2016/17. This could be due to structural changes, functions of the different governments, or transfer of the account officers and office chiefs. It has to be noted that special attention should be given to clear the cumulative audit backlog that was observed during structural transition.

This analysis shows that MoHP has received an increased budget compared to last FY. Additionally, as a result of its low absorptive capacity, the MoHP has surrendered more than NPR 4 billion to the MoF. The budget allocation pattern shows an increasing trend in the capital budget. Further analysis is required to analyse the need to infrastructure budget in health sector.

CHAPTER 6: BUDGET ALLOCATED TO PROVINCIAL AND LOCAL GOVERNMENT

This chapter analyses the total budget and health budget, including conditional grants allocated to the provincial and local governments for FY 2019/20. A brief background is provided, which focuses on the resource pools at provincial and local levels as well as the budget allocation and reporting mechanism, followed by the actual budget analysis of SNGs for FY 2019/20. Note that the intention of this analysis is to provide an indicative snapshot of budget preparation practices as 29 Palikas have not yet passed their budget and 61 Palikas have not entered their budget in SuTRA. The source of the analysis is the macro-level table from the Red Book; detailed analysis comes from the LMBIS and SuTRA. Macro-level analysis gives a complete picture, while micro-level analysis provides indicative information on the budget.

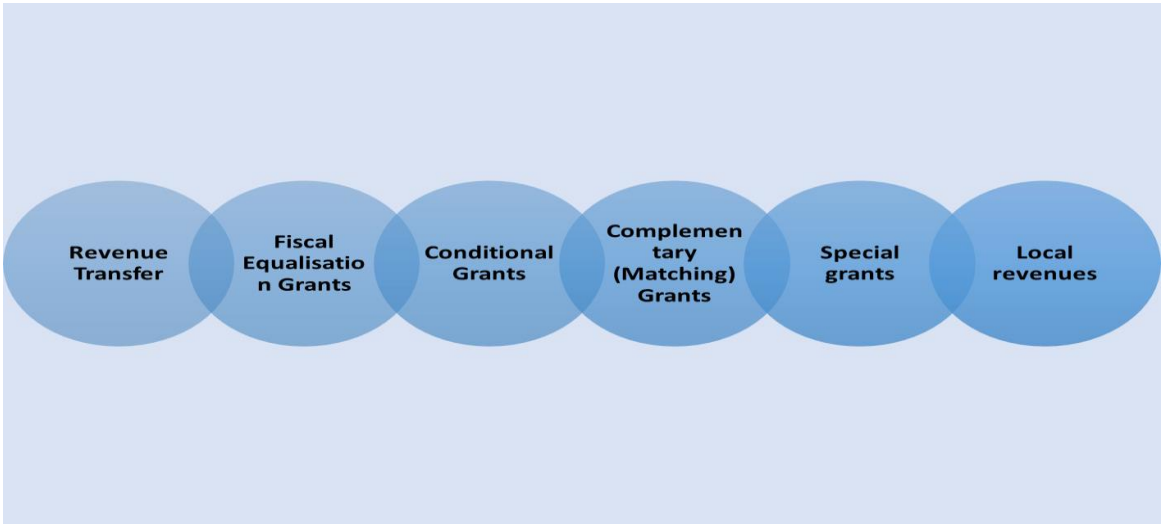
6.1 Background

In FY 2017/18, the GoN started practising its constitutional mandate through equalisation funds and conditional grants to the LGs. From this FY (2018/19), the GoN has provided different forms of grants including revenue transfer, equalisation, conditional, special and matching funds to the PGs and LGs. As devolution progresses, the planning, budgeting, expenditure, and reporting mechanisms may evolve over time. This analysis only covers the indicative budget in the form of grants received by PGs and LGs for FY 2019/20. FY 2019/20 is the second year that PGs, and the third year that LGs, have practised devolution. There is no standard nationally rolled-out electronic reporting system in place to capture expenditure. Many SNGs are still facing problems with basic infrastructure and trained Human Resources (HR) with knowledge in health-related activities, including staff adjustment.

6.2 Resource Pool at PG- and LG-level

The respective governments have their own resources and receive different forms of grants from the FG. Since FY 2019/20, the GoN has provided Revenue transfer, equalisation, conditional, special and matching funds to PGs and LGs. In FY 2019/20, the PGs have been allocated NPR 4.8bn and LGs have been allocated NPR 21.2bn as health conditional grants. In addition to the conditional grants for health, PGs and LGs can allocate resources to the health sector from the following resource pool.

Figure 6.1: Resource Pool for Provincial and Local Government



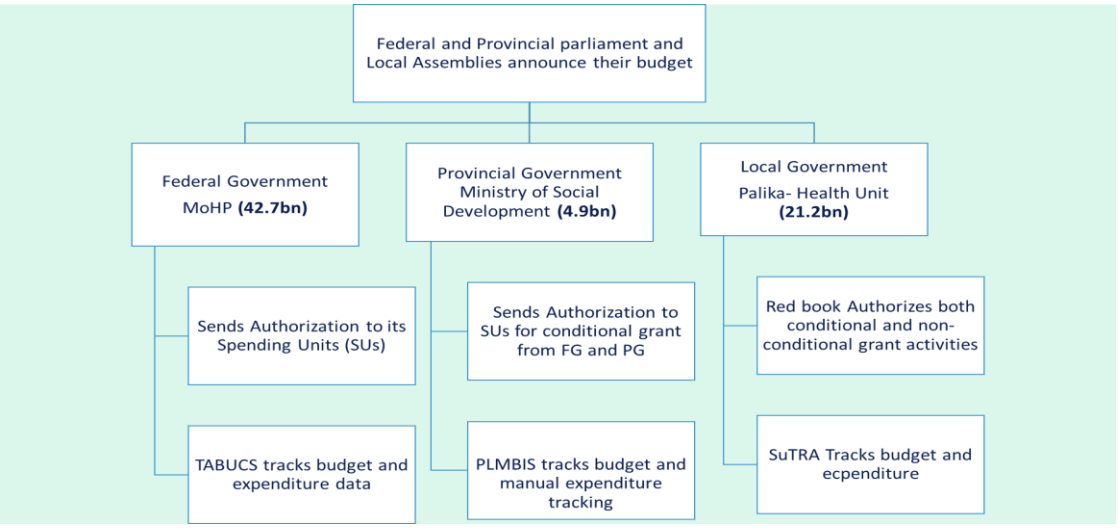
Source: Inter Governmental Fiscal Transfer Act 2017

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 have been reported in the report of the OAG.

6.3 Budgeting and Reporting Mechanism in FY 2019/20

At the federal level, the planning and budgeting process starts at the beginning of January. The operational planning cycle at LGs and PGs is yet to be institutionalised. The constitution obligates both LGs and PGs to prepare their AWPBs through a standard process. During this FY, 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 2019/20.

Figure 6.2: Budgeting and Reporting Mechanism for FY 2019/20



TABUCS tracks both the budget and expenditure channelled to MoHP SUs. Similarly, the Provincial Line Ministry Budget and Information System (PLMBIS) tracks the budget; however, there is no consolidated mechanism to track expenditure. At the same time, SuTRA tracks both budget and expenditure at LG. It is important to note that TABUCS can be used at both PGs and LGs and can also produce information/data as per the chart of accounts, Government Financial Statistics (GFS) 2014 and by level of activity. PGs and LGs are still confronted with HR challenges and their limited capacity in terms of skill, equipment and infrastructure. The PGs and LGs are mandated to comply with existing financial rules and regulations and to maintain financial records in their offices. They prepare reports in the forms and formats prescribed by the OAG. In FY 2019/20, it was made a mandatory provision for all LGs to enter their budget in SuTRA to be able to receive the FG grant. It is to be noted that reports at PG level are still being prepared manually and there is no standard, nationally rolled-out electronic system to consolidate and report budget and expenditure at the aggregated level.

6.4 Total Budget of Provincial Government by Revenue Sources

Table 6.1 describes the different forms of revenue that make up the budget of the PGs in FY 2019/20. Internal (provincial government) sources (which include internal revenue and revenue transfer from FG) account for one-third of the PGs' budget (35 percent) followed by equalisation grants (20.4 percent) and conditional grants (18.9 percent). Matching and special grants make up less than six percent of the PGs' budget.

Table 6.1: Total Budget of Provincial Government by Revenue Sources in FY 2019/20 *Amount in NPR Billion*

Province	Internal (Provincial Government)		Equalization Grant		Conditional Grant		Special Grant		Matching Grant		Total
	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR
Province-1	20.97	48.3	8.16	18.8	8.26	19.0	4.00	9.2	2.00	4.6	43.40
Province-2	22.59	57.9	7.09	18.2	7.35	18.8	0.50	1.3	1.50	3.8	39.02
Province-3	29.57	62.1	7.60	16.0	7.44	15.6	2.00	4.2	1.00	2.1	47.61
Gandaki	16.89	50.4	7.10	21.2	8.00	23.9	0.75	2.2	0.75	2.2	33.50
Province-5	21.74	56.4	6.43	16.7	9.06	23.5	0.80	2.1	0.50	1.3	38.53
Karnali	18.82	53.0	9.85	27.8	5.27	14.9	0.90	2.5	0.63	1.8	35.47
Sudurpash-chim	13.59	48.2	7.87	27.9	4.71	16.7	1.00	3.6	1.00	3.6	28.17
Total	**144.16**	**54.3**	**54.10**	**20.4**	**50.0**	**18.9**	**9.95**	**3.7**	**7.38**	**2.8**	**265.70**

Source: GoN 2019

Sudurpashchim province ranks lowest in receiving/allocating resources from internal/provincial government. Karnali province is the highest in receiving fiscal equalisation grants (18%), followed by Province 1 (15%) and Sudurpashchim (14.5%). Gandaki province received the highest allocation in health conditional grants (18%). Similarly, Province 1 was the highest in receiving matching (40%) and special grants (27%). Table 6.1 only provides an indicative picture of budget allocation practices and may be subjected to fluctuation or reclassification. Findings need to be interpreted with caution.

6.5 Health Budget of Provincial Government by Revenue Sources

Table 6.2 shows the total health budget in respective provinces. An additional NPR 7.9bn budget has been allocated by the PG on top of the NPR 4.8bn conditional grant to health allocated by the FG. This means that the health sector budget is more than NPR 78.4bn for FY 2019/20.

Table 6.2: Health Budget of Provincial Government by Revenue Sources in FY 2019/20 *Amount in NPR Million*

Province	Internal (Provincial Government)		Equalization Grant		Conditional Grant		Special Grant		Matching Grant		Total
	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR	(%)	NPR
Province-1	915	50	92	5	756	41	13	1	62	3	1,837
Province-2	674	47	-	-	749	53	-	-	-	-	1,423
Province-3	1,146	61	4	0	740	39	-	-	-	-	1,889
Gandaki	1,052	63	-	-	608	37	-	-	-	-	1,660
Province-5	983	44	509	23	766	34	-	-	-	-	2,257
Karnali	1,109	56	-	-	678	34	-	-	200	10	1,987
Sudurpashchim	1,180	66	18	1	582	33	-	-	-	-	1,780
Total	**7,059**	**55**	**622**	**5**	**4,879**	**38**	**13**	**0**	**262**	**2**	**12,84**

Source: GoN 2019

As evident in Table 6.2 above there are different sources of revenue for health budget at the provincial level beyond the conditional grant. Province 1 has allocated additional budget to health from equalisation, matching and special grants. Province 3, Province 5 and Sudurpashchim province have made additional allocation to health through equalisation grants and Karnali province through matching grants.

6.6 Recurrent and Capital Budget Allocation at PG by Revenue Sources

Table 6.3 shows total the budget allocated at PG by revenue sources aggregated under capital and recurrent budget headings. The majority (86%) of the PG budget is spent on recurrent activities.

Table 6.3: Recurrent and Capital Health Budget Allocation at PGs by revenue sources (NPR million)

Budget Type	Provincial Government	Financial Equalization Grant	Conditional Grant	Matching Grant	Special Grant	Total Amount
Recurrent	6,014	257	4,744	-	57	11,071
Capital	1,045	366	114	13	205	1,742
Total	**7,059**	**622**	**4,858**	**13**	**262**	**12,813**

Source: GoN 2019

Fifty-four percent of recurrent activities are funded through PG (including both revenue transfer from FG and internal revenue), with conditional grants providing the next largest proportion (43 percent).

6.7 Line-item-wise Health Budget Allocation at Provincial Government by Revenue Source

Table 6.4 shows the total budget allocated at PG by revenue sources aggregated under major line item headings. The majority (27%) of PG budget is spent on programme activities followed by 26 percent on wages and salaries.

Table 6.4: Major Line Item-wise Health Budget Allocation at PGs by Revenue Sources (NPR million)

Line Item	Provincial Government	Financial Equalisation Grant	Conditional Grant	Matching Grant	Special Grant	Total Amount	% Allocation
Wages and Salaries	3,241	12	95	-	-	3,347	26
Support Services	788	22	318	-	1	1,128	9
Capacity Building	231	16	44	-	1	292	2
Programme Activities	849	148	2,451	-	45	3,494	27
Medicine Purchases	236	59	542	-	-	837	7
Grants to Hospitals	634	-	560	-	5	1,199	9
Capital Construction	456	138	68	-	-	662	5
Capital Goods	589	227	46	13	205	1,080	8
Social Security	35	-	735	-	5	775	6
Total	**7,059**	**622**	**4,858**[4]	**13**	**262**	**12,813**	**100**

Source: GoN 2019

Almost 97 percent of the budget under wages and salary is funded through the PG budget, whereas the conditional grant shares 70 percent of the programme budget.

6.8 Health Budget at Local Government by Revenue sources

Table 6.5 shows the total health budget allocated to LG by province. The table indicates that an additional NPR 5.0bn budget has been allocated by LG to health on top of the NPR 21.5bn conditional grant by the FG. This allocation is done from different sources of grant coming from both FG and PGs. Almost 81 percent of the LG budget for health comes through conditional grants, followed by equalisation grants (8.6 percent) and revenue transfer (5.6 percent). A separate analysis is suggested to capture the details.

[4] Conditional grant amount is different to that of the actual amount of NPR 4,879 million which can be attributed to error in the data entry at PGs.

Table 6.5: Health Budget at Local Government by Revenue Source (NPR million)

Province	Revenue Transfer		Equalis-ation Grant		Condition al Grant		Special Grant		Internal Revenue		Matching Grant		Foreign Grant		Other Grant		Total
	NPR	(%)	NPR	(%)	NPR	(%)	NP R	(%)	NPR	(%)	NP R	(%)	NP R	(%)	NP R	(%)	
Province-1	275	6	395	8	3,807	81			197	4			1	0	11	0	4,685
Province-2	131	3	251	5	4,079	88	7	0	173	4	4	0	5	0	5	0	4,655
Province-3	382	8	389	8	3,758	75			450	9					3	0	4,982
Gandaki	130	4	265	9	2,559	85	1	0	71	2					2	0	3,028
Province-5	319	8	382	9	3,246	79	7	0	153	4	3	0			2	0	4,113
Karnali	106	5	239	11	1,790	80			63	3	35	2	2	0	1	0	2,236
Sudurpash-chim	163	6	360	13	2,215	79			63	2					0	0	2,801
Total	**1,505**	**6**	**2,282**	**9**	**21,455**	**81**	**15**	**0**	**1,169**	**4**	**42**	**0**	**7**	**0**	**24**	**0**	**26,499**

Source: GoN 2019

6.9 Line Item-wise Health Budget Allocation at Local Government by Revenue Source

Table 6.6 shows the total health budget allocated at LG by revenue source aggregated under major line item headings. Forty-six percent of LG budget is spent on wages and salaries followed by 29 percent on programme activities.

Table 6.6: Major Line-item-wise Health Budget Allocation at LGs by Revenue Source (NPR million)

Line Item	Revenue Transfer - FG	Revenue Transfer - Provincial	FG	Provin-cial Govern-ment	Peoples' Particip-ation	Foreign Source	Internal Source	Other Internal Source	Total Amount
Wages and Salaries	114	20	12,044	29	-	-	79	0	12,287
Support Services	149	20	1,330	52	-	0	112	0	1,663
Capacity Building	27	2	114	3	-	1	14	1	163
Programme Activities	464	123	6,635	186	1	6	341	4	7,759
Medicine Purchases	115	26	1,109	26	-	-	149	-	1,425
Grants to Hospitals	7	1	589	6	-	-	4	-	608
Subsidy	72	8	357	20	0	-	50	0	508
Capital – Construction	154	64	665	158	1	-	239	3	1,284
Capital Goods	84	37	405	36	0	-	162	-	723
Investment (Loan and Share)	0	-	0	0	-	-	-	-	0
Internal Loan	-	-	0	-	-	-	-	-	0
Social Security	14	4	53	2	-	-	7	0	80
Total	**1,200**	**304**	**23,301**	**517**	**2**	**7**	**1,158**	**10**	**26,499**

FG grants (conditional-majority, matching and special) are the major source (almost 88%) of funding line items followed by FG revenue transfer (4.5%) and internal revenue (4.4%).

6.10 Health Conditional Grants at PGs and LGs by GoN, EDP and Pool Fund

Table 6.7 provides disaggregation on the source of health conditional grant provided by the FG (NPR 26.1bn) to PGs and LGs. Over 85 percent of health conditional grants at the PG level come from government sources, followed by EDPs (13 percent) and the pool fund (almost two percent).

Table 6.7: Source of Conditional Grants at the Provincial and Local Governments (NPR million)

Province	Province Government				Local Government				Total (PG+LG)
	GoN	EDP	Pool Fund	Total	GoN	EDP	Pool Fund	Total	
Province-1	656	94	6	756	3,801	4	1	3,807	4,563
Province-2	623	98	27	749	4,018	57	4	4,079	4,828
Province-3	642	91	7	740	3,547	2	-	3,549	4,289
Gandaki	510	69	29	608	2,557	2	0	2,559	3,167
Province-5	680	80	6	766	3,221	10	0	3,231	3,997
Karnali	524	124	30	678	1,783	7	0	1,790	2,468
Sudurpashchim	516	61	6	582	2,206	7	0	2,214	2,796
Total	**4,150**	**618**	**110**	**4,878**	**21,134**	**90**	**5**	**21,230**	**26,108**

Source: GoN 2019

At the local level, the GoN is the only source of the health conditional grant (99.5%); only 0.5 percent is contributed by the EDPs and pool fund combined. It is to be noted that the pooled fund is only allocated for child health programme.

6.11 Health Conditional Grants at PGs and LGs by Capital and Recurrent Allocations

Table 6.8 provides disaggregation of the health conditional grants provided by the FG (NPR 26.1bn) to PGs and LGs at provincial and local levels. Around three percent of conditional grants is spent on capital budget. About nine percent of the conditional grant is allocated under capital budget in PGs and two percent in the LGs.

Table 6.8: Capital and Recurrent Budget Allocation by PGs and LGs (NPR million)

Province	Provincial Government			Local Government			Total (PG+LG)		
	Capital	Recurrent	Total	Capital	Recurrent	Total	Capital	Recurrent	Total
Province-1	43	713	756	97	3,710	3,807	140	4,422	4,563
Province-2	71	678	749	63	4,016	4,079	134	4,694	4,828
Province-3	60	680	740	67	3,483	3,549	127	4,162	4,289
Gandaki	106	502	608	44	2,515	2,559	150	3,017	3,167
Province-5	53	712	766	62	3,170	3,231	115	3,882	3,997
Karnali	71	607	678	37	1,753	1,790	108	2,360	2,468
Sudurpashchim	34	548	582	38	2,175	2,214	72	2,724	2,796
Total	**438**	**4,440**	**4,878**	**408**	**20,822**	**21,200**	**846**	**25,262**	**26,108**

Source: GoN 2019

At the provincial level, Gandaki province receives the highest percentage allocation under capital budget (24%) whereas Province 1 receives the highest proportion under the capital budget of the LGs' budget (24%).

6.12 Health Conditional Grants at PGs and LGs by Administrative and Programme Allocation

Table 6.9 provides the disaggregation of health conditional grants at provincial and local level by administrative and programme allocation. On average, 65 percent of the health conditional grant is allocated for administrative purposes at the local level while only 24 percent is allocated at the provincial level. Karnali province has the lowest allocation for administration (only 16 percent) whereas Sudurpashchim has the highest allocation (almost 36 percent).

Table 6.9: Administrative and Programme Budget Allocation by PGs and LGs (NPR million)

Province	Provincial Government			Local Government			Total		
	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme	Total
Province-1	186	569	756	2,727	1,080	3,807	2,914	1,649	4,563
Province-2	189	560	749	3,061	1,018	4,079	3,250	1,578	4,828
Province-3	200	540	740	2,709	840	3,550	2,910	1,380	4,290
Gandaki	200	408	608	2,059	500	2,559	2,259	908	3,167
Province-5	193	572	766	2,393	839	3,232	2,586	1,411	3,998
Karnali	156	522	678	1,339	451	1,790	1,494	973	2,468
Sudurpashchim	136	446	582	1,602	611	2,214	1,739	1,057	2,796
Total	**1,261**	**3,618**	**4,878**	**15,891**	**5,340**	**21,231**	**17,152**	**8,957**	**26,109**

Source: Red-Book FY 2019/20

CHAPTER 8: CONCLUSION AND WAY FORWARD

This chapter provides a summary of the findings and presents a conclusion, way forward and policy note. The policy note included in this chapter may require further discussions with the officials working at the LGs, PGs and FG. This BA suggests that all level of governments have given precedence to health as their priority area. This exercise has shown that the volume of budget is not fully aligned with the technical HR assigned to different levels of governments

8.1 Conclusion

In the early stage of federalism, the fiscal space in health is observed to have increased. FG has allocated NPR 78.4 billion, provincial government has allocated NPR 7.9 and LG has allocated 5.0 billion. This adds up to NPR 91.3 billion for FY 2019/20. This suggests that the conditional grant is not the single source of the health budget. However, LGs heavily rely on the health conditional grant (81%) from FG; in contrast, the majority (62%) of the PG health budget comes from their resources (fiscal equalisation, revenue transfer and internal revenue).

Recent evidence in UHC suggests that lower- and middle-income countries should spend at least five percent of their GDP on health, which translates to USD 86 (NPR 9630) per capita spending in Nepal. This analysis confirms that government health spending as share of GDP is far less (1.8 percent in FY 2018/19) then the desired level. Similarly, health sector budget as a share of national budget fell four percent short of achieving the NHSS target of nine percent for 2019. At the same time it was encouraging to observe that per capita expenditure doubled from NPR 1,072 in FY 2014/15 to NPR 2,295 in FY 2018/19. One of the key factors to have contributed to this was additional resource allocation to health from PG and LGs. This analysis suggests that the current investment in health is not sufficient to achieve UHC and attainment of SDGs by 2030.

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 was also allocated to PGs. In FY 2019/20, the GoN provided a conditional grant of NPR 4.9bn to PGs (7%), NPR 21.2bn to LGs (32%) with NPR 42.7bn remaining at the MoHP (62%). Key drivers for health budget are salary and wages for LGs (69%), capacity building for PGs (19%) and grants to hospitals for FG (65%). Programme activities are the second most important health budget driver for SNG. Under procurement of drugs and supplies, the main cost driver at LGs and PGs is the purchase of free health drugs, constituting of 77 percent and 60 percent of the entire procurement budget respectively. Similarly, for FG, the purchase of vaccines, diluent and syringes is the major driver. Almost 85 percent of the budget for equipment purchase remains at the federal level, and almost a quarter of it is spent in purchasing medical equipment. More than half of SNGs' free health budget is occupied by MCH services, followed by free health services. At the federal level, a quarter of the free health budget is allocated for treatment of target populations and target diseases.

This analysis reveals that the SNGs have started allocating budget in the health sector using resources other than conditional grants, such as revenue transfer, fiscal equalisation, matching and special grants, and internal revenue. This suggests that the health sector budget is more than NPR. 78.4bn. Yet there are no specific policy directives that provide the basis for determining the volume of health conditional grants to SNGs. This leads to both under- and overallocation. Allocations in conditional grants have marginally improved compared to FY2018/19. The initial analysis and anecdotal evidence suggest that there were some issues in spending conditional grants within the stipulated time. The reasons for this could be the lack of programme implementation guidelines, delays in fund flow, issues with the release in donor budget, and lack of trained HR. Additionally, some Palikas delayed their assemblies and, as a result, the health conditional grant could not be transferred in a timely manner to the respective health facilities. It needs to be noted that health budget for the MoHP has hugely increased in FY 2019/20 compared to FY 2018/2019, which has not corroborated as per the increase at SNG.

Nepal has practised a Sector-wide Approach (SWAp) in health since FY 2005/06. One of the intentions of the SWAp is to improve budgetary commitment from the government. It was observed that the GoN has been increasing the share of the health budget over the years. The proportion of EDPs' budget against total government allocation is in reducing trend. As a result, flagship programmes such as Aama and reform programmes like TABUCS are now fully funded by the government. In general, the absorptive capacity of the MoHP has improved over the years. In FY 2018/19, the MoHP absorbed 83 percent of the allocated budget. The actual budget absorption for the MoHP budget has been weak given that the MoHP has surrendered NPR 4.75bn from its initial budget of NPR 34.08bn to the MoF; this was further reallocated to fund conditional grant activities at SNGs. At an organisational level, the DoHS holds the major share of the MoHP budget (48%). Similarly, at the economic code level, the majority of the MoHP budget is allocated to hospital/academies grants. This analysis indicates the trend of increasing grants to hospital/academies every year. At the same time, hospitals are the only MoHP entities with more than 90 percent absorptive capacity. The MoHP has been successful in securing more than 55 percent budget for EHCS. It should be noted that the majority of budget allocated to SNGs goes to EHCS. There has been an increasing trend in disclosing and depositing revenue in the central treasury, which is a good sign of improving governance and transparency. MoHP's audit queries against the audited expenditure is in decreasing trend from 13.7 percent in FY 2012/13 to 4.7 percent in FY 2017/18. Similarly, the cumulative audit queries clearance was in increasing trend from 36.8 percent in FY 2012/13 to 41 percent in FY 2017/18.

This BA tried to capture budgeting practices at provincial and local levels. The analysis shows that internal or provincial government sources (which include internal revenue and revenue transfer from FG) accounts for one-third of the PGs' budget (35 percent) followed by equalisation grants (20.4 percent) and conditional grants (18.9 percent). An additional 7.9bn budget has been allocated by PGs on top of the 4.8bn conditional grant to health allocated by the FG. Similarly, an additional NPR 5.0bn budget has been allocated by LG to health on top of the NPR 21.5bn conditional grant to health allocated by the FG. This analysis suggests that health sector budget is more than the budget reflected in the federal Red Book. Conditional grants are one of the major sources of revenue for programme activity and internal/provincial government grants are a major source of funding salaries and wages at PG, whereas conditional grants are a major source of funding programmes, salaries and wages at LG.

This analysis raises an important question regarding capacity around allocative efficiency. The budget for infrastructure and procurement remains high at federal level, whereas a significant portion of PGs' and LGs' budget is allocated for HR and programmes. It is also important to note that most of the procurement budget for free drugs has been provided to SNGs. This analysis found that a small proportion of the pooled fund in child health activities is allocated to SNGs. The policies and programmes of FG, PGs and LGs are not sufficiently translated into budget.

8.2 Way Forward

This analysis has brought up some important questions that need to be addressed by the MoHP. The current challenge for the health sector is to sustain the progress made in achieving health outcomes and refining policies that will facilitate the process of bringing health services closer to the underserved population and respond to the agenda of 'leaving no one behind'. The evidence-based AWPBs in all spheres of government needs to be harmonised through a comprehensive policy framework that is acceptable to FG, PGs and LGs. 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. The MoHP should initiate the process of preparing the health sector transitional plan, which will support in securing required resources and distributing them. It should be noted that PGs and LGs with higher levels of revenue can allocate additional resources for health, which may not be possible for Palikas and provinces with lower levels of revenue. This may bring some level of disparity in health care delivery.

2. MoHP needs to take a lead role in developing understanding on budget allocation under conditional grants. The current practice of budget allocation under conditional grants needs to be changed. Over the years the conditional grants to SNGs needs to be downsized and harmonised within equalisation grants.

3. The forthcoming health sector strategy (the Fourth Nepal Health Sector Plan, NHSP-4) should outline specific systems and programme-level targets in all spheres of government. It is anticipated that each government has the authority to formulate their own health policy and strategy, which need to be harmonised within the wider policy and strategy umbrella.

4. 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 the respective Health Accounts. This will also contribute to PGs and LGs preparing their periodic and annual health plans.

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

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

7. Health spending should be captured at all levels of government, including resources for health beyond the conditional grant. TABUCS should be updated to capture budget and expenditure in the devolved context. The capacity of hospitals should be built so as to capture local revenue in TABUCs to give a more comprehensive picture of income and expenditure.

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

8.3 Policy Brief

The Constitution of Nepal mandates health as a fundamental right of the people (GoN, 2015) and the National Health Policy 2019 aims to carry out these rights by ensuring equitable access to high-quality health care services for all (GoN, 2019). The evidence of other countries suggests that institutionalising the budget formulation process with the provision of the budget calendar is not in itself enough to responds to health needs. It should be coordinated with other important elements of overall PFM reform, including MTEF, procurement, budget-tracking systems, cash management, financial information and progress reporting systems. The classification and organisation of a budget are centrally important issues when preparing sector budgets. Budget classifications serve to present and categorise public expenditure in financial 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. Following are the major policy areas that could be further discussed at all levels of government. To start with, the MoHP can take the lead role.

1. The health policy and health sector strategy need to be updated to address the evolving needs and priorities of all spheres of government. During this process a clear set of outcome, output, process 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 the respective AWPBs.

2. An integrated recoding and reporting system for service statistics, PFM, procurement, supply chain and HR needs to be developed and implemented in all spheres of government. These systems should talk to other systems including LMBIS and the TSA.

3. The MoHP needs to take a lead role in developing guidelines that should foster better budget allocation under conditional grants.

4. A specific framework should be prepared to sustain the achievements and prevent widening disparity in health care delivery. This can be achieved through the provision of special or matching grants to the identified PGs and LGs. A policy for determining the special and matching grants need to be developed and endorsed by all spheres of government.

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

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

References

ADB (2019). Macroeconomic Update: Nepal. Asian Development Bank, Manilla, Philippines, April 2019

DoHS (2014/15-2019/20). Health management Information System: Population Projection. Department of Health Services, Kathmandu, Nepal.

GoN (2019). National Health Policy, Government of Nepal, Kathmandu, Nepal.

GoN (2015). The Constitution of Nepal. Government of Nepal, Kathmandu, Nepal.

GoN (2016). Nepal Health Sector Strategy 2015-2020. Government of Nepal, Kathmandu, Nepal.

GoN (2014/15-2019/20). Red Book. Government of Nepal, Ministry of Finance, Kathmandu, Nepal.

Mcintyre D (2014) 'Shared Responsibilities for Health: A Coherent Global Framework for Health Financing', Final Report of the Centre on Global Health Security Working Group on Health Financing. 2014

Mcintyre D., Meheus F. & Rottingen JA (2017) 'What level of domestic government health expenditure should we aspire to for universal health coverage?' Health Economics, Policy and Law. 12, 2; 125-137

MoHP (2018/19). Budget analysis of Ministry of Health and Population. Kathmandu, Nepal.

MoHP (2014/15-2019/20). Annual Work Plan and Budget. Federal Ministry of Health and Population, Kathmandu, Nepal.

MoHP (2014/15-2018/19). Financial Monitoring Report. Federal Ministry of Health and Population, Kathmandu, Nepal.

MoHP (2016/17-2021/22). Financial Management Improvement Plan. Federal Ministry of Health and Population, Kathmandu, Nepal.

MoHP (2019). Transaction Accounting and Budget Control System. Federal Ministry of Health and Population, Kathmandu, Nepal.

MoF (2014/15-2017/18). Economic Survey. Ministry of Finance, Kathmandu, Nepal

MoFAGA (2019/20). Health Conditional Grant. Ministry of Federal Affairs and General Administration, Kathmandu, Nepal. Can be accessed at www.mofaga.gov.np .

WHO (2010). Health systems financing: the path to universal coverage. World Health Report 2010. World Health Organization, Geneva, Switzerland.

WHO (2018). Policy Brief: Budget matters for Health: Key formulation and classification issues. World Health Organization Geneva, Switzerland