HEALTH:
EXPENDITURE BRIEF

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PREFACE

This health budget brief is one of four budget briefs that explore the extent to which the national budget addresses the needs of the children in Nepal. The briefs analyse the magnitude and structural composition of approved budget allocations over several years to assess efficiency, equity and adequacy of spending. These briefs also address financial issues and examine implications of changing patterns of finance through time. The main objectives are to synthesize complex budget data so that they are understood by stakeholders to advocate for budget allocations that are responsive to the needs of children in Nepal.

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SECTION 1: INTRODUCTION

1.1 HEALTH SECTOR OVERVIEW

Currently, budget provisions for health services at the federal level amount to 67 per cent of the total health budget. Provincial governments (PGs) and local governments (LGs) are also responsible for the provision of health and are allocated 6 per cent and 27 per cent of the total education budget respectively. Other ministries are also involved in the health sector: Ministry of Commerce & Supplies for Outpatient Services, Ministry of Defense, Ministry of Education, and the Ministry of Federal Affairs and Local Development which is responsible for coordination, cooperation, facilitation and monitoring and evaluation of all activities undertaken by LGs. In addition, the private sector as well as external donors contribute significantly to the country's overall health budget.

The health sector strategy (2015/16-2020/21) provides an overarching framework for Nepal's health sector. It envisions "all Nepali citizens to have productive and quality lives with the highest levels of physical, mental, social and emotional health". The mission is to "ensure citizen's fundamental rights to stay healthy by utilizing service providers, service users, and other stakeholders".

Periodic reports (Joint Annual Review Reports) indicate progress in numerous areas. Recently, however, several challenges have emerged, including challenges imposed by the emerging federal structure. The Constitution of Nepal provides guidelines on the assignment of functions at different levels of government. Issues related to planning, budgeting, human resource management, health infrastructure, procurement of medical assets and supplies, delivering services and monitoring results are still being negotiated between the different layers of government. Subnational governments differ widely in terms of resource endowments, capacity, willingness and institutional memory, and this new, fragmented and diverse local governance structure is creating a wide range of challenges related to cooperation and coordination in the health sector. Recent data from the DHS and other sources show that health outcomes continue to be fragmented based on wealth, geographic location, and caste.

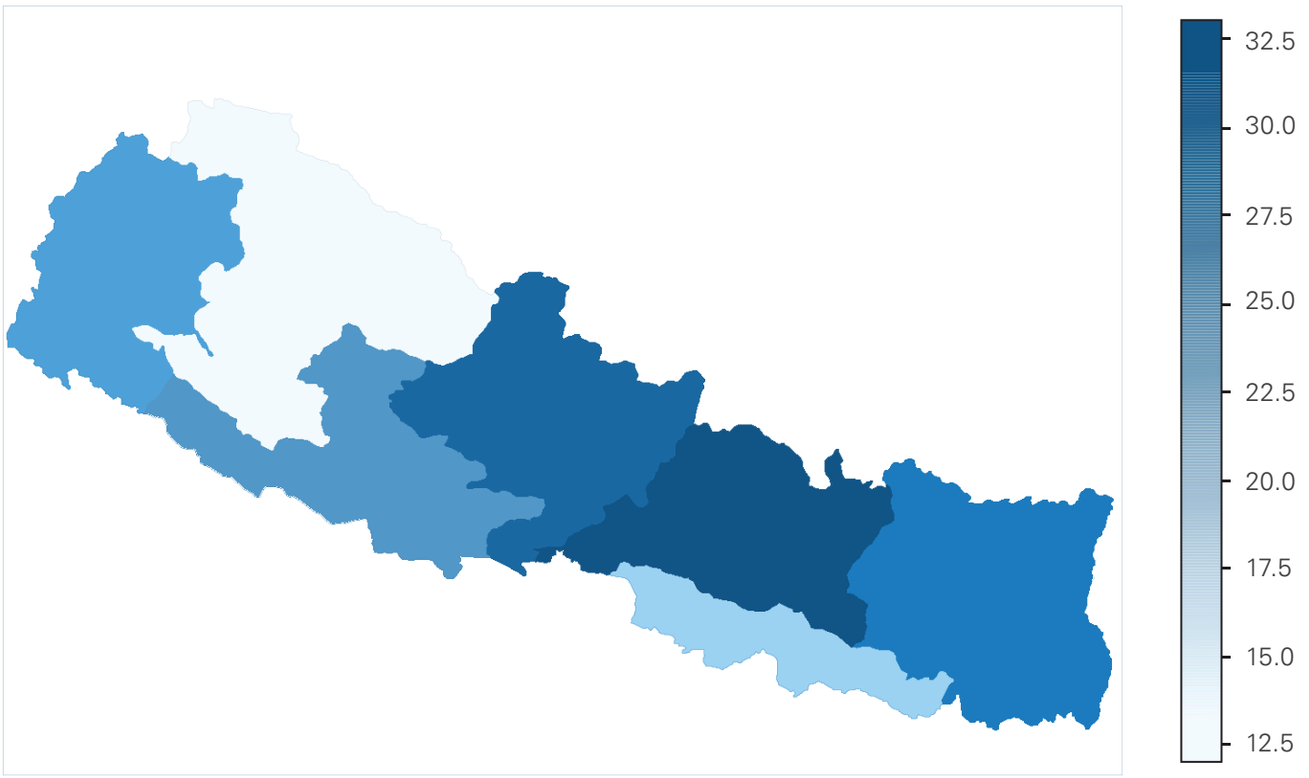
1.2 MAIN DOCUMENTS AND TARGETS

Constitution	2015	Mandates health as a fundamental right of the people
National Health Policy	2014	Comes as an overarching framework of the constitution, aims to implement rights by ensuring equitable access to quality health-care services for all
Nepal Health Sector Support Program	2016-2021	Provides the budgetary framework to ensure Nepal's commitment to achieve Universal Health Coverage and Sustainable Development Goals by 2030
Nepal 15th Year Approach Paper	2019/20-2023/24	
SDG		Goal 3

1.3 SECTOR PERFORMANCE

Overview: Nepal's health sector has made considerable progress in recent years. Several key Acts were passed to further an enabling environment (e.g., Public Health Service Act, Safe Motherhood & Reproductive Health Act, Social Health Insurance Act), provincial health directorates and offices were established, the Ministry of Health & Population and the Department of Health Services were restructured, urban and community health facilities were operationalized in all districts and trachoma (a leading cause of blindness) was eliminated in Nepal. Progress on major outcomes, such as under five mortality, fertility and stunting remain on track. Nepal is committed to achieving universal health care as well as SDG health targets. In this section, the state of health infrastructure along with its distribution across provinces in Nepal is examined. In addition, a few select indicators are used to demonstrate disparities in health outcomes between and within provinces, and by gender, age, education, employment and marital status among households within municipalities.

Distribution of health facilities: There were 125 public hospitals in Nepal in 2017 (HMIS 2017), equivalent to four hospitals per 10,000 population. The distribution of hospitals across the provinces is not even (Figure 1) with Province 3 (not all provinces in Nepal have been named) accounting for nearly 25 per cent of them. In addition to public hospitals, the government provides health centres, health posts, urban health-care centres and community health-care centres.



Number of public hospitals

Source: Created from HIMS data

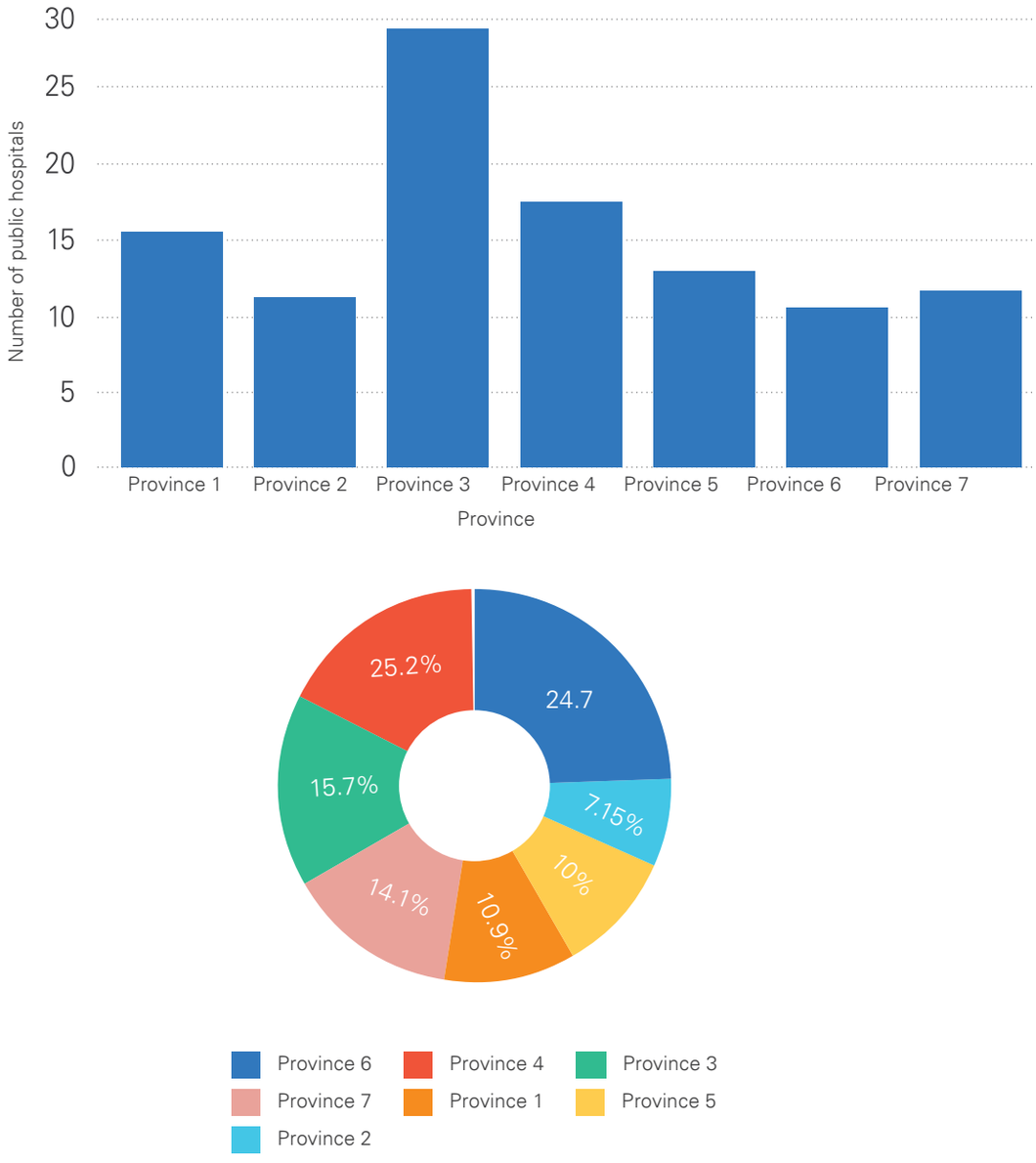
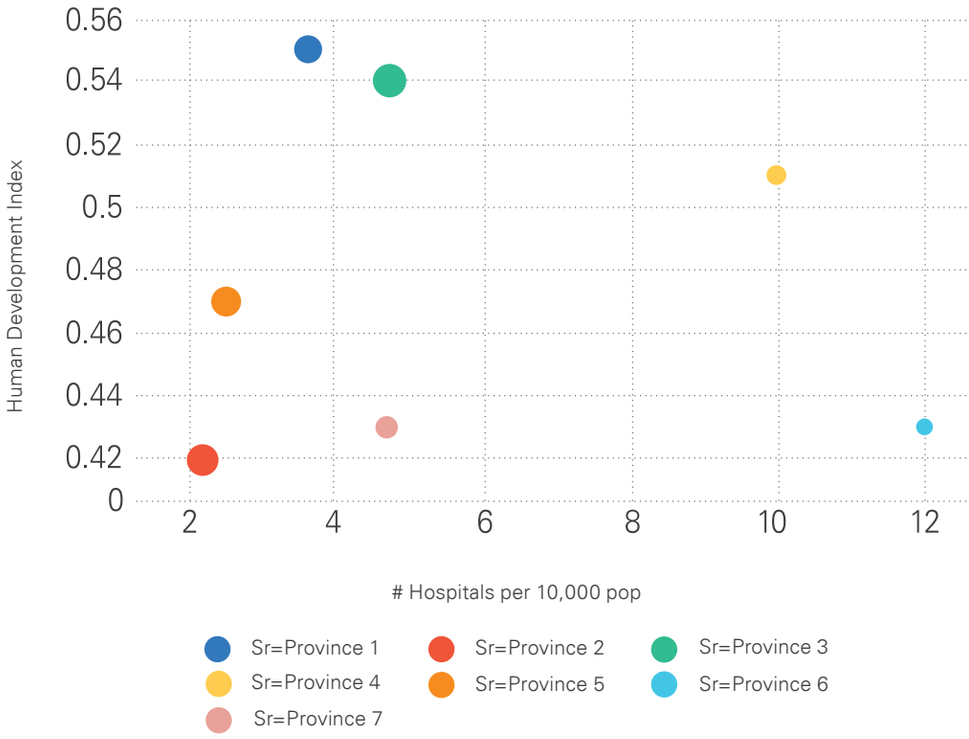
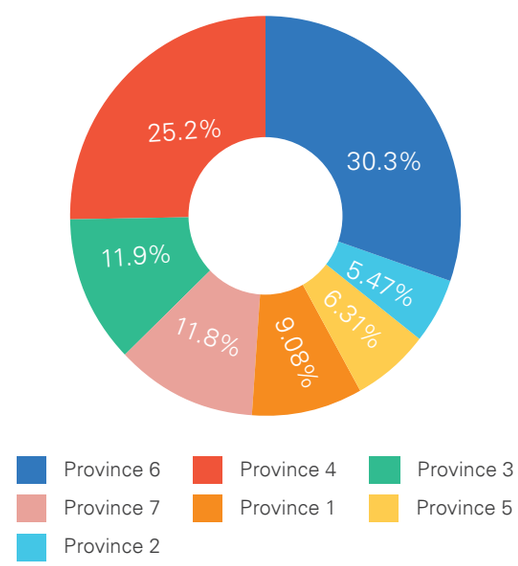


FIGURE 1: DISTRIBUTION OF PUBLIC HOSPITALS[1]

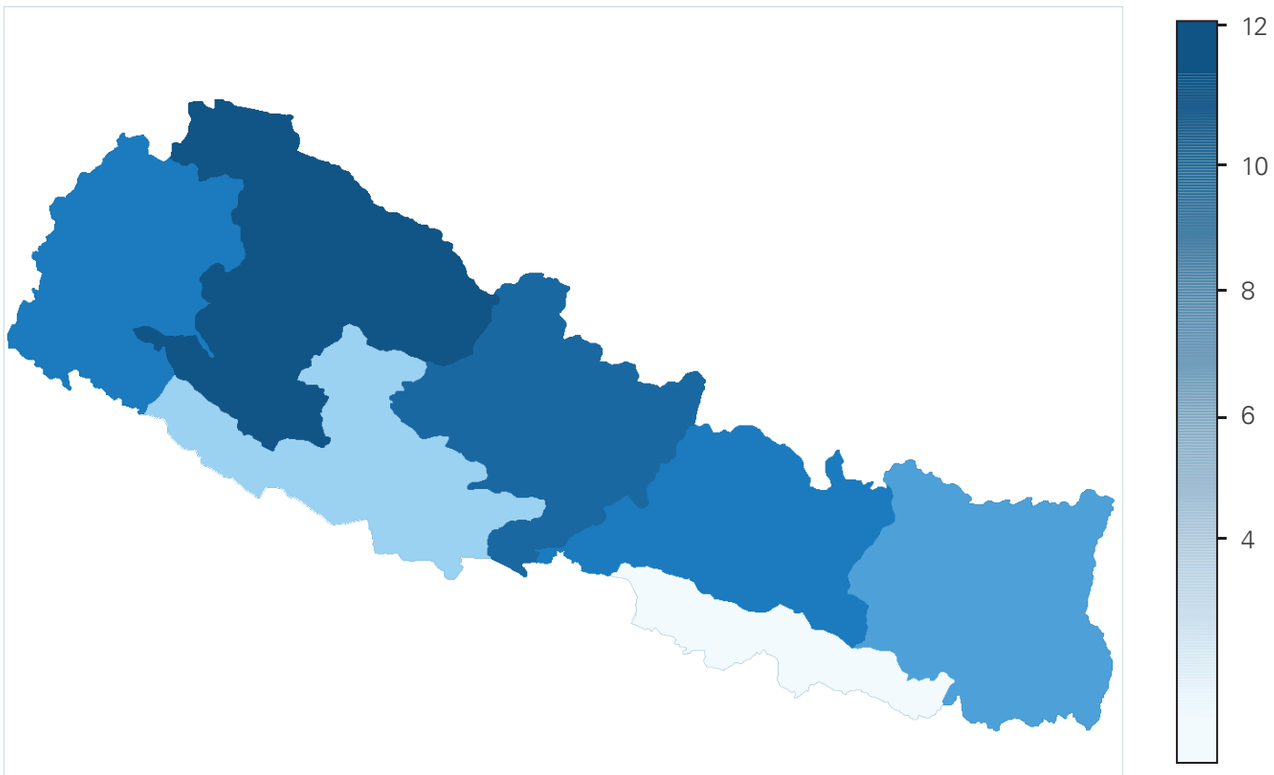
[1] Created from HMIS 2017 data.



HDI and public hospital access



Distribution of public hospitals per 10,000 pop



Number of public hospitals per 10,000 population

Source: Created from HIMS data

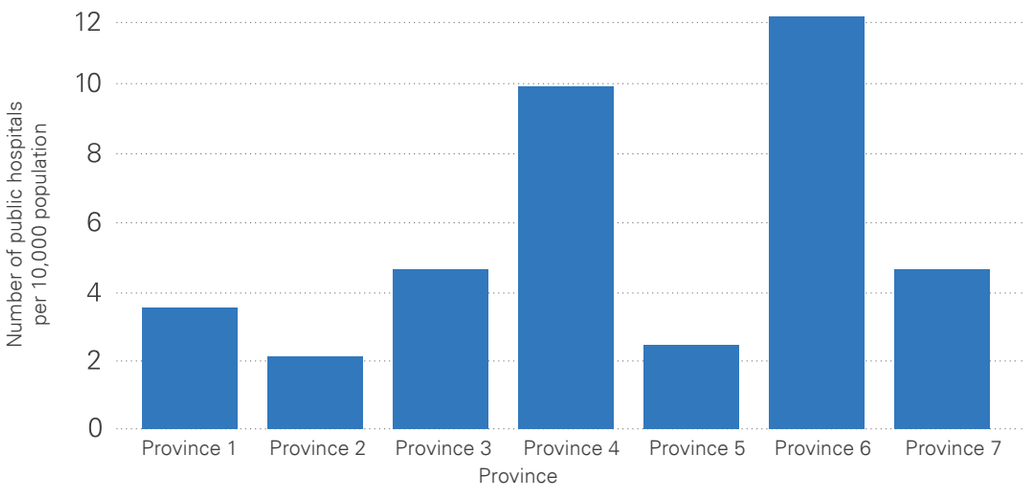
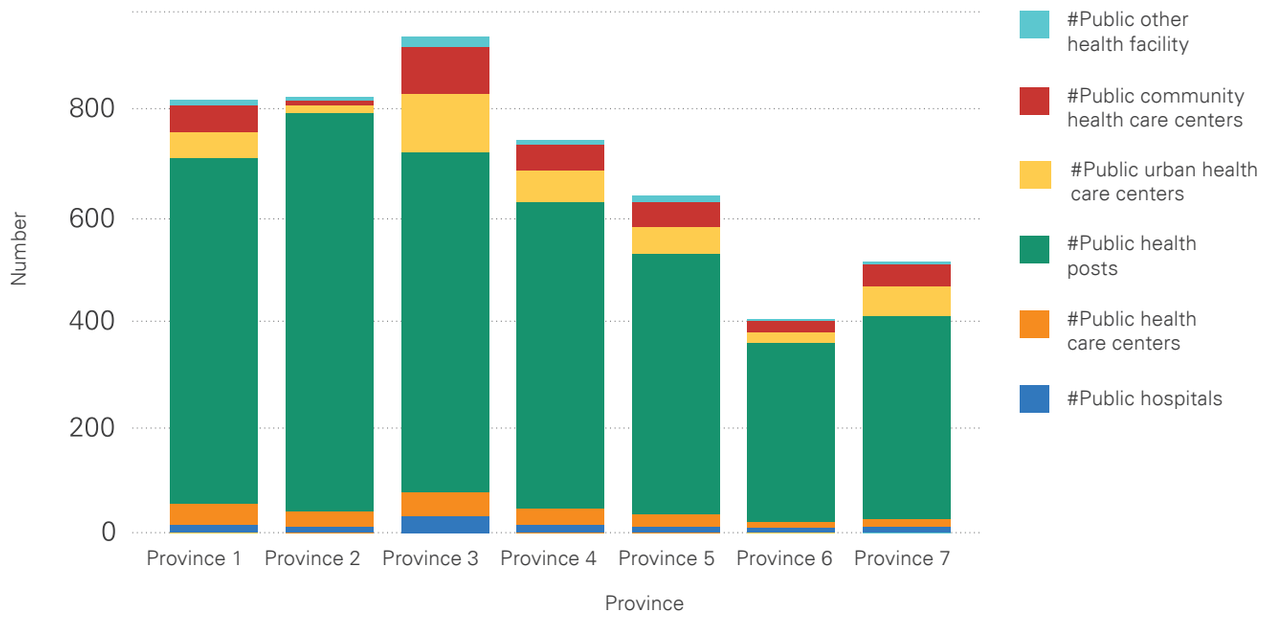


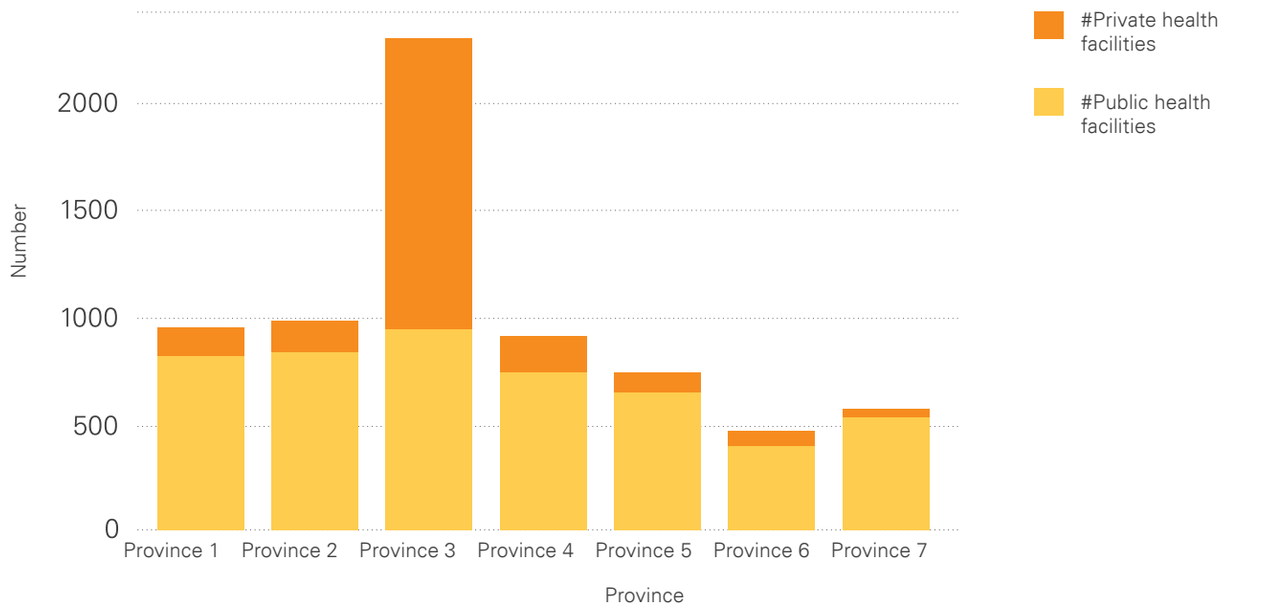
FIGURE 2: ACCESS TO PUBLIC HOSPITALS (PER 10,000 POPULATIONS)[2]

[2] Created from HMIS (2017).

On a per capita (or per 10,000 population) basis, the distribution of hospitals across provinces is signifcantly different (Figure 2). Provinces 6 and 4 have the largest number of hospitals per 10,000 population. The data suggest that Province 2, which has a similar level of HDI compared to Province 6, has fewer hospitals per 10,000 population.



PUBLIC HEALTH FACILITIES



TOTAL HEALTH FACILITIES

FIGURE 3: DISTRIBUTION OF HEALTH FACILITIES

Examining the distribution of all the health facilities (public and private) together – two interesting observations can be made. First, public health posts continue to be the most dominant health facility in every province. Second, the private sector has started contributing to health infrastructure, especially in Province 3 where more than half of all health facilities are private.

Disparities in health outcomes: Recent household data suggest that health outcomes are fragmented in Nepal along various dimensions, such as wealth, caste and place of residence, among others. Macro-level gains in health care have not yet been adequately translated into micro-level gains.

TABLE 1: DISPARITIES IN HEALTH OUTCOMES

VARIABLE	U5MR	% STUNTED	% INSTITUTIONAL DELIVERY	% CHILDREN FULLY IMMUNIZED
DALIT	63	40	45	73
JANAJATI	42	32	58	83
OTHER TERAI CASTE	51	42	48	64
MUSLIM	47	38	52	68
NEWAR	33	27	75	89
BRAHMIN/CHETTRI	39	35	68	87
WEALTH Q1	62	49	34	77
WEALTH Q5	24	16	90	82
NATIONAL	39	36	57	77

Source: NDHS 2016.

Table 1 summarizes secondary analyses of DHS data where select indicators are used to demonstrate diversity in health outcomes among castes. Among Dalits, 6 out of 100 children would probably not live to see their fifth birthday. Stunting is the highest in other Terai households. Children belonging to Dalits, other Terai castes and Muslims are least likely to have institutional deliveries. Wealth can be seen to have a strong and significant impact on health outcomes. Because out-of-pocket spending (shown in the next section) comprises more than 50 per cent of health expenditures, the wealth effect is likely to be very strong and a major cause of inequalities.

SECTION 2: TREND ANALYSIS

2.1 SIZE, COMPOSITION & TRENDS

This section reports on trends in health spending observed since the year 2000. Data sources rely on publicly accessible data on national health accounts from WHO (global repository on health expenditures) and the Red Books made public by the Government of Nepal. As per the national health accounts in Nepal, current health spending consists of domestic health spending plus external health spending. The former category can be split into public and private health spending (mainly out-of- pocket spending). The interaction between these three components of expenditure is interesting and influences the sustainability of health-care financing.

2.1.1 Total health spending

In just under two decades, total health spending in Nepal surged from NPR 16.2 billion in 2000 to NPR 161 billion in 2017 – an increase of 894 per cent, and a compound annual average growth rate of 14.4 per cent per year (Figure 4). Over the same period, inflation averaged about 8 per cent, hence the average real growth rate of health expenditures is about 6 per cent annually for almost two decades. Although these long-term averages are useful for planning, the data suggest variations – the post 2010 growth rate appears to be faster before slowing down again marginally.

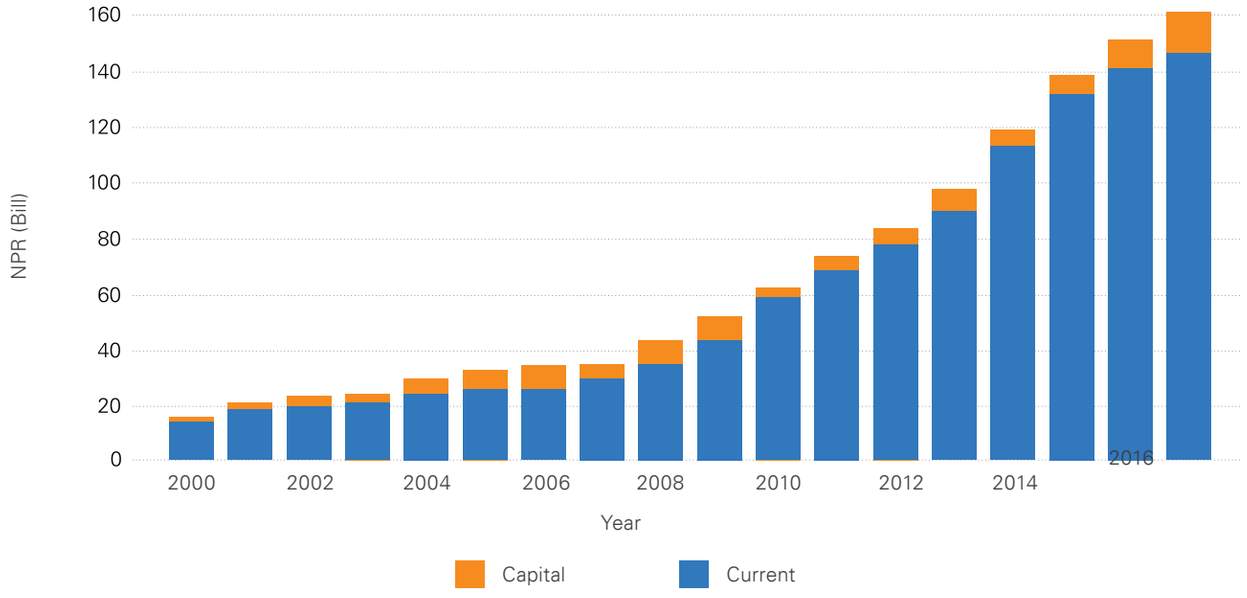


FIGURE 4: TOTAL HEALTH EXPENDITURES[3]

Current health expenditures: Current health expenditure (CHE) absorbs most health expenditures. In relation to GDP, CHE has averaged close to 6 per cent in recent years, following a strong surge since 2009. In per capita terms, CHE has increased from below USD 10 to USD 48 over the same period (Figure 5).

[3] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

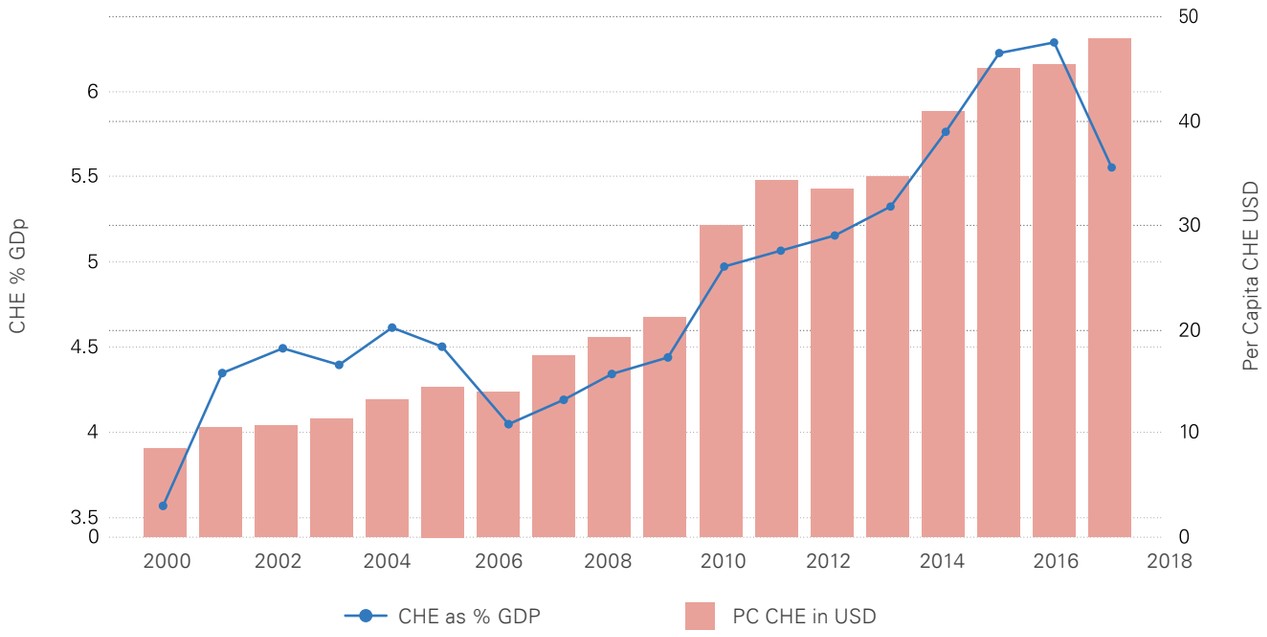


FIGURE 5: CURRENT HEALTH EXPENDITURES[4]

CHE can be disaggregated into domestic (government + domestic private) and external (aid/partners).

The data illuminate some important facts (Figure 6):

1. Private out-of-pocket spending continues to dominate health-care financing, as it has for nearly two decades (55 per cent on average).
2. The contribution of general government to CHEs has been on average 18 per cent and has been steady with few exceptions.
3. The contribution of external financing to CHEs has declined significantly since 2007. On average, external financing contributed 17 per cent to CHEs in Nepal (2000-2017).
4. This changing dynamics of external financing with steady government financing means the burden for health-care financing falls on private financing (mainly OOPS). While the private sectors contribution to health is significant, it can be argued that some of the inequitable outcomes being observed stem from the reliance on private financing where quality and profit concerns may not necessarily coincide with the delivery of fundamental human rights.

[4] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

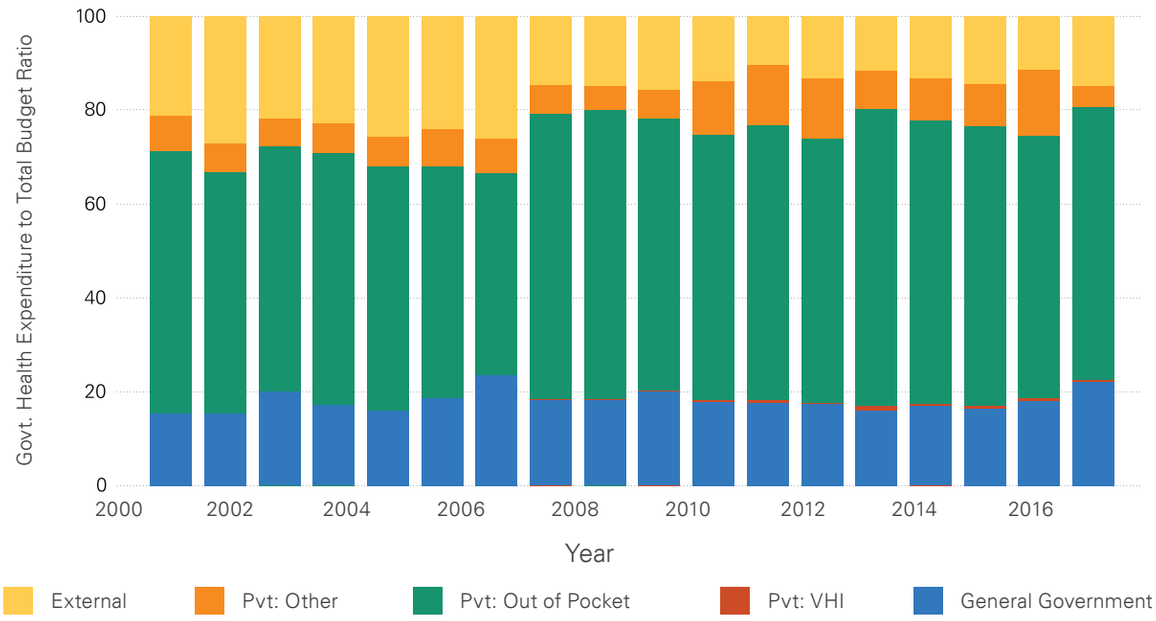


FIGURE 6: BREAKDOWN OF CURRENT HEALTH EXPENDITURE BY SOURCE[5]

In terms of health expenditure (total) to GDP ratios, the data suggest a rising trend observed recently with small variations in early years. In recent years, total health spending has averaged about 6 per cent of GDP – a large component of which has been financed from out-of-pocket spending.

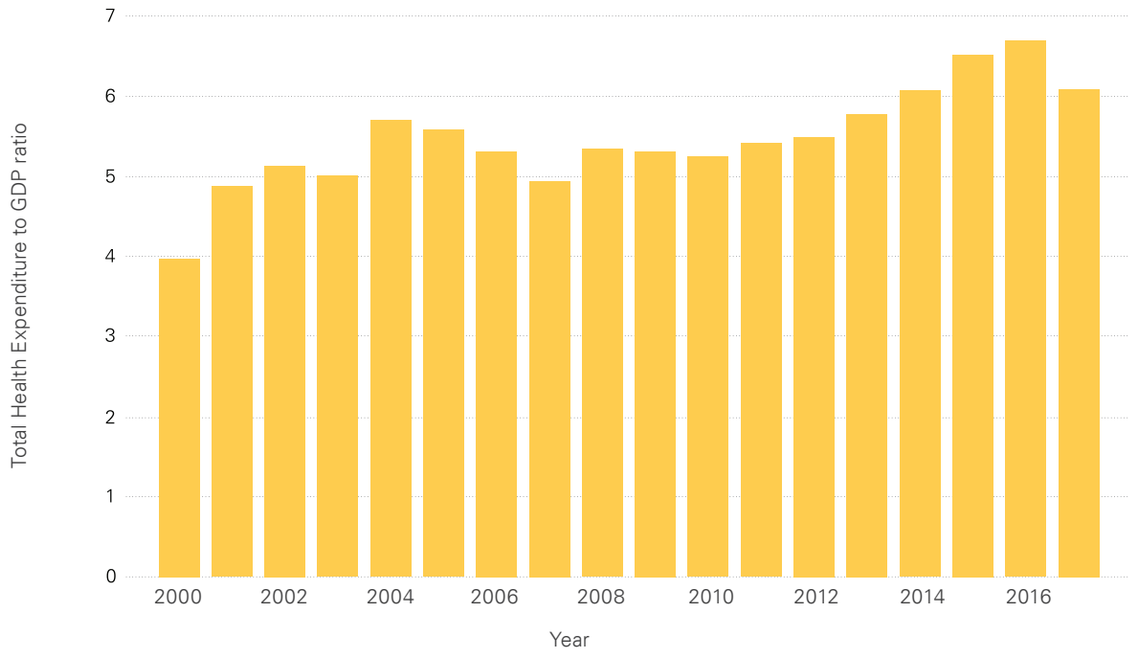


FIGURE 7: TOTAL HEALTH EXPENDITURE TO GDP (%)[6]

[5] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).
[6] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

2.1.2 Government expenditure

General government health expenditures play an important role in the overall financing of health. Although its share of the overall financing is about 18 per cent on average, it alone has the mandate to deliver basic health and human rights. In terms of budget allocation, the data reveal a flat trend with government health budgets comprising 5 per cent of the total budget (Figure 8).

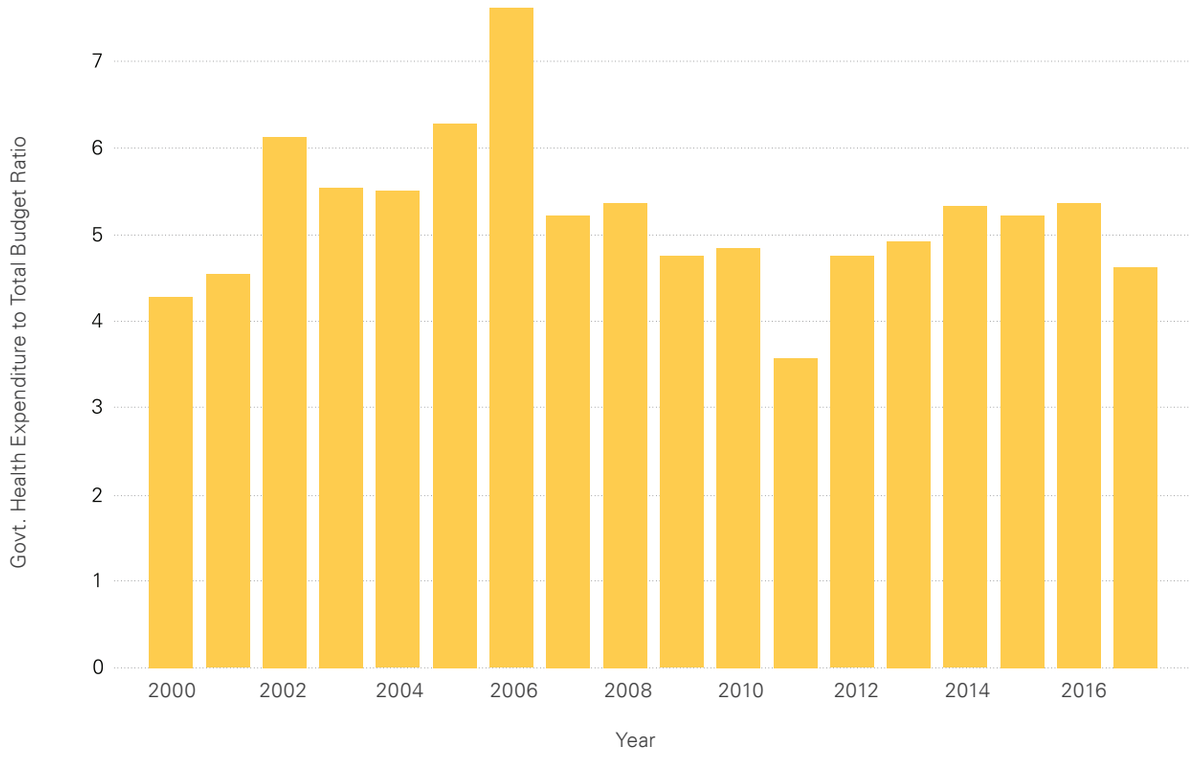


FIGURE 8: PRIORITIZING GOVERNMENT HEALTH SPENDING[7]

In terms of general government health expenditures as a share of GDP, a rising trend can be observed after 2013 (Figure 9). By 2017, general government health expenditures as a per cent of GDP had crossed 1.2 per cent of GDP. In per capita terms, general government health expenditures rose from USD 1.3 in 2000 to USD 11 by 2017. The rising trend needs to be maintained if Nepal's commitment for the government to spend 5 per cent of GDP is to be met. At the same time, it must be realized that increased expenditures have implications for governance, M&E, institutional coordination and cooperation, which need to be addressed in tandem.

[7] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

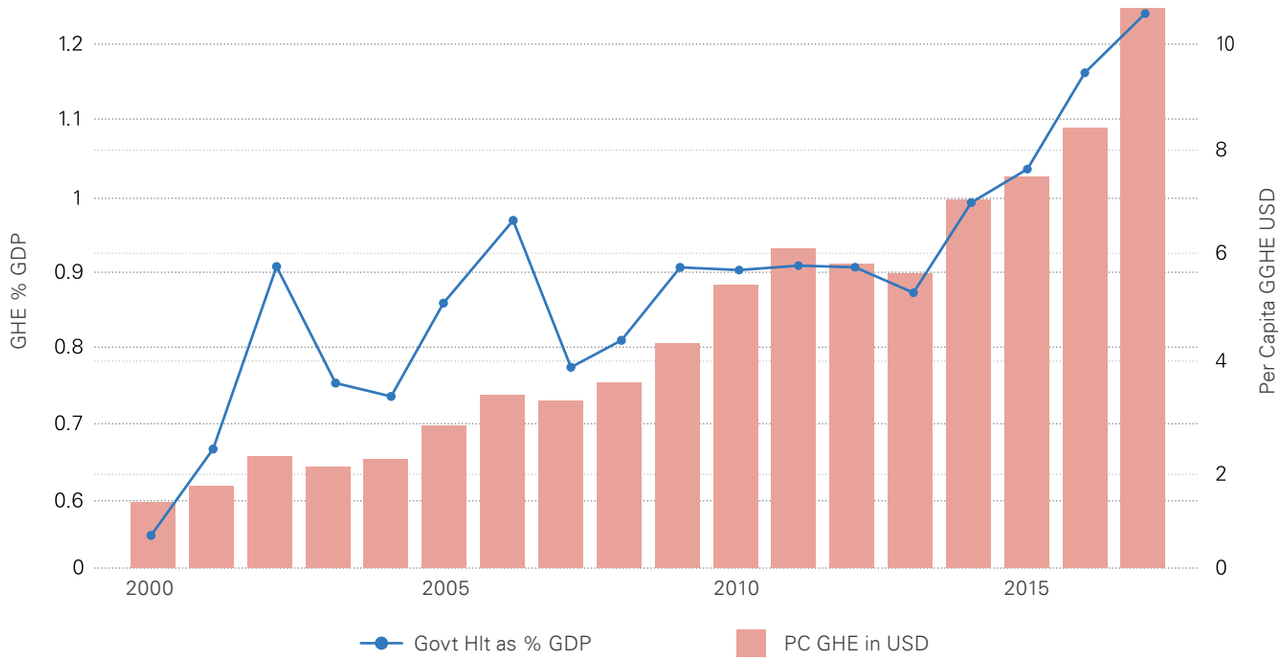


FIGURE 9: GOVERNMENT SPENDING AS % GDP AND IN PER CAPITA USD[8]

2.1.3 Out-of-pocket spending

Out-of-pocket spending (OOPS) remains the main source of health-care financing in Nepal. On average, OOPS contributed more than half of all current expenditures on health. From 2009 to 2015, OOPS increased before falling in recent years to 3.2 per cent of GDP. In per capita terms, OOPS rose from under USD 2 in 2000 to over USD 25 in 2017 – more than a ten-fold increase (Figure 10).

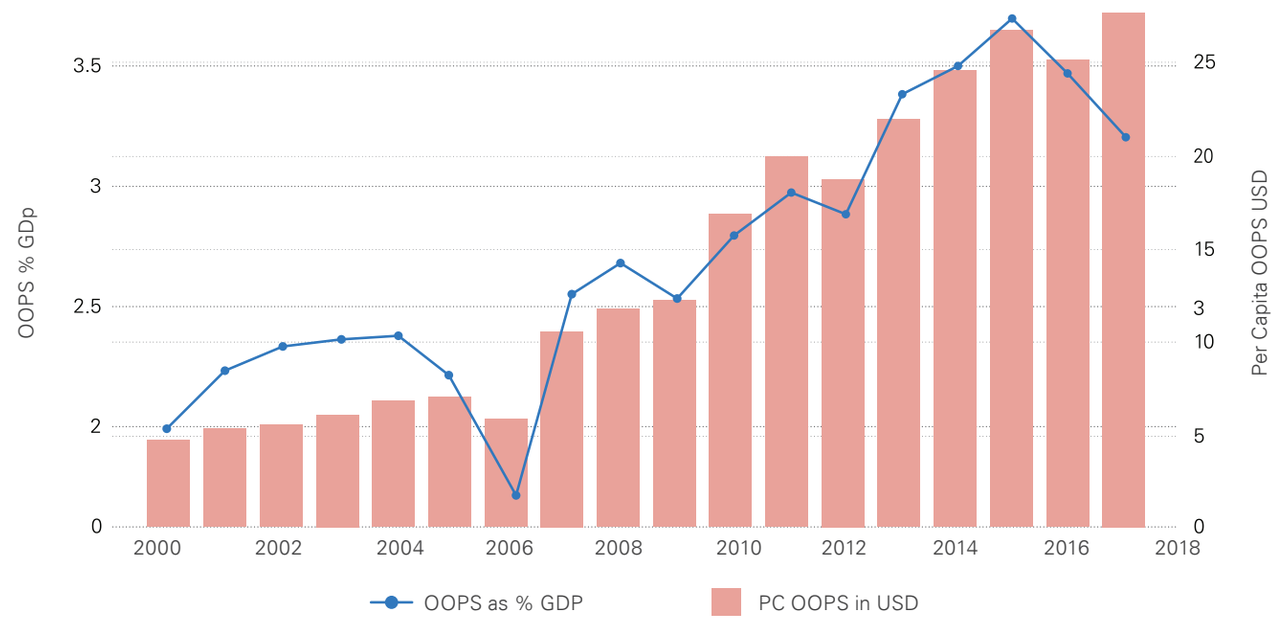


FIGURE 10: OOPS AS % GDP AND PER CAPITA (USD)

[8] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

2.1.4 External health financing

External health financing as a percent of GDP is far lower in recent years compared to the beginning of the millenium (Figure 11). In per capita terms, the 2017 estimate for external health financing was USD 7. The data show that there was a considerable drop in external financing as a percentage of GDP between the years 2005-2010 after which it does not seem to have recovered to earlier levels.

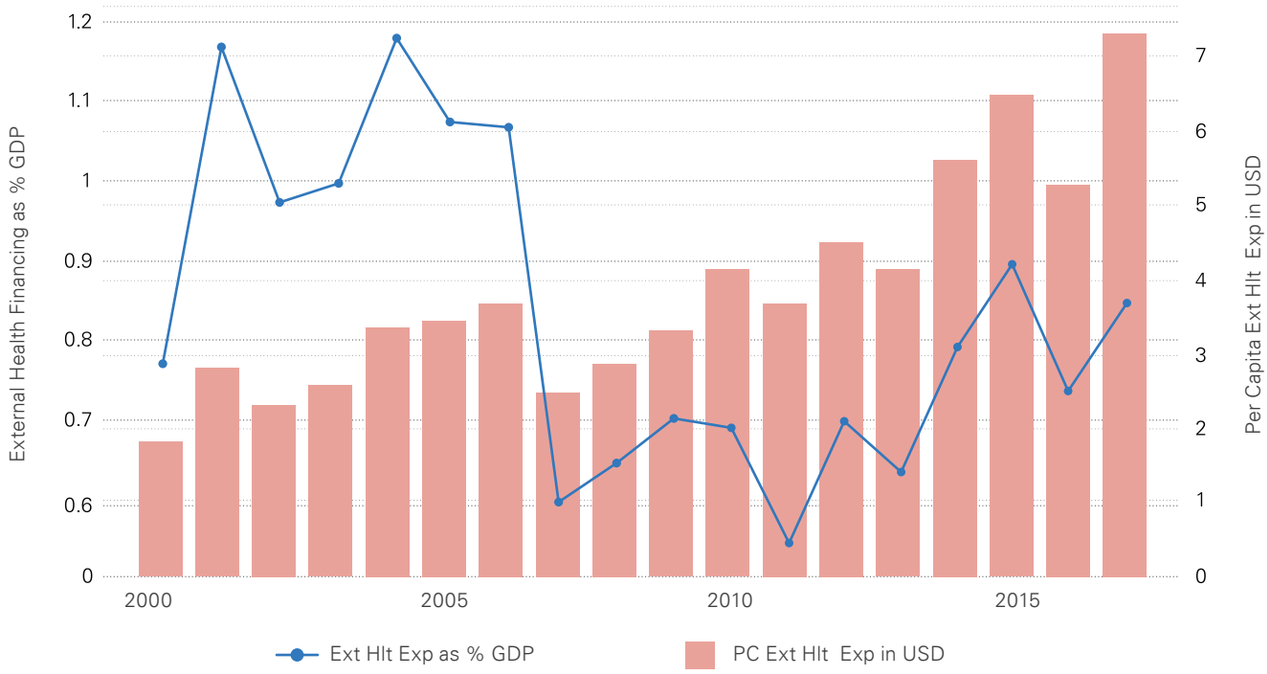


FIGURE 11: EXTERNAL HEALTH EXPENDITURES AS % GDP AND PER CAPITA USD

The negative correlation observed between external financing and OOPS over time is best demonstrated through a trend analysis between the two (Figure 12). As per capita GDP started rising rapidly in 2006/07 in Nepal, external financing dropped while OOPS increased. This negative correlation can be partially explained by rising per capita incomes, which tend to increase OOPS as households become better positioned to afford medical care.

[9] Created from National Health Accounts (MoHP) & Global Health Expenditure Database (WHO).

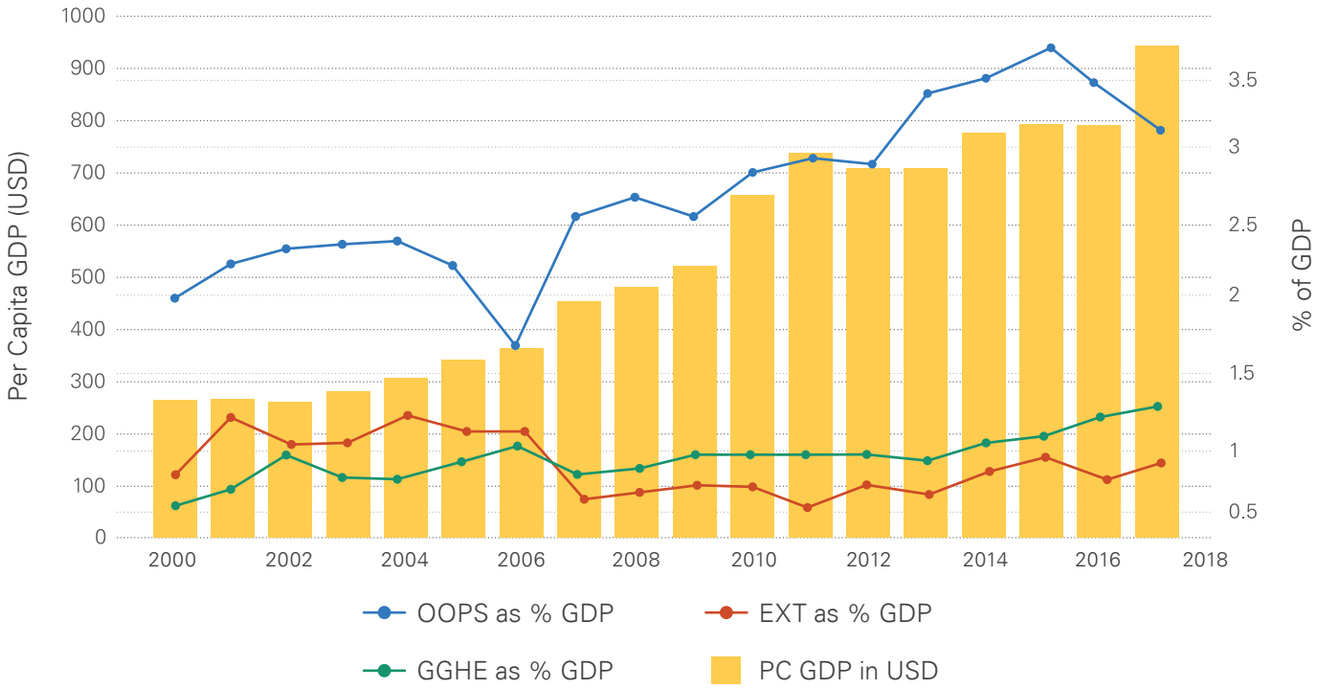


FIGURE 12: HEALTH FINANCING DYNAMICS AND PER CAPITA GDP

2.1.5 Underspending in health

Red Book budget data reveal significant underspending in the health sector. This is of concern as it affects the flow of expenditures and available financing patterns. The extent of underspending is most serious in the provision of out-patient services, R&D on health, and medical products, appliances and equipment. Although these data are five years old, there is no reason to believe that this problem is going to become easier within the context of federalism in Nepal where significant financial flows are being allocated to LLGs who may not have the capacity, experience or incentives to deliver mandated health services.

TABLE 2: ESTIMATED UNDER SPENDING IN HEALTH

TYPE OF GENERAL GOVERNMENT EXPENDITURE	2014/15	2015/16
MEDICAL PRODUCTS, APPLIANCES AND EQUIPMENT	17%	52%
OUT-PATIENT SERVICES	67%	33%
HOSPITAL SERVICES	-7%	3%
PUBLIC HEALTH SERVICES	17%	16%
R&D HEALTH	51%	37%
TOTAL	**22%**	**18%**

2.1.6 Regional comparisons

This section examines the situation of Nepal with respect to select indicators vis-à-vis her South Asian neighbors. Data from 2017 – taken from the World Health Expenditure Database, which is maintained by WHO as part of SDG monitoring on health financing – are used to make the regional comparisons.

TABLE 3: REGIONAL HEALTH EXPENDITURES: SELECT INDICATORS (2017)

	GDP PER CAPITA	PER CAPITA HEALTH EXPENDITURE (CURRENT IN USD)	HEALTH EXPENDITURE AS % GDP (CURRENT)	DOMESTIC GENERAL GOVERNMENT HEALTH EXPENDITURE AS % GDP	DOMESTIC GENERAL GOVT HEALTH EXPENDITURE PER CAPITA IN US$	PER CAPITA OUT OF POCKET SPENDING IN US$	EXTERNAL/ AID AS % OF HEALTH EXP (CURRENT)
AFG	569.94	67.12	11.78	0.60	3.42	50.67	19.42
BGD	1595.35	36.28	2.27	0.38	6.06	26.81	6.75
BTN	3037.35	96.80	3.19	2.37	72.13	12.88	11.17
IND	1960.22	69.29	3.53	0.96	18.80	43.24	0.8
MDV	11151.07	1006.94	9.03	6.45	719.52	207.90	0.08
NPL	962.83	47.92	5.55	1.24	10.70	27.69	15.26
PAK	1538.41	44.59	2.90	0.92	14.08	26.86	1.34
SLK	4184.39	159.48	3.81	1.64	68.50	79.36	1.74

Source: Created from World Health Expenditure Database (WHO, 2019)

The South Asian region displays remarkable diversity with respect to expenditures on health care. There is considerable variation in external health spending as a percentage of total current health spending. Nepal receives the second highest external aid as a percentage of total health expenditures (despite the decreasing trend noted earlier), while in India and especially in the Maldives external expenditures account for less than 1 percent of health expenditures. Government health expenditures as a percentage of GDP is at par with countries such as India and Pakistan but considerably lower than Bhutan, Maldives & Sri Lanka. OOPS is the highest in Maldives, which it also has the highest per capita GDP in the region. In terms of OOPS as a percentage of per-capita GDP, Nepal has the second highest ratio in South Asia where nearly 3 per cent of per capita GDP are private expenditures on health. In terms of government spending per capita, Nepal spends about USD 11. This is lower than countries such as India, Bhutan, Maldives, Pakistan and Sri Lanka. In short, Nepal performs at par with her neighbours on many indicators and has the opportunity to increase the government expenditure component of total health expenditures.

Federalism & health expenditure: This section explores health spending within the nascent federal structure that has evolved since 2018/19. As delineated in the Constitution, the balance underlying the federal structure in Nepal is supposed to be rooted in a joint willingness to cooperate, coordinate and coexist. The Constitution specifies health-care responsibilities among the different layers of government through schedules 5, 6, 8 and 9 (Figure 13).

FIGURE 13: CONSTITUTION ALLOCATION OF HEALTH FUNCTIONS

The layered structure of responsibilities delineated in the Constitution is new for Nepal and is still being unpacked in terms of horizontal and vertical hierarchical relationships. Matters such as human resource management, assessments and infrastructure are still being resolved within the federal policy space of Nepal. While the new federal structure offers rich rewards in terms of localizing development, there are three concerns. First, innate differences in willingness and ability between and among the different levels of government could result in inequitable outcomes for many children. Second, the fragmentation of local governance in Nepal into 753 different entities could lead to high unit costs and fragmentation of programs rather than coherence. Third, the level of coordination and cooperation that is required with the new federal structure (with a central government, seven PGs and 753 LGs) could take time to achieve within the context of any developing country going through multiple political and economic transitions.

As of 2018/19, about 6 per cent of the consolidated budget goes to PGs, while 27 to 28 per cent of the budget goes to LGs (Figure 14). The allocations are supposed to be aligned with the functional responsibilities of subnational governments.

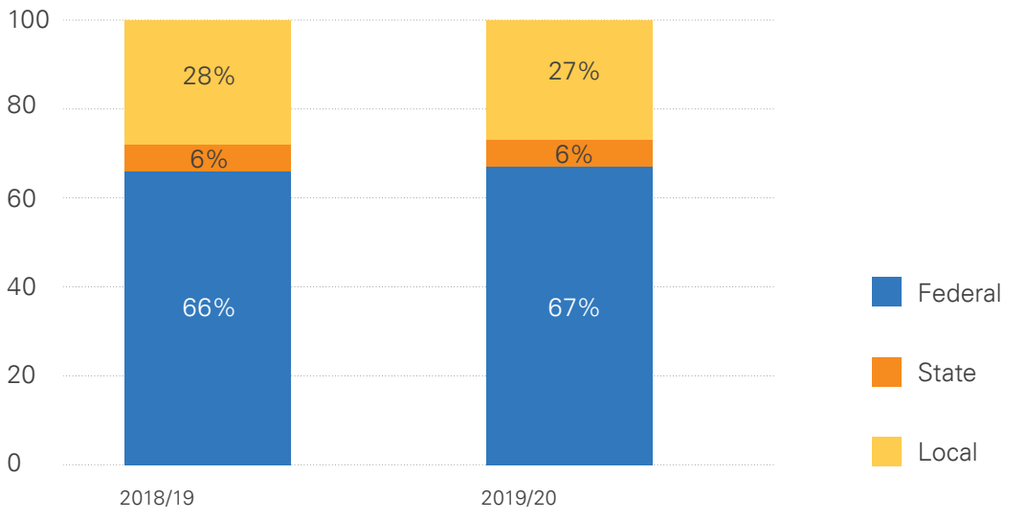


FIGURE 14: BREAKDOWN OF EXPENDITURE BETWEEN FEDERAL, PROVINCE AND LOCAL GOVERNMENT[10]

Data on expenditures by functional classification (Table 4) show that public health services, hospital services and R&D in health received the largest share of the consolidated budget for 2018/19 and 2019/20. Expenditures on public health services were shared almost equally between the center and LGs for both fiscal years. In 2019/20, however, LGs were allotted more monies for OOPS and hospital services. Data from 2014/15 and 2015/16, however, show considerable underspending in some functional areas such as OOPS and public health services. To the extent that these expenditures were allotted to LGs that may not have had the capacity to absorb them, the risk of underspending remained – a situation that stands in the new federal structure of Nepal.

[10] Created from Red Book (various years).

TABLE 4: FUNCTIONAL ALLOCATION OF THE BUDGET

	MEDICAL PRODUCTS, APPLIANCES & EQUIP	OUT-PATIENT SERVICES	HOSPITAL SERVICES	PUBLIC HEALTH SERVICES	R&D HEALTH	HEALTH NOT MENTION	TOTAL BUDGET (NPR MILLIONS)
2018/19							
TOTAL BUDGET	556700	5171900	18817400	32624200	8173000		65343200
% OF TOTAL	1%	8%	29%	50%	13%		
% CENTER	87%	78%	81%	47%	96%		43120700
% PROVINCES	13%	22%	5%	5%	3%		4069800
% LOCAL	0%	1%	13%	48%	1%		18152700
2019/20							
Total Budget	436100	9041900	20932200	34123900	11039800	2830500	78404400
% of Total	1%	12%	27%	44%	14%	4%	
% Center	100%	57%	77%	50%	97%	100%	52296200
% Province	0%	24%	6%	4%	1%	0%	4878500
% Local	0%	20%	17%	47%	1%	0%	21229700

Source: Created from Red Book data (various years)

CONCLUSION

This brief has provided an overview of health sector expenditures and recent trends observed. In this section, the key findings are summarized:

1. Access to health systems and services remains a challenge. There are only four public hospitals per 10,000 population in Nepal, and they are unevenly distributed across the provinces. Private sector health facilities exist in all provinces but are the most noticeable in Province 3.

2. Despite commendable progress on many fronts, including, inter alia, the elimination of trachoma and the enactment of crucial bills that impact health systems, progress on some indicators has stalled (e.g, MMR). Recent household data illuminate the stark inequities that persist in health outcomes among people. The present analysis confirms that the reliance on OOPS to finance more than 50 per cent of health expenditures in Nepal is a major factor contributing to this outcome due to the 'wealth effect' on health outcomes.

3. Overall, health expenditures continue to grow even though the share of government spending on health systems/services remains less than 20 percent of total spending. Government health share in the budget remains around 5 per cent. The share of external financing for health expenditures is currently and substantially lower than it was in 2000-2005. These dynamics have created pressure on OOPS to fill the gap by having to contribute more than half of all health expenditures in Nepal.

4. In per capita terms, health expenditures are estimated to be USD 48 in Nepal. The government health expenditure per capita is USD 11, while OOPS per capita is USD 28. External expenditure per capita is USD 9 – just lower than the domestic government share. The shortage of health-expenditures on health services is mainly impacting private households. The risks of catastrophic health expenditures are, therefore, likely to remain high. Current levels of expenditure, though on an increasing trend, are considerably below international recommendations or the government's own targets.

5. Government expenditures face underspending risks. For the pre-federal years for which data are available, underspending varied between 18-22% of the budget.

6. Since 2018/29, the government has directed close to 27-28% of the health budget to LGs, as they are being allotted increased responsibilities for primary health care, hospital services and OOPS. As there is considerable diversity among various LG units with respect to absorptive capacity, the risk of service disruption remains high.

The central recommendation emerging from this brief is that there is an urgent need to examine the balance of health expenditures in Nepal and expand the government's role in it. Private households are forced to finance more than 50 per cent of total health expenditures, which means that the upper wealth quintiles are in a better position to absorb health expenditures. In addition, the fact that government expenditures are increasingly being borne by PGs and LGs suggests that efforts at increasing capacity and fostering results-based planning and budgeting at subnational levels are urgently needed.