Health Sector Budget Analysis: First Five Years of Federalism

Federal Ministry of Health and Population
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Contributors: Dr. Guna Raj Lohani, Dr. Guna Nidhi Sharma, Hema Bhatt, Dr. Suresh Tiwari, Dhruba Raj Ghimire, Dr. Devendra Gnawali, and Rajan Adhikari

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For more information and clarification contact Ms. Hema Bhatt, hema@nhssp.org.np .

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Study team
January 2022

Executive Summary

The report "Health Sector Budget Analysis: First Five Years of Federalism" intends to enable the Federal Government (FG), Provincial Governments (PG), Local Level (LL) and their entities to understand the trends in health sector budget allocation in the first five years of federalism in Nepal, including the expenditure pattern for the four years from fiscal year (FY) 2017/18 to FY 2020/21. It further enables policy makers, planners, programme managers and external development partners (EDPs) to grasp how policy commitments are being funded through the annual work plan and budget (AWPB) in the context of federalism. It attempts to capture the spirit of federalism by analysing resource allocation to the health sector from all spheres of government, held against constitutional provisions. The report encompasses resource allocation in health beyond conditional grants from the FG, including other fiscal transfers (such as equalisation, matching and special transfers), and internal sources (revenue sharing and internal revenue) from subnational governments (SNGs). The analysis has been carried out using data from electronic annual work plans and budgets (e-AWPBs), the Government of Nepal's Red Book, financial monitoring reports (FMRs), TABUCS, the Line Ministry Budget Information System (LMBIS), the Provincial Line Ministry Budget Information System (PLMBIS) and SuTRAs. For comparison, indicators have also been reported since FY 2016/17. Authors have also used statistical estimation through regression to provide completeness to the data, especially for FY 2017/18 and FY 2018/19. The adjusted budgets of consecutive FYs have been used to capture final expenditures. As a result, minor changes from the previous budget analysis (BA) report are possible. For FY 2021/22, the initial budget is used in the analysis.

Findings

In the first five years of federalism, government spending in health as a share of Gross Domestic Product (GDP) slowly increased from 1.5% in FY 2016/17 to 2.4% in FY 2020/21. Evidence suggests that countries should strive to spend 5% of their GDP to progress towards Universal Health Coverage (UHC). This translates to increasing per capita government spending in health from Nepalese Rupee (NPR) 1,821 to NPR 3,432 (United States Dollar 15 to 29) in real terms between FY 2016/17 and FY 2020/21. However, in constant terms (base year fixed to FY 2010/11) within the same period, the share of government spending has increased very little, from NPR 1,080 (USD 7.3) to NPR 1,973 (USD 11.3). Chatham House recommends that low-income countries spend USD 86 per capita to ensure universal access to primary care services.

Since the implementation of federalism, both the volume and amount of health budget has dramatically increased, from NPR 46.8 billion in FY 2017/18 to NPR 133.1 billion in FY 2021/22. At the same time, the share of the health sector budget against the national budget rose from 4.6% (NPR 60.4 billion) in FY 2016/17 to 8.6% (NPR 179.6 billion) in FY 2020/21. This clear increase in health sector budget can be attributed to the response to the COVID-19 pandemic and resource allocation in health through internal sources in SNGs rising from 0.5% in FY 2017/18 to 14% by FY 2021/22. This supports the fact that federalism has opened fiscal space for health. Following the implementation of federalism, the largest part of the health sector budget is allocated to the federal Ministry of Health and Population (FMoHP). The proportion of health budget allocated in the form of conditional grants to SNGs declined from 40% in FY 2018/19 to 24% in FY 2021/22. Similarly, the share of administrative budget to SNGs through conditional grants declined from 75% in FY 2017/18 to 26% in FY 2021/22. The same applies to capital budgets. EDPs predominantly fund the activities of the federal government. SNG activities are heavily reliant on funding from government sources. Line items, salaries and wages are key cost drivers for SNGs, followed by capacity building. Similarly, by the Chart of Activities, the majority of the Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) and nutrition programmes, as well as Female Community Health Volunteer (FCHV) and other community programmes are allocated to SNGs.

In the first five years of federalism, SNGs were found to have spent between 0.3% to 2.9% of GDP on the health sector. Similarly, per capita spending on health for provinces was found to be between NPR 384 and NPR 3,338 in real terms. At the same time, health sector allocation against provincial budgets (Province and Palika) were observed to be between 5.8% and 10%. These differences across provinces can be attributed to provinces' share of GDP, population, and volume of provincial budgets. Over the years, the share of health budget in PG budgetary allocations is increasing. In addition to the fiscal transfer from the FG, PGs have started to increasingly allocate their health budgets through internal sources, which rose from 34% in FY 2018/19 to 63% in FY 2021/22. Most of the PG health budget is spent under recurrent headings. Line item-wise, more than one third of the health budget is spent on programmes. LLs follow a similar trend in health budget allocation, though there was a slight decline in FY 2021/22. However, fiscal transfers from the FG and PGs are the key funding source for LL health budgets.

In the early days of federalism, most of the budget was spent on administrative headings. Later, this shifted to programme spending. Line item-wise, two fifths of the health budget is now spent on salaries and wages. However, the absorptive capacity of LLs has decreased in recent years while PG expenditure does not follow a definitive pattern. Most activities by NHSS outcome indicator, namely rebuilt and strengthened health system, improved sustainability of health sector financing, and strengthened management of public health emergencies, are allocated to the FG.

Since the implementation of federalism, the FMoHP budget has tripled from NPR 33.3 billion in FY 2017/18 to NPR 101 billion in FY 2021/22. The increase in FMoHP budget volume can be attributed to the COVID-19 response. At the same time, the increase in budget does not corroborate with an improvement in budget absorption, which declined from 82% in FY 2017/18 to 67% in FY 2020/21. Only 50% of the capital budget and 72% of the recurrent budget could be spent in FY 2020/21, while only 43% of pool fund activities could be implemented last year. From the very beginning of federalism, almost all the EDP budget channelled through the treasury has funded the activities of FMoHP. In FY 2020/21, more than 62% of FMoHP's budget was funded by EDPs, which dropped to 48% in FY 2021/22. Budget to FMoHP as a spending unit increased drastically, from NPR 4.2 billion to NPR 74.3 billion between FY 2017/18 and FY 2021/22. In the same period, grants to hospitals almost doubled, from NPR 14.6 billion to NPR 37.8 billion. However, the budget for wages and salaries and capacity building is decreasing, mainly because activities under these line items are devolved to SNGs. Over the years, FMoHP has allocated more than half of its budget to programmes that directly contribute to women and to poverty reduction activities. The actual budget absorption for FMoHP has been weak, demonstrated by the fact that FMoHP surrenders some budget towards the end of the FY.

The Constitution of Nepal has provisioned health as a fundamental right of citizens and mandated all spheres of government to ensure that right. As is evident, federalism has opened avenues for increased fiscal space in health. Some SNGs have been able to tap into those avenues while others need to be capacitated. A coherent health policy that is acceptable to all spheres of government would help in prioritising health and securing resource allocation. At the same time, a comprehensive policy framework advocating the consideration of health issues in all policies would facilitate in harmonising evidence based AWPB at all levels of government. A discussion around transitioning away from health conditional grants for PGs and making PGs responsible for planning conditional grants for their LLs should be initiated to facilitate proper planning and budgeting as well as capacity building. A costed health financing strategy that is applicable to all levels of government needs to be formulated. This strategy should set out a roadmap for achieving a target of at least USD 86 per capita for improving access to primary care or spending 5% of GDP for progressing towards UHC. Finally, health accounts applicable to federal, provincial, and local government are required to capture the total health expenditure in the country.

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Acronyms and Abbreviations

AWPB	Annual work plan and budget
BA	Budget analysis
CG	Conditional grant
CoA	Chart of Activity
CGAS	Computerised government accounting system
DDA	Department of Drug Administration
DoA	Department of Ayurveda
DoHS	Department of Health Services
DHO	District Health Office
DTCO	District Treasury Comptroller Office
e-AWPB	Electronic annual work plan and budget
EDP	External development partner
EHCS	Essential health care services
FCGO	Financial Comptroller General Office
FCHV	Female Community Health Volunteer
FG	Federal Government
FMIS	Financial Management Information System
FMoHP	Federal Ministry of Health and Population
FMR	Financial monitoring report
FWD	Family Welfare Division
FY	Fiscal year
GDP	Gross Domestic Product
GESI	Gender and social inclusion
GoN	Government of Nepal
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IDA	International Development Association
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
LL	Local Level
LMBIS	Line Ministry Budget Information System
MoEAP	Ministry of Economic Affairs and Planning
MoFAGA	Ministry of Federal Affairs and General Administration
MoHPFW	Ministry of Health, Population and Family Welfare
MoF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
NA	Not applicable
NHSP	Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NNRFC	National Natural Resources and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese Rupee
PFM	Public financial management

PG	Provincial Government
PIP	Procurement Improvement Plan
PLMBIS	Provincial Line Ministry Budget Information System
PPMD	Policy, Planning and Monitoring Division
PMoSD	Provincial Ministry of Social Development
PTCO	Provincial Treasury Comptroller Office
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SNG	Sub-national government
SU	Spending units
SuTRA	Subnational Government Treasury Regulatory Application
SWAp	Sector wide approach
TABUCS	Transaction Accounting and Budget Control System
UHC	Universal Health Coverage
USD	United States Dollar

Chapter 1: Introduction

This chapter provides a brief background on Nepal's health system, policy and planning, and the objectives and methodology used in this analysis.

1.1 Background

The Constitution of Nepal 2015 mandates health as a fundamental right of the people (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 quality health care services for all (GoN, 2019). The Nepal Health Sector Strategy (NHSS) 2016-2021 lays out the strategic direction and specific roadmap for the implementation of the constitutional mandate (GoN, 2016). The Federal Ministry of Health and Population (FMoHP) has endorsed the NHSS implementation plan, which provides a budgetary framework to ensure Nepal's commitment to the achievement of Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) by 2030. The recent initiative in localising SDGs has contributed to sub-national governments (SNGs) prioritising social indicators in their planning and budgeting. In this context, Nepal's health sector has an opportunity to create 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. The Public Financial Management Strategic Framework (PFMSF – 2020/21–2024/25) and Procurement Improvement Plan (PIP) (2017/18–2022/23) have been developed and subsequently implemented by the Federal Government (FG). Their implementation has improved efficiency in resource allocation in the health sector. These practices need to be implemented at both provincial and local level. Financial planning and budgeting provides the foundation for effective, efficient and quality service delivery. The annual budget reflects policy and resource allocation decisions that determine the activities, programmes and services to be delivered by various entities. This analysis focuses on the health sector budget over the first five years of federalism in Nepal.

1.2 Objectives

The purpose of this budget analysis (BA) is to support FMoHP, the Provincial Ministry of Health and Population (PMoHP), the Ministry of Social Development (PMoSD), the Ministry of Health, Population and Family Welfare (MoHPFW), the local level, external development partners (EDPs), policy makers and planners by providing consolidated information on the health sector budget and expenditure from the first five years of federalism. It also aims to provide the reader with a synthesis of the main features of budget allocations and comparisons with actual spending from last four fiscal years (FYs) – 2017/18, 2018/19, 2019/20 and 2020/21 – by source, programme and disbursement level.

The specific objectives of the BA are as follows:

- analyse budget allocation and expenditure under conditional grant from the FG to PGs and LLs from FY 2017/18 to FY 2021/22;
- analyse budget allocation and expenditure under grants other than conditional grants to the health sector from provinces and Palikas from FY 2017/18 to FY 2021/22;

- analyse health sector budget allocation and expenditure according to the Chart of Activity (COA) for conditional and other grants from provinces and Palikas from FY 2017/18 to FY 2021/22;
- analyse health sector budget allocation and expenditure according to NHSS indicators (outcome and output level indicators) from the FG, PGs and LLs.

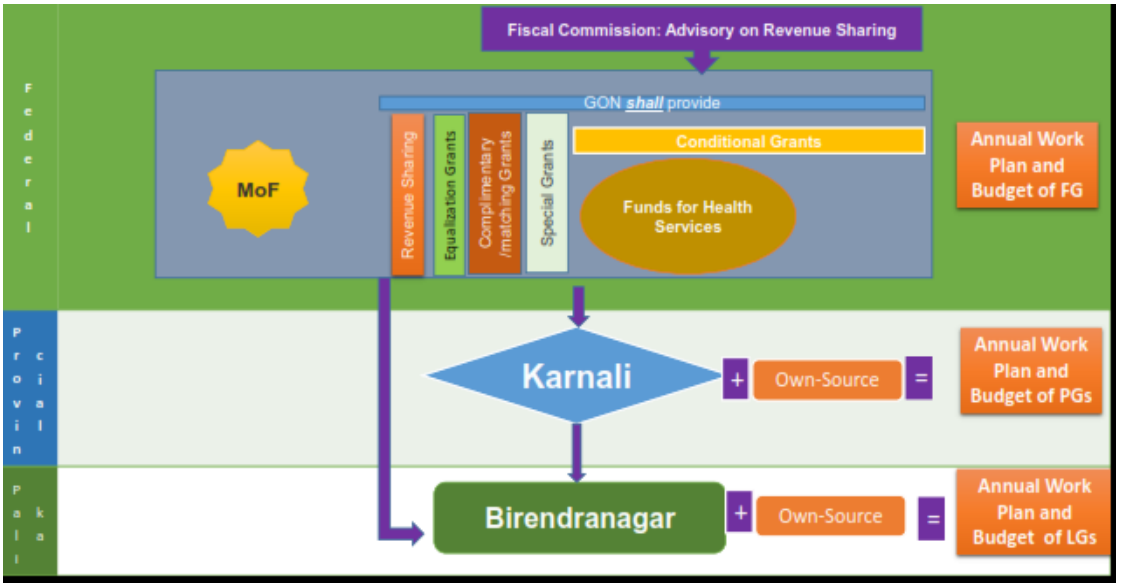
1.3 Methodology

Secondary data was analysed using the Red Book of the Government of Nepal (GoN) and outputs from the Line Ministry Budget Information System (LMBIS), Provincial Line Ministry Budget Information System (PLMBIS), electronic Annual Workplan and Budget (e-AWPB), Transaction Accounting and Budget Control System (TABUCS), the Computerised Government Accounting System (CGAS) output captured from PLMBIS and the Subnational Government Treasury Regulatory Application (SuTRA) FY 2017/18 and FY 2021/22. Budget and expenditure reports from the Financial Comptroller General Office (FCGO) were also used for PGs and LLs from FY 2017/18 to FY 2019/20. Local level budget books and expenditure records were also tracked. At the same time, the authors utilised regression estimates to populate missing data points at raw data level. For example, in FY 2017/18 and FY 2018/19, health sector internal source of budget and expenditure estimates have been produced using regression estimates from reported Palikas (for more detail, see Annex). To enable comparisons, macro-level indicators have also been reported from FY 2016/17, including for SNGs. The task was performed in three phases:

- collect, review, organise and analyse budget and expenditure data;
- conduct a workshop to validate data;
- prepare the policy briefs.

This year's BA will produce with a subset of three NHSSP focus provincial BAs and 32 local level (LL) BAs. The analysis also considered different sources in all spheres of government. Figure 1.3 represents an optimum modality of budget allocation in the health sector.

Figure 1.3: Example of Funding Sources Available in all Spheres of Government



Source: Created by the authors

The adjusted budgets of consecutive FYs have been used to reflect the final expenditures. There may be minor differences in the amounts calculated compared to the previous BA report. However, the total budget remains the same. For FY 2021/22, the initial budget is used in the analysis. The analysis of conditional grants was carried out by collecting information from FMoHP. The data was compiled into standard templates, which then provided the platform for analysis. Technical consultations and discussions took place with FMoHP's planning section and the Department of Health Service's (DoHS) planning and financial officials also provided useful comments. Similarly, key points that emerged from consultations with health planning section chiefs from NHSSP focal provinces and Palika health coordinators have also been incorporated into this report.

1.4 Limitations

This study is based on secondary data, particularly budget and expenditure data from government sources. Thus, it does not intend to explore the factors contributing to lower budget allocation and expenditure. It also does not build associations among the variables. Nepal started practicing federalism in FY 2017/18, as soon as the local elections were completed. However, PGs only came into existence in the middle of FY 2017/18. In this FY, LLs had a full year of implementing federalism, whereas PGs had only half a year or less. For the purpose of the analysis, FY 2017/18 is taken as the baseline of Nepal's experience of federalism.

Chapter 2: Planning, Budgeting and Expenditure Tracking

This chapter provides background on budget characteristics, budget planning, the budgeting process and expenditure tracking.

2.1 Budget Characteristics

Public sector planning and the budgeting process are key to 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. How budget allocations are presented, organised and classified in policies and programmes has a direct impact on actual spending and ultimately on the performance of the health sector. Health budgets are formulated and executed based on goal-oriented programmes (rather than a list of inputs), which 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; sector coordination for budget formulation; realistic and credible estimates of costs; and an open and transparent consultation process.

this context, the health sector budget refers to allocations to FMoHP, related authorities and other ministries involved in the delivery of health-related services.

2.2 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 was a major issue during the first Nepal Health Sector Programme (NHSP-1), NHSP-2 and the early stages of NHSS implementation. In the changed context, budget preparation and endorsement at different levels of government are done through the planning commissions, parliaments and assemblies, as shown in the figure 2.1. FMoHP needs to address these issues by better aligning its policy priorities and actual expenditures with budgets. Challenges that persist with planning and budgeting in the health sector include:

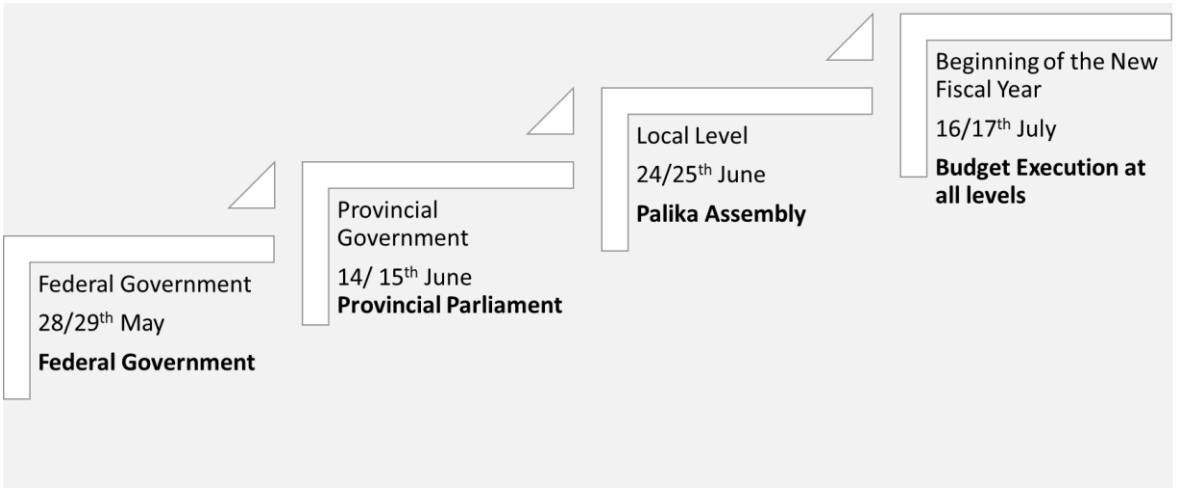
- aligning or harmonising the exclusive functions of federal, provincial and local government;
- defining concurrent planning and budgeting functions in terms of systems, organisations and people;
- developing and harmonising health policies and priorities at all spheres of government;
- re-aligning the health strategy, plan and budget across federal, provincial and local level;
- developing and harmonising a consistent health planning cycle in all spheres of government;

- standardising the Medium Term Expenditure Framework (MTEF) applicable to all levels of governments;
- determining a health budget and programme consistent with national and international commitments at all spheres of government;
- enhancing the capacity of officials engaged in planning at all spheres of government;
- standardising the budget and expenditure tracking system at federal, provincial and local level.

2.3 Overview of the Planning and Budget Preparation Process

Nepal's budget planning process begins in January each year with the Resource Commission f the Government of Nepal (GoN) defining the overall budget for the country. The National Natural Resources and Fiscal Commission (NNRFC) is the constitutional body charged with the objective of ensuring the just and equitable distribution of natural and fiscal resources between all three spheres of government. The Ministry of Finance (MoF) then consolidates policies and programmes from sectoral ministries, which is announced by the President of Nepal. Based on the decisions of the Resource Council/Committee, MoF provides budget ceilings and guidelines for sectoral ministries, and sends estimates of revenue transfer and equalisation grants to PGs and LLs. The planning and budgeting process is completed in three phases, starting from the federal level and moving through the provincial and local levels (see Figure 2.3).

Figure 2.3 Timeline for Planning and Budgeting at the Federal, Provincial and Local Level



Source: Recreated by the authors, 2022

MoF compiles sectoral budgets, prepares the national budget and submits the final budget to Parliament for endorsement, with this being publicly presented through the budget speech. Parliament then endorses the budget for the coming FY through the "Red Book". In FY 2017/18, Parliament formally abolished the provision of sending authorisation to spending units, hence the Red Book serves as the authorisation. Before the budget speech, MoF locks respective AWPBs in the LMBIS. Budget approval equates to the approval of AWPBs in LMBIS, thus does not require further authorisation by line ministries or departments.

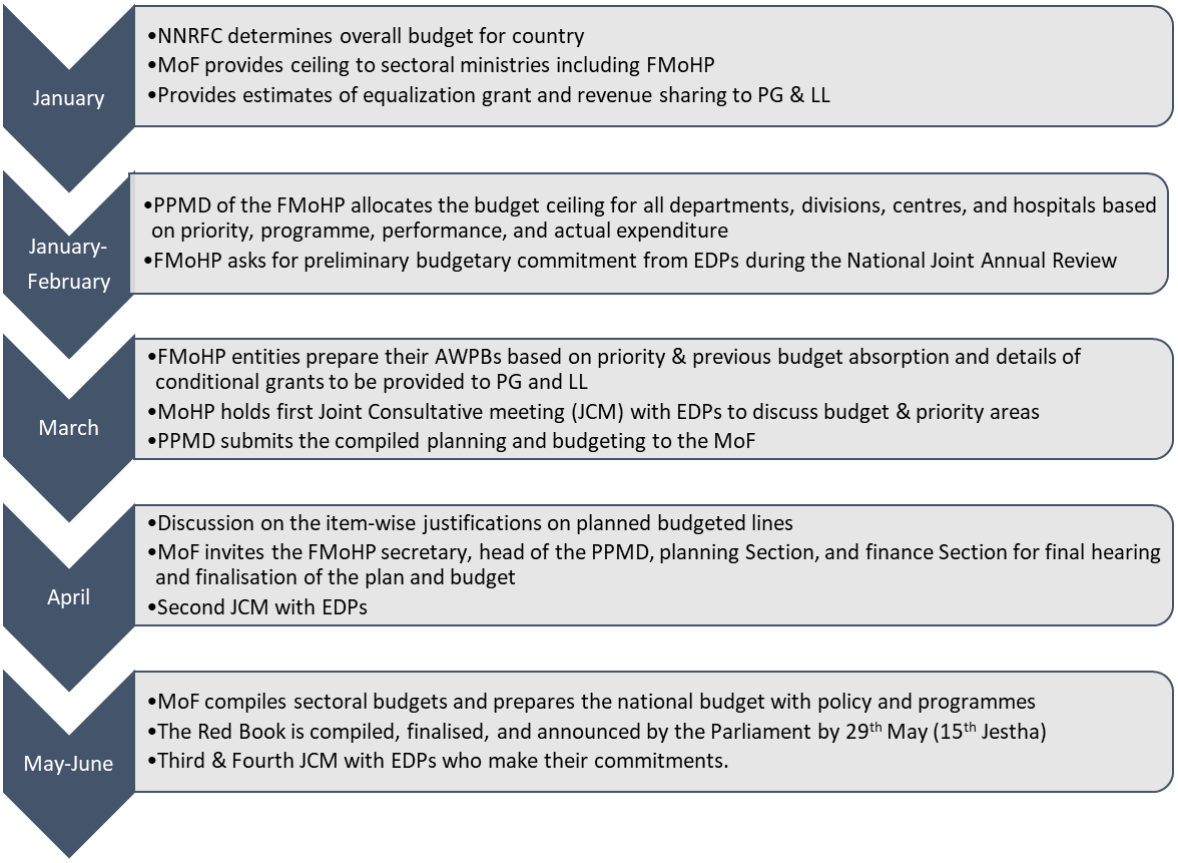
2.3.1 Health Planning and Budgeting at Federal Level

FMoHP's Policy, Planning and Monitoring Division (PPMD) is responsible for the entire planning and budgeting process. Based on the budget ceilings provided by MoF, it takes a lead role in

finalising the budget details for all departments, divisions, centres, hospitals and councils under them. The concerned departments are responsible for preparing their respective budgets. The PPMD's Planning Unit reviews draft budgets from all departments, centres, hospitals and councils. FMoHP organises four Joint Consultative Meetings (JCMs) per year with EDPs to discuss the budget and priority areas. EDPs make their official annual commitments to FMoHP at the fourth JCM. FMoHP follows an annual calendar within the framework of the FG. The sequence of events is summarised in Figure 2.3.1.

Programmes planned under the health conditional grant are sent to SNGs through MoFAGA. A guideline on implementing programmes under conditional grants is also sent to SNGs to guide programme implementation.

Figure 2.3.1: Annual Calendar for the Health AWPB at Federal Level



Source: Recreated by the authors, 2022

2.3.2 Health Planning and Budgeting at Sub-national Level

Planning and budgeting starts in mid-January at the sub-national level. The table below lists major activities for planning and budgeting by timeline at the provincial and local levels. Mid-January to mid-June is the planning period for PGs whereas the LLs are allowed a broader planning timeframe to accommodate plans from the FG and PG. LL planning and budgeting follows a series of seven steps.

Table 2.3.2: A – Planning and Budgeting at the Provincial Level

Major Activity	Details	Date
Projection of revenue and expenditure	Provinces submit financial statistics, including projections of revenue and expenditure for the upcoming FY to MoF	**By mid-January**
	MoF makes the projected details of revenue distribution and fiscal equalisation grants available to the provinces	**By mid-March**
MTEF, resource estimation of budget ceilings and guidelines	The Ministry of Economic Affairs and Planning (MoEAP) provides guidelines and frameworks to prepare MTEF and budget for provincial ministries. Budget ceilings are provided to the respective ministries and agencies. MoEAP enters the ministry-wise budget ceilings in PLMBIS and sends it to concerned ministries and agencies.	**By mid-March**
	Provincial ministries and agencies enter their programmes in PLMBIS, staying within budget ceilings and guidelines, and send this to MoEAP	**By the third week of April**
Pre-budget discussion	Respective ministries and agencies of the provinces submit physical and financial progress on the previous FY and that of the first six months of the current FY. Submitted budgets are discussed at MoEAP and the Provincial Planning Commission.	
Budget presentation	PGs present their budgets at their respective provincial assemblies	**By mid-June**

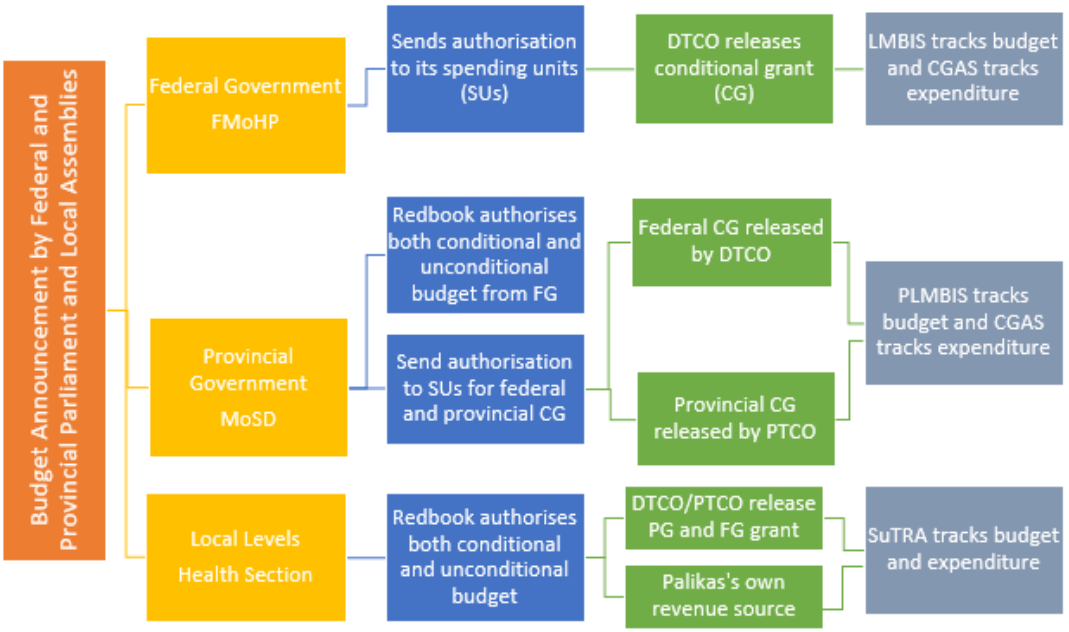
Table 2.3.2: B – Planning and Budgeting at the Local Level

Major Activity	Details	Date
Revenue and expenditure estimation	Make preparations for budgeting by submitting detailed estimates of revenue generation and expenditure to the FG as per the recommendation of the revenue consultation committee and the budget and source estimation committee	**By mid-January**
Obtain budget ceiling	Obtain the budget ceiling of revenue transfer and equalisation from the FG by mid-March and the PG by mid-April	**By mid-April**
Determine budget ceiling	Estimation of source and determine budget ceiling	**By end of April**
Tole level plan selection	Selection of plans at tole level	**By mid-May**
Ward level plan selection	Selection of plans at ward level and prioritisation	**By end of May**
Formulate plan and budget	Formulation of budget and programmes	**By 20 June**
Budget presentation	Approval of budget and programmes by Palika executives; budget and programme presentation	**By 25 June**
Final approval	Approval of budget and programmes by the Local Assembly	**By 15 July**

2.4 Budgeting and Expenditure Tracking

The planning and budgeting process starts at the beginning of January at the federal level, and in mid-January at the provincial and local level. The constitution obligates both local and provincial governments to prepare their AWPBs through a standard process. Figure 2.4 shows the budgeting and expenditure tracking mechanism of the FG, PGs and LLLs.

Figure 2.4: Budgeting and Reporting Mechanism for all spheres of government



Source: Created by the authors

Budget mobilisation begins after the budget is announced by the Federal and Provincial Parliaments and Local Assemblies. The Red Book acts as authorisation. However, the FG sends budget authorisation to its spending units and the District Treasury Comptroller Office (DTCO) releases conditional grants. The budget at FMoHP and its spending units is tracked with the help of LMBIS while expenditure is tracked usingCGAS and/or TABUCS. MoF also sends a circular to the DTCO to release conditional as well as unconditional grants to PGs and LLs. As PGs also formulate their own plans and budget, they send authorisation to their spending units[1] for both federal and provincial conditional grants. The federal conditional grant is released through the DTCO while the provincial conditional grant is released through the Provincial Treasury Comptroller Officer (PTCO). Here, PLMBIS is used for recording the budget-related data and expenditure is tracked with the help of CGAS. Similarly, the Subnational Government Treasury Regulatory Application (SuTRA) is used at the local level to track both budget and expenditure-related data. Financial reports from all spheres of government are prepared in the forms and formats prescribed by the Office of the Auditor General (OAG), as they are mandated to comply with the existing financial rules and regulations and to maintain financial discipline within their jurisdiction.

[1] Provincial spending units include the Provincial Health Directorate, Provincial Health Logistic Management Centre, Provincial Health Training Centre, Provincial Public Health Laboratory, Provincial Hospitals, health offices, ayurveda hospitals and health centres.

Chapter 3: Analysis of Macro Indicators for the Health Sector at National Level

This chapter provides a snapshot of the country's macro-economic status and investment in the health sector[2] through an analysis of public spending in health as a share of GDP, per capita health spending, and health sector budget as a share of the national budget. The following analysis does not provide definitive reasons for the trends observed but does try to elucidate potential factors behind some of the findings.

3.1 Trends in Health Sector Budget Allocation and Expenditure against GDP

Table 3.1 shows macro-economic indicators for the health sector at federal, provincial and local level. The FG announces the budget through the Annual Red Book, which includes the budget required for the FG, and fiscal/grant transfers to SNGs. Similarly, PGs announce their respective Red Books, which include fiscal grants from the FG, revenue sharing, internal revenue and fiscal grant to the local level. At the same time, LLs prepare their Red Books, covering fiscal grants from the FG, PGs, internal revenue and grants to other LLs.

Table 3.1: Macro-economic Indicators, Health Sector Budget and Expenditure (Amount in NPR millions)

Description	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22*
Macro-economic Indicators					
GDP at Producer Price	3,455,949.3	3,858,930.4	3,914,701.1	4,266,321.5	4,394,311.1
Population (in millions)	29.1	29.5	29.9	30.3	30.4
National Budget (Federal, Provincial, Local)	1,308,090.9	1,497,508.3	1,810,623.9	1,966,105.8	2,093,905.1
Federal Government Budget	1,278,994.9	1,315,161.7	1,532,967.1	1,474,645.4	1,632,829.2
Provincial Government Budget	-	80,987.0	142,144.4	161,741.2	151,783.4
Local Level Budget	29,096.03	101,359.60	135,512.36	329,719.27	309,292.44
National Expenditure (FG, PG, LL)	1,111,806.2	1,227,171.0	1,284,689.1	1,532,435.9	-
Federal Government Expenditure	1,087,279.9	1,110,457.1	1,091,333.1	1,179,243.8	-
Provincial Government Expenditure		35,538.3	86,080.3	112,095.9	-
Local Level Expenditure	24,526.3	81,175.6	107,275.7	241,096.2	-
Health Sector Budget					
Health Sector (FG, PG, LL)	60,454.9	77,611.1	105,844.6	143,118.1	179,652.5
Ministry of Health and Population	31,781.1	34,082.3	42,670.9	60,678.8	100,974.8
Federal Ministries other than MoHP	9,563.7	9,564.8	10,440.7	18,209.5	13,379.7
Fiscal Transfer to PGs	164.1	6,153.0	9,258.7	11,869.7	10,590.7
Fiscal Transfer to LLs	18,652.9	23,330.7	29,469.6	30,830.6	29,305.0
Fiscal transfer from PGs to LLs	-	-	826.8	1,684.3	975.1
Internal source from PGs	-	3,103.0	9,396.2	14,419.1	18,326.1
Internal Source LLs	293.1	1,377.3	3,781.6	5,426.1	6,101.1
Health Sector Expenditure					
Health Sector (FG, PG, LL)	53,002.6	66,470.0	87,305.5	103,968.6	-
Ministry of Health and Population	27,370.3	24,485.6	30,855.8	41,516.7	-
Federal Ministries other than MoHP	8,583.2	12,120.6	10,028.9	8,935.0	-
Fiscal Transfer to PGs	164.1	4,645.5	7,609.6	10,262.5	-
Fiscal Transfer to LLs	16,778.8	21,525.6	27,713.0	28,133.2	-
Fiscal transfer from PG to LLs	-	-	762.6	1,553.5	-
Internal source from PGs	-	2,803.8	7,861.2	10,223.2	-
Internal Source LLs	106.2	888.9	2,474.4	3,344.3	-

Source: GDP for all year from National Accounts – FY 2020/21; Central Bureau of Statistics (CBS) for FY 2021/22; GDP estimates taken from Macroeconomic Update, Nepal, Volume 9, No.1, April 2021, Asian Development Bank; Population projection from CBS in millions Budget: Red Book FY 2017/16–FY 2021/22, PLMBIS: FY 2019/20–FY 2021/22, Sub-national Treasury Regulatory Application (SuTRA), FY 2017/18–FY 2021/22

[2] The health sector budget at the national level is defined as the budget allocated to FMoHP and ministries other than health implementing health related programmes); fiscal transfer from the FG and PGs (which include conditional, equalisation, special and matching grants); and internal sources (which include the health budget allocated by PGs, and local level from revenue sharing and internal revenue).

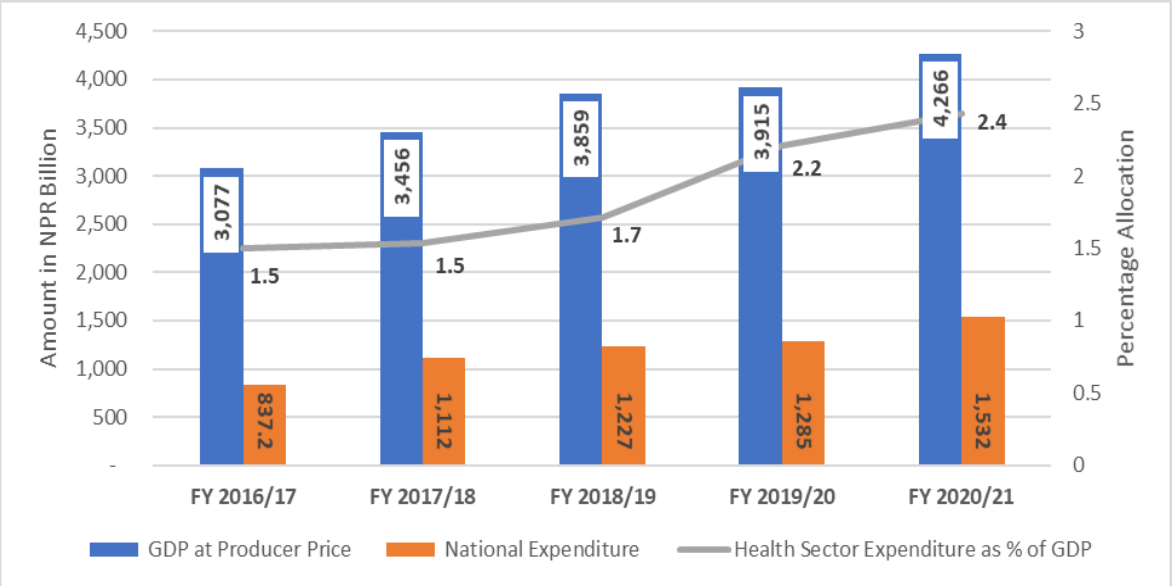
In FY 2021/22, GoN allocated NPR 179.5 billion to health sector out which the health conditional grant to FMoHP is NPR 100.9 billion, and NPR 13.3 billion to ministries other than FMoHP. Additionally, PGs received NPR 10.4 billion as fiscal transfers/grants from the FG (including conditional grants) and allocated NPR 18.3 billion from internal sources to the health sector. LLs received NPR 29.3 billion as fiscal transfers from the FG, NPR 0.97 billion as fiscal transfer from PGs and NPR 6.1 billion was allocated from internal sources to the health sector. There has been a steady rise in the health sector budget over the years, but a drastic rise maybe observed since FY 2020/21, from NPR 101.9 billion to NPR 179.5 billion. This can be largely attributed to the response to the COVID-19 pandemic. It is encouraging to note that PGs and LLs have allocated resources to health sector through fiscal grants other than conditional grants, revenue sharing and internal revenue. Furthermore, it is interesting to note that the majority of the health sector budget remains with FMoHP.

Over the past three years, the health sector has maintained budget absorption levels that are 80% higher than national budget absorption. However, health sector absorption dropped to 73% in FY 2020/21. The health sector's low absorption is the cumulative effect of weak absorption at FMoHP, other ministries, and internal source absorption in PGs and LLs. For this analysis, the national budget and expenditure is the sum of the total budget at federal, provincial and local level. Caution has been taken to avoid potential double counting of budget and expenditure at the provincial and local levels. For actual budget and expenditure of PGs and LLs, see Chapter 5 on SNGs.

3.2 Trends in Government Health Sector Spending

Figure 3.2 provides an indication of the trends in government health sector spending as a percentage of GDP, which rose from 1.5% in FY 2016/17 to 2.4% in FY 2020/21.

Figure 3.2: Trends in Government Health Spending as a Percentage of GDP (Amount in NPR billions)



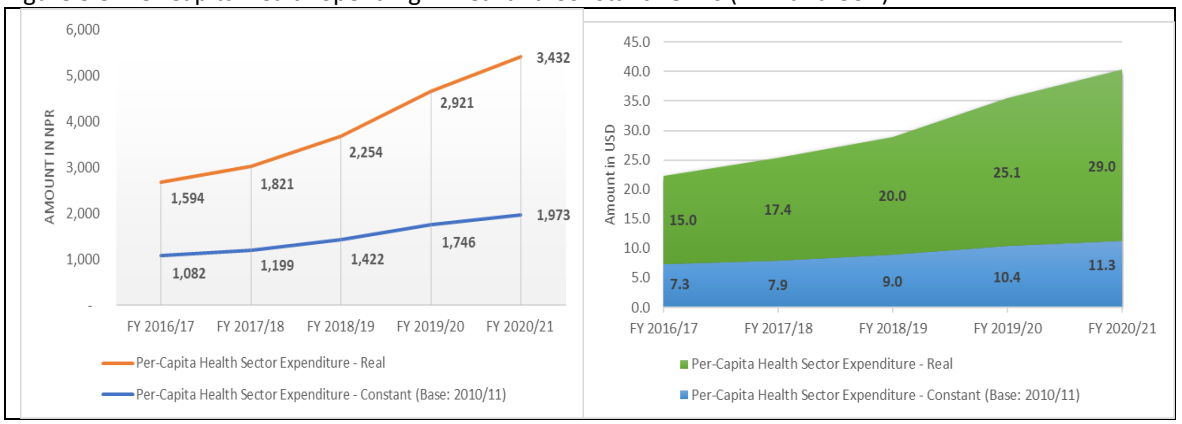
Source: Red Book FY 2016/17–FY 2020/21, PLMBIS, SuTRA

Government spending on health includes the budget allocated to FMoHP, ministries[3] other than health, health conditional grants and other fiscal transfers to health, and resources from internal sources in PGs and LLs. Government health expenditure as a percentage of the GDP was stagnant till FY 2017/18, at 1.5%. By FY 2019/20, this had risen to 2.2%, with a further increase to 2.4% by the following year. A Chatham House report recommends that countries spend 5% of their GDP to progress towards UHC (Mcintyre, 2014). The 2010 World Health Report states that public spending of about 6% of GDP on health will limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible (WHO, 2010). Government spending on health of more than 5% of GDP is required to achieve a conservative target of 90% coverage of maternal and child health services (Mcintyre et al, 2017). By these standards, GoN's health investments fall short of what is required for UHC.

3.3 Per Capita Government Health Expenditure

Per capita government spending gradually increased from NPR 1,594 (USD 15.0) in FY 2016/17 to NPR 3,432 (USD 29) in FY 2020/10 in real terms. However, in constant terms (base year fixed to FY 2010/11), within the same time period, per capita government health spending has increased very little, from NPR 1082 (USD 7.3) to NPR 1973 (USD 11.3).

Figure 3.3: Per Capita Health Spending in Real and Constant Terms (NPR and USD)



Source: Red Book FY 2015/16–FY 2020/21, PLMBIS, SuTRA, population projection obtained from HMIS

Since FY 2017/18, per capita health expenditure has also included expenditure from PG and LL internal sources and other fiscal transfers in addition to conditional grants. The Chatham House report, among other recent evidence, recommends that low-income countries spend USD 86 per capita to promote universal access to primary care services (Mcintyre, 2014). This implies that per capita public spending in Nepal is far behind the level recommended to achieve universal access to primary care services.

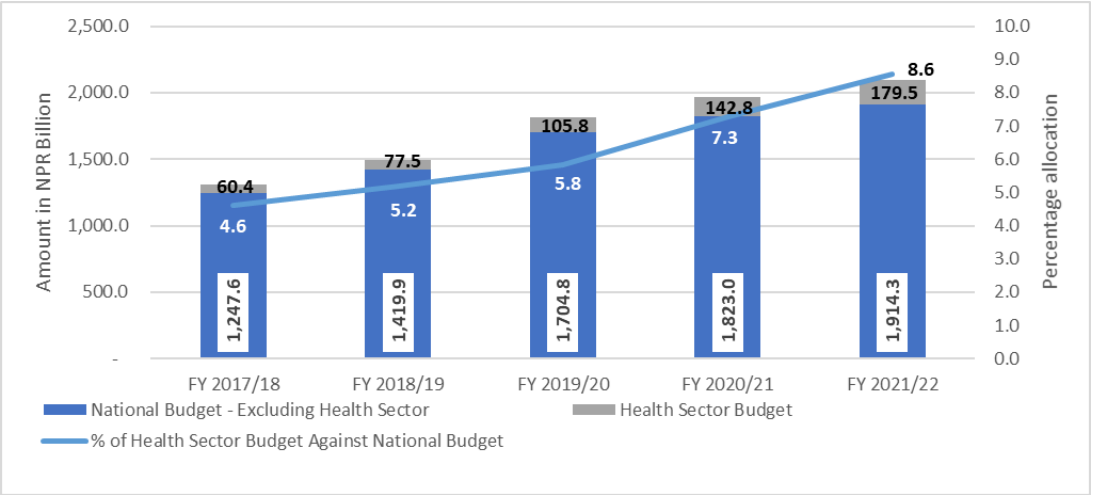
3.4 Share of Health Sector Budget out of Total Government Budget

Figure 3.4 shows trends in the health sector budget as a percentage of the national budget. As indicated, the volume of the health sector budget has increased almost three fold, from NPR 60.4

[3] Ministries other than FMoHP include MoF, the Ministry of Commerce and Supply, the Ministry of Defence, the Home Affairs Ministry, the Ministry of General Administration, the Ministry of Education, and the Ministry of Federal Affairs and Local Development.

billion in FY 2017/18 to NPR 179.5 billion in FY 2021/22. Up to FY 2018/19, the share of the health sector against the national budget remained below or slightly above 5%.

Figure 3.4: Percentage of Health Sector Budget Against National Budget (Amount in NPR billions)



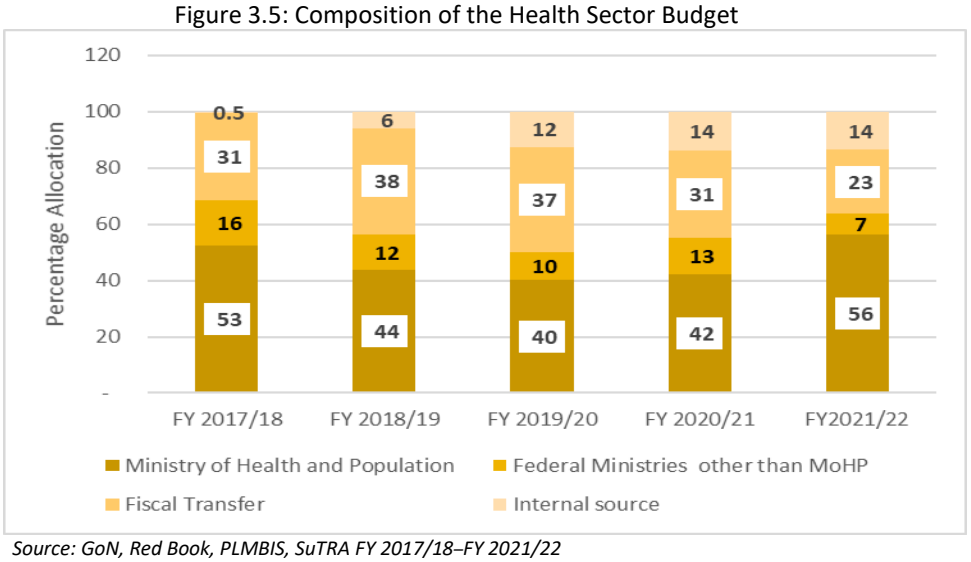
Source: GoN, Red Book, PLMBIS, SuTRA FY 2017/18– FY 2021/22

The health sector budget increased from 5.8% in FY 2019/20 to 7.3% in FY 2020/21, and rose further to 9% in FY 2021/22. If the health sector continues to receive allocations similar to that of the past two years, then GoN is very close to meeting the NHSS target of allocating 10% of the national budget to health. The increased budget allocation can also be attributed to COVID-19 pandemic management. In the above figure, the total national budget is obtained by adding the national budget and health sector budget.

3.5 Health Sector Budget

Figure 3.5 shows a stacked graph displaying the percentage distribution of the health sector budget across FMoHP, ministries other than health, fiscal grants from the FG and PGs (conditional and unconditional) and internal sources (revenue sharing and internal revenue).

Figure 3.5: Composition of the Health Sector Budget



Source: GoN, Red Book, PLMBIS, SuTRA FY 2017/18–FY 2021/22

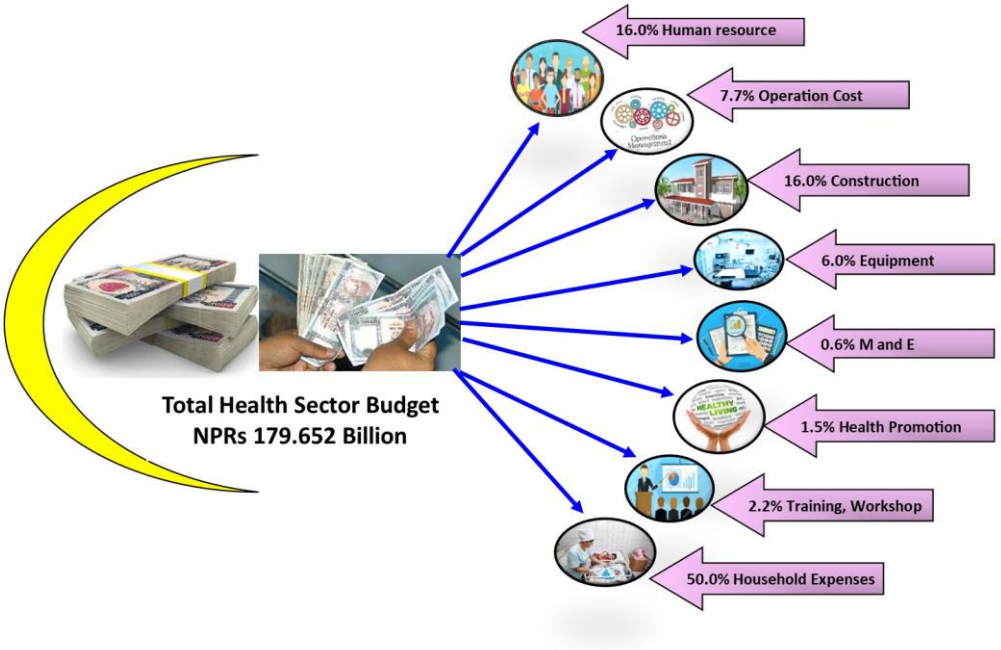
Over the years, FMoHP has taken up the largest share of the health sector budget, followed by fiscal grant from the FG to PGs and LLs, and PGs to LLs. It is encouraging to observe that internal

sources are emerging as an important source of funding to the health sector at the SNG level. This is a positive message in terms of increasing the fiscal space for health.

3.6 Distribution of Health Sector Budget by Support Functions and Actual Services, FY 2021/22

Figure 3.6 provides a breakdown of the health sector budget by support function and actual services. Around half a majority of the health sector budget directly reached households,[4] which is a 15% rise from the allocations in the previous year (35%). This could be due to the budget allocated for COVID-19 vaccinations. Other services included the Aama programme; free drug purchases; reproductive health and family planning; child immunisation and nutrition; treatment for tuberculosis and HIV/AIDS as well as non-communicable diseases for the ultra-poor; Ayurveda; the one stop crisis management centre (OCMC); and health insurance payments.

Figure 3.6: Health Sector Budget by Support Function and Actual Services



[4] Programmes that directly reach households include services and drugs and treatment received free at community level (i.e. FCHVs, community health centres, basic health units, health posts, and general and specialised hospitals)

Chapter 4: Analysis of Health Budget for Five Years

This chapter provides a detailed analysis of budget allocated to FMoHP denoted as FG, and conditional grants[5] provided by the federal government to PGs and LLs. Together they are defined as the health budget. This excludes the health budget allocated to ministries other than FMoHP and also health budget allocations from PGs and LLs through fiscal transfers and internal sources.

4.1 Health Budget to FG, PGs and LLs by FMoHP Organisation

Table 4.1 shows the percentage allocation of the health budget to FG, PGs and LLs by FMoHP organisation. Since FY 2018/19, the proportion of health budget allocated in the form of conditional grants to SNGs has been in decline, going from 40% to 24% in FY 2021/22. By FY 2021/22, more than two thirds of the activities of the Department of Health Services and Department of Ayurveda and Alternate Medicine had been allocated to SNGs. However, activities from the centre remained at the federal level.

Table 4.1: Percentage Allocation of Health Budget to FG, PGs and LLs by FMoHP Organisation (Amount in NPR millions)

	FY2017/18			FY 2018/19				FY 2019/20				FY2020/21				FY2021/22			
		% Allocation			% Allocation				% Allocation				% Allocation				% Allocation		
Organization	Budget	FG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL
Ministry of Health and Population	4,385	100	#	15,135	93	7	#	19,725	100	#	#	36,238	96	#	#	74,468	100	#	#
Department of Health Services	30,380	54	46	25,880	25	40	65	32,086	24	14	63	33,505	21	14	63	38,364	23	14	63
Department of Drug Administration	152	100	#	168	100	#	#	191	100	#	#	165	100	#	#	161	100	#	#
Department of Ayurveda and Alternative Medicine	1,581	44	56	1,511	26	13	71	1,226	21	9	69	1,665	13	28	59	1,718	13	28	59
Centers	3,167	95	5	2,506	69	30	10	2,362	72	15	13	2,535	75	21	12	2,624	67	21	12
Central Hospitals	2,558	100	#	2,337	100	#	#	2,843	100	#	#	2,984	100	#	#	2,852	100	#	#
Health Insurance Board	2,000	100	#	6,000	100	#	#	6,000	100	#	#	7,500	100	#	#	7,500	100	#	#
Council and Academy	2,643	100	#	2,883	100	#	#	4,348	100	#	#	6,098	100	#	#	5,434	100	#	#
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**19**	**133,121**	**76**	**5**	**19**

Source: LMBIS FY 2017/18–FY 2021/22

None of the activities from the Department of Drug Administration (DDA), the Health Insurance Board, the Council and the Academy is allocated to the PGs and LLs.

4.2 Health Budget to FG, PGs and LLs by Programme, Budget Type, Priority and Gender-responsive Heading

Table 4.2 shows the percentage allocation of health budget to the FG, PGs and LLs by programme, budget type, priority, and gender-responsive heading. Over the years, the share of administrative budget through conditional grants to SNGs has declined, from 75% in FY 2017/18 to 26% in FY 2021/22. This could be primarily because in recent times, most revenue sharing has been utilised to fund administrative costs. Still, more than two thirds of the programme budget sit with the FG. However, most of the budget under recurrent, capital, priority one and priority two programmes from conditional grants remains at the federal level.

[5] Details of health conditional grant activities provided to PGs and LGs can be found at www.mofaga.gov.np. Please note that these are initial allocations and are subject to change as SNGs may receive additional allocations under specific headings from the FG budget.

Table 4.2: Percentage Allocation of Health Budge to the FG, PGs and LLs by Programme, Budget, Priority and Gender-rresponsive Heading (Amount in NPR millions)

Categories	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
		% Allocation			% Allocation				% Allocation				% Allocation				% Allocation		
	Budget	FG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL
By Programme																			
Administrative	11,739	25	75	13,111	14	8	79	18,980	22	#	78	29,096	38	2	60	68,918	74	#	26
Programme	35,127	82	18	43,309	75	7	18	49,799	77	10	13	61,594	81	7	13	64,204	77	#	13
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**
By Budget																			
Recurrent	39,253	66	34	45,927	56	9	35	59,959	58	8	35	75,086	60	6	34	119,184	73	5	22
Capital	7,613	78	22	10,492	81	1	18	8,820	93	1	6	15,604	98	1	1	13,938	100	#	#
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**
By Budget Priority																			
Priority One	37,560	66	34	47,439	59	8	33	61,243	59	8	33	81,793	65	5	30	126,462	75	5	20
Priority Two	9,305	76	24	8,981	68	4	28	7,536	88	1	10	8,897	81	7	12	6,660	97	1	2
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**
By Gender Reponsive																			
Direct Contribution to Women	32,837	61	39	36,939	51	7	42	49,132	52	8	40	62,724	57	5	38	109,019	74	5	22
Indirect Contribution to Women	14,029	83	17	19,481	78	8	14	19,647	87	5	8	27,966	88	5	7	24,102	86	6	8
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**

Source: LMBIS FY 2017/18–FY 2021/22

Initially, SNGs received their fair share of the capital budget, budget for priority one programmes and programmes directly contributing to women. Over the last two FYs, this has declined, which could be mainly because SNGs are allocating budget under capital headings from their own sources or other fiscal transfers. Almost all the budget for the COVID-19 response, including vaccine procurement, remains with FMoHP.

4.3 Health Budget to FG, PGs and LLs by Source of Funding, Funding Modality and Donor Type

Table 4.3 shows the percentage allocation of health budget to the FG, PGs, and LLs by source of funding, funding modality and donor type. Most of the EDP budget sits with the FG. This means that all SNG activities are heavily reliant on funding from the FG.

Table 4.3: Health Budget to FG, PGs and LLs by Source of Funding, Funding Modality and Donor Type (Amount in NPR millions)

Organization	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
		% Allocation			% Allocation				% Allocation				% Allocation				% Allocation		
	Budget	FG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL
By GoN & EDP																			
GON/Federal	39,006	61	39	43,531	52	9	40	59,895	57	8	35	52,048	43	8	49	83,791	63	7	31
EDPs	7,860	100	#	12,889	90	3	7	8,884	99	#	1	38,642	99	1	#	49,331	98	2	#
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**
By Funding Modality																			
GoN	39,006	61	39	43,531	52	9	40	59,895	57	8	35	52,048	43	8	49	83,791	63	7	31
Pool Fund	4,100	100	#	8,954	94	1	5	6,564	100	#	#	10,064	97	3	#	11,692	98	2	#
Direct Fund	3,760	100	#	3,935	81	8	12	2,320	96	#	4	28,579	100	#	#	37,639	98	2	#
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**
By Donor Type																			
Multilateral	626	100	#	656	36	15	50	265	67	#	33	26,150	100	#	#	31,659	100	#	#
Bilateral	446	100	#	1,451	83	10	7	267	100	#	#	768	94	6	#	1,085	100	#	#
I/NGOs	6,788	100	#	10,782	94	2	5	8,353	100	#	#	11,724	98	2	#	16,587	95	5	#
GoN	39,006	61	39	43,531	52	9	40	59,895	57	8	35	52,048	43	8	49	83,791	63	7	31
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**

Source: LMBIS FY 2017/18–FY 2021/22

Since FY 2018/19, some level of funding has been provided to SNGs by multinational, bilateral and international and national non-governmental organisations (I/NGOs). By FY 2020/21, no external

support has been observed for LLs, while I/NGOs appear to be the only source of external funding to PGs in FY 2021/22.

4.4 Health Budget to FG, PGs, and LLs by Line Item

Table 4.4 shows the percentage allocation of health budget to FG, PGs and LLs by line item or economic code. Over the years, more programme budget has been allocated to SNGs. The budget allocated to SNGs under capital construction decreased from 5% in FY 2017/18 to zero in FY 2021/22, while most of the capacity-building budget has shifted from the FG to SNGs, more specifically to PGs in FY 2020/21 and to LLs in FY 2021/22.

Table 4.4: Health Budget to FG, PGs, and LLs by Line Item (Amount in NPR millions)

Line Item	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
		% Allocation			% Allocation				% Allocation				% Allocation				% Allocation		
	Budget	FG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL	Budget	FG	PG	LL
Wages & Salaries	11,395	14	86	13,800	10	7	83	15,149	2	#	98	18,539	3	2	95	18,375	4	#	96
Support Services	1,826	35	65	1,594	22	5	73	933	52	33	15	2,325	85	6	9	570	94	1	5
Capacity Building	914	77	23	852	20	56	24	514	26	16	58	711	17	67	16	631	11	5	83
Program Activities	5,737	69	31	4,726	27	17	55	6,658	19	40	41	10,321	40	14	46	15,062	29	#	30
Medicine Purchases	5,910	92	8	5,316	66	15	19	6,337	72	12	16	5,674	71	12	17	44,907	97	#	3
Grants and Social Security	14,794	91	9	21,073	89	5	6	30,368	91	3	6	37,516	92	3	5	39,475	96	#	4
Capital Construction	4,906	95	5	7,732	97	#	3	7,926	94	1	5	14,685	99	#	1	13,391	99	#	#
Capital Goods	1,385	91	9	1,327	80	5	15	894	78	6	16	919	77	19	4	712	80	4	16
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**80**	**4**	**16**

Source: LMBIS FY 2017/18–FY 2021/22

Most of the budget under "medicine purchases", "grants and social security" and "capital goods" remains with the FG.

4.5 Health Budget to FG, PGs, and LLs by Chart of Activities

Table 4.5 shows the percentage allocation of health budget to FG, PGs, and LLs by chart of activities. Almost all the budget for physical infrastructure development and improvement, health research and survey, social health protection services, laboratory and diagnostic services, the academy and hospitals are allocated to the FG.

Table 4.5: Health Budget to FG, PGs, and LLs by Chart of Activities (Amount in NPR millions)

Chart of Activities	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
	Total	% Allocation		Total	% Allocation			Total	% Allocation			Total	% Allocation			Total	% Allocation		
		FG	LL		FG	PG	LL		FG	PG	LL		FG	PG	LL		FG	PG	LL
Administration, HR & Office Management	17,577	41	59	18,099	25	7	68	21,763	30	3	67	24,662	29	1	69	25,669	29	2	69
RMNCAH & Nutrition	7,917	65	35	7,537	39	25	36	9,694	38	24	38	10,043	45	23	32	14,254	45	24	31
FCHV & Community Health Programmes	1,277	30	70	1,135	1	#	99	791	#	70	30	2,577	12	7	81	1,585	21	16	62
Communicable Disease, Infectious Disease, & Epidemic Control	3,225	95	5	2,703	61	18	21	2,418	60	19	21	3,705	71	15	14	2,957	68	16	16
Non Communicable Diseases & Human Organ Transplant	1,327	100	#	1,364	92	7	1	788	69	18	13	2,078	92	5	3	3,492	81	6	13
Eye & Other Health Services	198	65	35	166	69	3	28	54	35	65	#	137	70	2	29	134	84	7	10
Social Health Protection Services	2,974	96	4	7,316	98	2	#	17,510	100	#	#	10,365	98	2	#	12,691	98	2	#
Laboratory and Diagnostic Services	207	100	#	150	99	1	#	173	100	#	#	366	100	#	#	348	93	7	1
Academy and Hospitals	306	100	#	613	99	1	#	115	100	#	#	2,553	95	#	5	685	97	#	3
Health Education and Information	372	71	29	245	49	21	30	325	42	28	30	362	36	15	49	361	41	15	44
Ayurveda and Alternative Medicines	339	52	48	421	22	7	71	1,062	5	10	84	1,667	13	29	57	597	20	80	#
Free Drug Purchase, Drug Regulation and Supply Chain Management	4,071	90	10	3,078	61	6	33	3,604	62	6	32	3,301	59	11	30	3,376	63	5	32
Health Research and Surveys	64	100	#	73	100	#	#	55	100	#	#	199	100	#	#	146	100	#	#
Physical Infrastructure Development and Improvement	7,010	100	#	13,520	100	#	#	10,427	99	1	#	22,563	100	#	#	18,709	99	#	1
COVID-19 Response												6,113	99	#	1	48,116	98.2	1.3	0.4
Total	**46,866**	**79**	**21**	**56,420**	**65**	**7**	**28**	**68,779**	**60**	**17**	**23**	**90,690**	**66**	**8**	**26**	**133,121**	**67**	**13**	**20**

Source: LMBIS FY 2017/18–FY 2021/22

Since the early years of federalism, more than half to a majority of the budget related to "RMNCAH & nutrition", "administration, HR & office management", and "health education and information" has been allocated to SNGs. The federal government has always maintained two thirds or more share of the budget under "drug purchase, drug regulation and supply management" and "communicable diseases, infectious diseases & epidemic control". In both FYs, almost all the budget under the COVID-19 response is allocated to the FG. This is the initial budget, pending redistribution of the budget to SNGs.[6] For more detailed information on COVID-19, please see the report on COVID-19 budget analysis.

4.6 Health Budget to FG, PGs, and LLs by NHSS Outcome Indicator

Table 4.6 shows the percentage allocation of health budget to FG, PGs, and LLs by NHSS outcome indicator. Almost all to most of the activities under "rebuilt and strengthened health systems", "improved sustainability of health sector financing" and "strengthened management of public health emergencies" are allocated to the FG.

Table 4.6: Health Budget to FG, PGs and LLs by NHSS outcome indicator (Amount in NPR millions)

NHSS Outcome Indicators	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
	Budget	% Allocation		Budget	% Allocation			Budget	% Allocation			Budget	% Allocation			Budget	% Allocation		
		FG	LG		FG	PG	LG		FG	PG	LG		FG	PG	LG		FG	PG	LG
Rebuilt and strengthened health systems: Infrastructure, HRH management, Procurement and Supply chain management	12,502	95	5	18,068	90	3	7	15,913	87	3	9	26,389	94	2	4	24,524	94	1	5
Improved quality of care at point-of-delivery	21,107	50	50	24,563	43	5	51	28,224	46	3	52	34,906	49	2	49	36,965	48	2	50
Equitable utilization of health care services	7,079	65	35	8,508	61	11	28	8,586	39	27	34	13,033	59	14	27	10,674	53	27	20
Improved sector management and governance	1,437	52	48	1,853	3	35	62	2,287	13	24	63	2,805	14	28	58	2,820	14	26	60
Improved sustainability of health sector financing	1,470	91	9	1,235	100	0	#	11,525	100	0	#	2,605	99	1	-	4,648	100	-	0
Improved healthy lifestyles and environment	2,500	83	17	1,703	26	35	40	1,655	33	27	40	3,374	34	15	51	3,975	27	23	49
Strengthened management of public health emergencies	99	100	-	261	63	12	25	185	43	29	29	6,897	98	1	1	48,200	98	1	0
Improved availability and use of evidence in decision-making processes at all levels	672	98	2	228	82	12	6	404	31	40	29	681	46	27	27	1,317	67	11	22
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**

Source: LMBIS FY 2017/18–FY 2021/22

More than half to most of the activities under "improved quality of care at point-of-delivery", "improved sector management and governance", "improved healthy lifestyles and environment" have been allocated to SNGs over the years. It is worth noting that the outcome indicator "decentralised planning and budgeting" is not reported as it is no longer relevant in the context of federalism.

4.7 Health Budget to FG, PGs and LLs by NHSS Output Indicator

Table 4.7 shows the percentage allocation of health budget to FG, PGs, and LLs by NHSS output indicator. There are 20 output indicators, and most activities under the outputs "improved health sector reviews with functional linkages to the planning process", "health services delivered as per

[6] Please note these are initial allocations and may change. In FY 2020/21, FMoHP was initially provided with NPR 6 billion for the COVID-19 response, which was then increased to NPR 25 billion. Nearly 33% of this allocation was sent to SNGs. In FY 2021/22, NPR 46 billion was allocated to FMoHP, of which NPR 1 billion has been disbursed to SNGs.

standards and protocols" and "healthy behaviour and practices promoted" have been allocated to SNGs over the years.

Table 4.7: Health Conditional Grant to the FG, PGs and LLs by NHSSP output indicator (Amount in NPR millions)

NHSS Outcome Indicators	FY 2017/18			FY 2018/19				FY 2019/20				FY 2020/21				FY 2021/22			
	Budget	% Allocation		Budget	% Allocation			Budget	% Allocation			Budget	% Allocation			Budget	% Allocation		
		FG	LG		FG	PG	LG		FG	PG	LG		FG	PG	LG		FG	PG	LG
Health infrastructure developed as per plan and standards	7,196	97	3	12,701	98	0	2	10,508	97	1	2	21,609	100	#	0	18,554	100	0	0
Improved management of health infrastructure	219	100	-	1,058	100	#	#	139	100	-	#	791	93	7	-	154	73	-	27
Improved staff availability at all levels with focus on rural retention and enrolment	6	100	-	16	100	#	#	5	100	-	#	107	100	#	-	8	100	-	#
Improved human resource education and competencies	346	100	-	494	43	42	15	267	43	39	18	193	74	26	-	116	61	39	#
Improved procurement system	735	92	8	210	45	16	39	246	79	15	7	434	69	27	4	544	63	37	0
Improved supply chain management	4,001	90	10	3,589	67	9	24	4,747	68	7	24	3,255	59	10	30	5,147	79	1	20
Health services delivered as per standards and protocols	19,558	46	54	20,336	32	6	62	23,618	35	3	62	29,488	39	2	59	28,900	34	3	64
Quality assurance system strengthened	1,109	100	-	3,758	99	1	#	4,264	100	-	#	4,907	100	#	-	7,622	100	-	#
Improved infection prevention and health care waste management	441	97	3	470	85	11	4	342	83	3	13	511	93	6	1	443	97	3	#
Improved access to health services, especially for unreached population	6,891	64	36	8,291	63	12	26	8,570	39	27	34	11,373	65	16	19	10,582	53	27	20
Health service networks including referral system strengthened	188	100	-	217	4	4	92	16	60	-	40	1,659	18	1	81	92	90	-	10
Ministry of Health and Population (MoHP) structure is responsive to health sector needs	1,387	50	50	1,768	3	36	61	2,286	13	24	63	2,785	14	28	58	2,819	14	26	60
Improved governance of private sector	50	100	-	85	2	10	88	1	100	-	#	20	-	39	61	1	100	-	#
Health financing system strengthened	1,470	91	9	1,235	100	0	#	11,525	100	0	#	2,605	99	1	-	4,648	100	-	0
Healthy behaviours and practices promoted	2,500	83	17	1,703	26	35	40	1,655	33	27	40	3,374	34	15	51	3,975	27	23	49
Improved preparedness for public health emergencies	78	100	-	241	66	13	21	151	34	35	31	6,783	99	1	1	48,108	98	1	0
Strengthened response to public health emergencies	21	100	-	20	25	6	69	34	79	-	21	114	62	17	20	91	65	34	1
Integrated information management approach practiced	366	97	3	77	91	9	#	153	39	61	#	314	55	37	7	912	76	4	19
Survey, research and studies conducted in priority areas; and results used	114	95	5	143	77	14	9	103	62	38	#	135	94	6	-	162	96	4	#
Improved health sector reviews with functional linkage to planning process	192	100	-	8	100	#	#	149	2	20	78	232	4	25	71	242	11	43	46
Total	**46,866**	**68**	**32**	**56,420**	**60**	**7**	**32**	**68,779**	**62**	**7**	**31**	**90,690**	**67**	**5**	**28**	**133,121**	**76**	**5**	**19**

Source: LMBIS FY 2017/18–FY 2021/22

Almost half to most of the activities under "improved access to services, especially for unreached populations" is shared between the FG and SNGs. Almost all activities related to output related to infrastructure, health financing and public health emergencies are allocated to the FG.

Chapter 5: Budget Analysis of Subnational Governments for Five Years

This chapter provides an analysis of the subnational budget capturing the first five years of the implementation of federalism. It starts with a macro-economic analysis of SNGs over five years. by adding up the resources at the level of PGs (all seven) and 753 LLs aggregated at the province level. It then provides standalone analysis for PGs only and LLs for five years.

5.1 Health Sector Macro-economic Indicators at the Subnational Level

Table 5.1 lists macro-economic indicators at the subnational level. Over the years, Bagmati province is observed to have spent less compared to other provinces in terms of health sector spending as a percentage of GDP.[7] Health sector spending as a percentage of GDP is highest for Karnali province.[8]

Table 5.1: Macro-economic Indicators of SNGs

Province	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Health sector spending as a percentage of GDP					
National	**1.5**	**1.7**	**2.2**	**2.4**	-
Province-1	0.3	0.7	0.9	1.0	-
Madhesh Pradesh	0.5	1.0	1.2	1.4	-
Bagmati	0.2	0.3	0.4	0.5	-
Gandaki	0.6	1.1	1.2	1.2	-
Lumbini	0.4	0.8	1.0	1.3	-
Karnali	1.2	1.6	2.2	2.9	-
Sudurpaschim	0.7	1.4	1.8	2.2	-
Per capita spending in the health sector in real terms					
National	**1,821**	**2,254**	**2,921**	**3,432**	-
Province-1	384	841	1,133	1,380	-
Madhesh Pradesh	397	812	1,035	1,235	-
Bagmati	427	675	865	1,627	-
Gandaki	768	1,441	1,646	2,406	-
Lumbini	416	891	1,047	1,839	-
Karnali	968	1,371	1,909	3,338	-
Sudurpaschim	607	1,268	1,656	2,941	-
Health sector budget as a percentage of national/provincial budget					
National	**4.6**	**5.2**	**5.8**	**7.3**	**8.6**
Province-1	6.4	5.9	7.8	7.3	7.6
Madhesh Pradesh	10.1	7.4	9.6	7.6	7.0
Bagmati	6.8	4.6	5.7	6.1	8.9
Gandaki	7.2	7.2	8.7	6.9	7.3
Lumbini	7.7	6.4	7.7	8.2	7.9
Karnali	10.0	5.8	8.6	9.2	8.9
Sudurpaschim	8.3	7.2	10.3	9.4	8.9

Source: FCGO Report, PLMBIS and SUTRA FY 2017/18–FY 2021/22, author estimates

Madhesh Pradesh spends less in terms of per capita health expenditure[9] while Karnali province spends the highest. Health sector budgets as a percentage of provincial budgets do not follow a

[7] This could be because Bagmati has the largest share of GDP compared to other provinces.
[8] This could be mainly because Karnali province has the lowest population.
[9] Population wise, Madhesh Pradesh is second highest after Kathmandu.

definitive trend like that of the health sector budget as a percentage of the national budget. These findings need to be interpreted with caution (see the information in the footnotes).

5.2 Budget Analysis for Provincial Governments

PGs came into existence in Nepal in January-February of FY 2017/18. As it was already mid-year in fiscal terms and the provincial structures were entirely new, PGs were allocated a limited budget to establish and sustain themselves and implement a work plan for a six-month financial year.[10] Of the total allocated budget, the PGs allocated between 1.9% to 2.6% to the health sector. As they began to raise their own revenues in FY 2018/19, their budgets increased substantially. This section is purely an analysis of PGs and their entities.

5.2.1 Total Budget and Expenditure at Provincial Level

Table 5.2.1 shows the total PG budget and expenditure. Over the years, the total budget allocated to PGs has increased, except in FY 2021/22. The absorptive capacity of PGs has improved, from 35% in FY 2017/18 to 69% in FY 2021/22.

Table 5.2.1: Total Budget and Expenditure of PGs (Amount in NPR millions)

Name of Province	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Province-1	1,020.5	64	29,746	71	31,124	96	43,431	64	32,654
Madesh Pradesh	1,022.5	60	24,445	62	31,670	57	34,704	65	33,956
Bagmati	1,020.5	26	33,773	61	48,351	58	51,445	69	57,771
Gandaki	1,020.5	29	22,362	62	27,379	75	37,263	69	30,166
Lumbini	1,020.5	19	28,270	60	34,321	74	39,154	82	40,960
Karnali	1,020.5	23	22,451	45	33,458	50	35,013	65	36,582
Sudurpaschim	1,020.5	25	22,877	62	25,690	69	34,693	66	30,478
Total	**7,145**	**35**	**183,924**	**61**	**231,993**	**67**	**275,704**	**69**	**262,567**

Source: FCGO Report FY 2017/18–FY 2019/20, PLMBIS FY 2020/21–FY 2021/22

Bagmati, Lumbini and Karnali provinces have had a steady rise in budget allocation and absorptive capacity.

5.2.2 Total Health Budget and Expenditure at Provincial Level

Table 5.2.2 shows the total health budget of PGs. Over the years, the total health budget allocated by PGs has increased. However, the absorptive capacity of PGs does not follow a definitive trend, with a sudden dip in FY 2019/20 compared to the first full year of implementation in FY 2018/19. This could be attributed to the COVID-19 outbreak, although absorptive capacity did improve in FY 2021/22 to 75%, from 65% in FY 2019/20.

[10] An equal volume of budget (NPR 1,020.5 million) was allocated to each province except Madhesh Province (NPR 1022.5 million). PGs were entirely dependent on federal sources for their budget as they did not have internal sources of funding.

Table 5.2.2: Total Health Budget and Expenditure of PGs (Amount in NPR millions)

Name of Province	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Province-1	22	64	1,469	71	2,180	75	3,928	75	3,506
Madesh Pradesh	26	60	1,713	79	3,109	57	3,393	70	2,774
Bagmati	25	50	1,013	78	2,618	58	3,663	66	8,900
Gandaki	26	40	1,552	80	2,502	75	2,805	75	2,308
Lumbini	25	45	1,215	77	2,539	74	4,254	76	4,171
Karnali	20	32	931	57	2,464	50	4,050	79	3,865
Sudurpaschim	19	41	1,364	79	3,242	69	4,194	82	3,393
Total	**164**	**48**	**9,256**	**75**	**18,655**	**65**	**26,289**	**73**	**28,917**

Source: Budget: SuTRA FY 2017/18–FY 2018/19 for all provinces, Expenditure: TABUCS FY 2017/18–FY 2018/19 (Provinces: Madhesh Pradesh and Sudurpaschim), FCGO Report FY 2017/18–FY 2019/20 and expenditure trend of FY 2020/21 from PLMBIS was used for estimates in the remaining provinces, PLMBIS FY 2020/21–FY 2021/22

Bagmati is the only province with a steady increase in its health budget over the years. Meanwhile, the absorptive capacity of the health budget for Province 1 has improved.

5.2.3 Percentage Allocation of Health Budget at Provincial Level

Table 5.2.3 shows health budget allocation at provincial level by internal income and transfer/grants from FG. Over the years, the share of internal sources in PGs health budget allocation has evidently increased, from 34% in FY 2018/19 to 63% in FY 2021/22.

Table 5.2.3: Percentage Allocation of Health Budget at Provincial Level by Internal Income and Transfer from the FG (Amount in NPR millions)

Name of Province	FY 2017/18			FY 2018/19			FY 2019/20			FY 2020/21			FY 2021/22		
	Budget	% Internal Source	% Transfer FG	Budget	% Internal Source	% Transfer FG	Budget	% Internal Source	% Transfer FG	Budget	% Internal Source	% Transfer FG	Budget	% Internal Source	% Transfer FG
Province-1	22	-	100	1,469	20	80	2,180	45	55	3,928	43	57	3,506	46	54
Madesh Pradesh	26	-	100	1,713	54	46	3,109	36	64	3,393	54	46	2,774	61	39
Bagmati	25	-	100	1,013	42	58	2,618	55	45	3,663	53	47	8,900	81	19
Gandaki	26	-	100	1,552	11	89	2,502	48	52	2,805	60	40	2,308	62	38
Lumbini	25	-	100	1,215	13	87	2,539	39	61	4,254	44	56	4,171	62	38
Karnali	20	-	100	931	55	45	2,464	57	43	4,050	68	32	3,865	49	51
Sudurpaschim	19	-	100	1,364	45	55	3,242	70	30	4,194	64	36	3,393	56	44
Total	**164**	**-**	**100**	**9,256**	**34**	**66**	**18,655**	**50**	**50**	**26,289**	**55**	**45**	**28,917**	**63**	**37**

Source: Budget: SuTRA FY 2017/18–FY 2018/19 for all provinces, Expenditure: TABUCS FY 2017/18–FY 2018/19 (Provinces: Madhesh Pradesh and Sudurpaschim), FCGO Report FY 2017/18–FY 2019/20 and expenditure trend of FY 2020/21 was used for estimation of remaining provinces, PLMBIS FY 2020/21–FY 2021/22

Bagmati, Gandaki and Lumbini provinces have consistently funded their health budgets through internal income. In FY 2021/22, Bagmati province allocated almost 81% of its health budget from internal sources.

5.2.4 Percentage Allocation of Health Budget at Provincial Level by Budget and Programme Heading

Table 5.2.4 shows health budget allocation at provincial level by budget and programme heading. Over the years, most of the health budget has been allocated under recurrent headings. However, some increment in capital allocation has been observed, from 17% in FY 2017/18 to 25% in FY 2021/22.

Table 5.2.4: Percentage Allocation of Health Budget at Provincial Level by Budget and Programme Heading (Amount in NPR millions)

Budget Headings	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Total	% Allocation	Total	% Allocation	Total	% Allocation	Total	% Allocation	Total	% Allocation
By Recurrent and Capital										
Recurrent	78	83	7,641	83	15,876	85	19,049	72	21,605	75
Capital	16	17	1,615	17	2,779	15	7,240	28	7,312	25
Total	**94**	**100**	**9,256**	**100**	**18,655**	**100**	**26,289**	**100**	**28,917**	**100**
By Administrative & Programme										
Administrative	10	11	489	5	4,685	25	6,565	25	6,697	23
Programme	84	89	8,767	95	13,970	75	19,724	75	22,220	77
Total	**94**	**100**	**9,256**	**100**	**18,655**	**100**	**26,289**	**100**	**28,917**	**100**

Source: SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22

During the early years of federalism, the majority of the health budget was allocated under the programme heading, but since FY 2019/20 this has been slowly tending towards the administrative heading.

5.2.5 Percentage Allocation of Health Budget at Provincial Level by Type of Grant

Table 5.2.5 shows health budget allocation at provincial level by type of grant. Over the years, the majority of the health budget to PGs has been funded through federal grants, the share of which is decreasing, from 100% in FY 2017/18 to 33% in FY 2021/22.

Table 5.2.5: Percentage Allocation of Health Budget at Provincial Level by Type of Grant (Amount in NPR millions)

Types of Grant	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Federal Grant	93.9	100	6,153.0	66	8,432	45	10,185	39	9,616	33
Internal Source	-	-	3,103	34	10,223	55	15,456	59	18,414	64
Foreign	-	-	-	-	-	-	647	2	887	3
Total	**94**	**100**	**9,256**	**100**	**18,655**	**100**	**26,289**	**100**	**28,917**	**100**

Source: SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22

The decrease in the share of federal transfer/grant has been compensated for through an increase in the share of internal sources in the overall health budget, from 1% in FY 2019/20 to 60% in FY 2021/22. In FY 2019/20, PGs started providing fiscal transfer/grants to LLLs earmarked for the health sector. However, very limited budget has been allocated by foreign sources since FY 2020/21. No health budget has been funded through revenue sharing at the provincial level.

5.2.6 Percentage Allocation of Health Budget at Provincial Level by Line Item/Economic Code

Table 5.2.6 shows health budget allocation at provincial level by line item or economic code. Over the years, the majority of the health budget has been allocated to salaries and wages. Over the years, programme activities have come to occupy a majority of the health budget at provincial level followed by wages and salaries.

Table 5.2.6: Percentage Allocation of Health Budget at Provincial Level by Line Item/Economic Code (Amount in NPR millions)

Economic Code/ Line item	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Budget	% Allocation	Budget	Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Wages & Salaries	-	-	287	3	3,455	19	4,639	18	4,563	16
Support Services	10	11	202	2	1,231	7	1,927	7	2,134	7
Capacity Building	-	-	874	9	337	2	277	1	262	1
Program Activities	39	42	2,359	25	6,271	34	7,829	30	11,999	41
Medicine Purchases	8	9	1,034	11	1,120	6	1,567	6	949	3
Social Service Grants and Social Security	13	14	2,670	29	2,162	12	690	3	636	2
Subsidy for Institutions	5	5	116	1	-	-	163	1	46	0
Inter-governmental Fiscal Transfer	3	3	100	1	1,301	7	1,958	7	1,016	4
Capital Construction	1	1	819	9	1,525	8	2,323	9	4,989	17
Capital Goods	15	16	796	9	1,254	7	4,917	19	2,323	8
Total	**94**	**100**	**9,256**	**100**	**18,655**	**100**	**26,289**	**100**	**28,917**	**100**

Source: SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22

Over the years, the share of medicine purchases in PG health budgets has decreased, from 9% in FY 2017/18 to 3% in FY 2021/22. Capital construction is increasing, from 1% in FY 2017/18 to 17% in FY 2021/22. However, PG health budgets have a declining share of capacity building. This could be because the majority of activities under this line item are being transferred to LLs.

5.2.7 Percentage Allocation of Health Budget at PG by Chart of Activities

Table 5.2.7 shows health budget allocation at provincial level by chart of activities. Over the years, the majority of the health budget at provincial level has been allocated to administration, HR and office management, followed by the RMNACH and nutrition programme.

Table 5.2.7: Percentage Allocation of Health Budget at Provincial Level by Line Item/Economic Code (Amount in NPR millions)

Chart of Activities (Health Cluster)	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Administration, HR & Office Management	20	21	1,707	18	6,408	34	3,226	12	4,739	16
RMNCAH & Nutrition	20	21	2,408	26	3,499	19	3,273	12	3,867	13
FCHV & Community Health Programmes	5	5	225	2	1,203	6	442	2	460	2
Communicable, Infectious Disease, & Epidemic Control	13	14	654	7	869	5	498	2	649	2
Non Communicable Diseases & Human organ transplant	1	1	218	2	342	2	531	2	1,049	4
Eye & Other Health Services	2	2	75	1	61	0	41	0	100	0
Social Health Protection Services	1	1	245	3	291	2	307	1	446	2
Laboratory and Diagnostic Services	5	5	114	1	136	1	3,833	15	305	1
Academy and Hospitals	-	-	757	8	570	3	464	2	602	2
Health Education and Information	3	3	130	1	344	2	203	1	466	2
Ayurveda and Alternative Medicines	4	4	495	5	369	2	1,847	7	4,016	14
Free drug purchase, drug regulation and supply chain management	14	14	851	9	2,543	14	3,970	15	1,745	6
Health Research and Surveys	-	-	28	0	18	0	49	0	13	0
Physical Infrastructure Development and Improvement	9	9	1,350	15	2,001	11	2,628	10	2,990	10
COVID-19 response	-	-	-	-	-	-	4,976	18.93	7,470	26
Total	**94**	**100**	**9,256**	**100**	**18,655**	**100**	**26,289**	**100**	**28,917**	**100**

Source: SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22

Interestingly, the budget for Ayurveda and alternative medicine increased from 4% in FY 2017/18 to 14% in FY 2021/22. In FY 2019/20, PGs did not receive or allocate budget under the programme

heading. This implies that PGs might have disbursed funds for the COVID-19 response under different headings, which could not be traced following completion of the activities. In FY 2020/21, almost 19% of the budget was allocated for COVID-19 response in provinces, increasing to 26% in FY 2021/22.

5.3 Budget Analysis for Local Governments

This section features analysis of the health sector budget at the LL only. To be able to provide eligible information, the data for LLs is aggregated at province level.

5.3.1 Total Budget and Expenditure at Local Level

Table 5.3.1 shows total budget and expenditure at local level. Over the years, the total budget allocated to LLs has increased, except in FY 2021/22. However, the absorptive capacity of LLs has decreased, from 84% in FY 2017/18 to 73% in FY 2020/21. This can be attributed to the COVID-19 outbreak.

Table 5.3.1: Total Budget and Expenditure at Local Level (Amount in NPR millions)

Name of Province	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Province-1	47,273	87	68,696	85	70,033	84	89,653	75	89,422
Madesh Pradesh	41,972	75	63,808	72	66,380	73	89,545	70	86,720
Bagmati	51,929	82	81,317	77	93,130	74	124,195	66	126,936
Gandaki	29,806	88	41,520	85	41,957	81	54,950	75	54,990
Lumbini	41,559	87	58,316	82	63,869	80	81,426	76	78,732
Karnali	22,129	87	29,418	79	29,207	85	41,734	79	39,668
Sudurpaschim	28,409	88	39,526	86	39,744	87	51,332	82	46,750
Total	**263,078**	**84**	**382,602**	**80**	**404,319**	**79**	**532,836**	**73**	**523,218**

Source: SUTRA FY 2017/18–FY 2021/22, and FCGO's consolidated financial statements, FY 2017/18–FY 2019/20

Total budget allocation declined in FY 2021/22, except in Bagmati and Gandaki provinces. All other provinces, except for Karnali and Sudurpaschim, report a steady decline in absorptive capacity over the years.

5.3.2 Total Health Budget and Expenditure at Local Level

Table 5.3.2 shows the total health budget at the local level. Over the years, the total health budget allocated by LL has increased, except for a slight decline in FY 2021/22. The absorptive capacity of LLs regarding the health budget has been improving, though there was a sudden dip in FY 2019/20 to 71%, compared to 78% in FY 2018/19. This can be attributed to the COVID-19 outbreak, although the absorptive capacity did improve in FY 2021/22 compared to FY 2019/20.

Table 5.3.2: Total Health Budget and Expenditure at Local Level (Amount in NPR millions)

Name of Province	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Province-1	3,050	60	4,379	70	5,873	67	5,884	76	5,889
Madesh Pradesh	4,329	55	4,804	75	6,324	74	6,104	84	5,780
Bagmati	3,550	74	4,357	79	5,825	72	7,733	70	7,949
Gandaki	2,180	87	3,080	77	3,536	66	3,677	72	3,936
Lumbini	3,260	63	4,351	81	5,171	66	5,730	77	5,350
Karnali	2,301	73	2,055	93	2,997	75	3,109	83	2,978
Sudurpaschim	2,415	71	3,119	82	3,550	75	4,029	84	3,560
Total	**21,085**	**67**	**26,146**	**78**	**33,277**	**71**	**36,265**	**77**	**35,444**

Source: SUTRA FY 2017/18–FY 2021/22, authors' estimate using information from Palikas and FCGO's consolidated financial statements, FY 2017/18–FY 2019/20

Bagmati and Gandaki are the only provinces with a steady increase in health budget over the years. The absorptive capacity of the health budget for all provinces except for Bagmati improved in FY 2021/22 compared to FY 2019/20.

5.3.3 Percentage Allocation of Health Budget at Local Level

Table 5.3.3 shows health budget allocation at local level by internal income and transfer/grant from the FG and PGs. Over the years, the share of internal sources in health budget allocation has increased from 12% in FY 2017/18 to 17% in FY 2021/22. This increase can be attributed to the COVID-19 outbreak.

Table 5.3.3: Percentage Allocation of Health Budget at Local Level by Internal Income and Transfer from the FG and PGs (Amount in NPR millions)

Name of Province	FY 2017/18			FY 2018/19			FY 2019/20			FY 2020/21			FY 2021/22		
	Budget	Internal Income	Transfer FG & PG	Budget	Internal Income	Transfer FG & PG	Budget	Internal Income	Transfer FG & PG	Budget	Internal Income	Transfer FG & PG	Budget	Internal Income	Transfer FG & PG
Province-1	3,050	11	89	4,379	11	89	5,873	10	90	5,884	12	88	5,889	15	85
Madesh Pradesh	4,329	13	87	4,804	14	86	6,324	12	88	6,104	11	89	5,780	12	88
Bagmati	3,550	12	88	4,357	10	90	5,825	15	85	7,733	26	74	7,949	31	69
Gandaki	2,180	9	91	3,080	10	90	3,536	7	93	3,677	9	91	3,936	13	87
Lumbini	3,260	12	88	4,351	9	91	5,171	12	88	5,730	20	80	5,350	18	82
Karnali	2,301	10	90	2,055	9	91	2,997	9	91	3,109	7	93	2,978	9	91
Sudurpaschim	2,415	13	87	3,119	12	88	3,550	10	90	4,029	9	91	3,560	10	90
Total	**21,085**	**12**	**88**	**26,146**	**11**	**89**	**33,277**	**11**	**89**	**36,265**	**15**	**85**	**35,444**	**17**	**83**

Source: SUTRA FY 2017/18–FY 2021/22, authors' estimate using information from Palikas and FCGO's consolidated financial statements, FY 2017/18–FY 2019/20

LLLLs in Province-1, Madhesh Pradesh, Bagmati and Lumbini provinces have consistently allocated more than 10% of their internal income to their health budget over the years. In FY 2021/22, Bagmati province allocated almost 31% of its health budget from internal sources.

5.3.4 Percentage Allocation of Health Budget at Local Level by Budget and Programme Heading

Table 5.3.4 shows health budget allocation at local level by budget and programme heading. Over the years, most of the health budget has been allocated under recurrent headings. However, some increment in capital allocation can be observed, from 8% in FY 2017/18 to 17% in FY 2021/22.

Table 5.3.4: Percentage Allocation of Health Budget at Local Level by Budget and Programme Heading (Amount in NPR millions)

Budget Headings	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Total	% Allocation	Total	% Allocation	Total	% Allocation	Total	% Allocation	Total	% Allocation
By Recurrent and Capital										
Recurrent	19,460	92	24,266	93	29,849	90	33,025	91	29,359	83
Capital	1,625	8	1,880	7	3,428	10	3,240	9	6,085	17
Total	**21,085**	**100**	**26,146**	**100**	**33,277**	**100**	**36,265**	**100**	**35,444**	**100**
By Administrative & Programme										
Administrative	12,682	60	16,849	64	13,977	42	16,066	44	15,073	43
Programme	8,403	40	9,297	36	19,299	58	20,199	56	20,371	57
Total	**21,085**	**100**	**26,146**	**100**	**33,277**	**100**	**36,265**	**100**	**35,444**	**100**

Source: SUTRA FY 2017/18–FY 2021/22, authors' estimate using information from Palikas and FCGO report, FY 2017/18–FY 2019/20

During the early years of federalism, most of the health budget was allocated under the administrative heading, which since FY 2019/20 has tended towards the programme heading.

5.3.5 Percentage Allocation of Health Budget at Local Level by Type of Grant

Table 5.3.5 shows health budget allocation at local level by type of grant. Over the years, the majority of the health budget to LLs has been funded through federal grants, the share of which decreased from 94% in FY 2017/18 to 80% in FY 2021/22.

Table 5.3.5: Percentage Allocation of Health Budget at Local Level by Type of Grant (Amount in NPR millions)

	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
Types of Grant	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Federal Grant	19,861.8	94	23,230.5	89	28,243.6	85	29,484.7	81	28,390.4	80
Province Grant	7.9	0.04	598.9	2.3	941.9	2.8	1,350.3	3.7	868.0	2.4
Local - Other Grant	-	-	1.0	0.0037	-	-	-	-	-	-
Revenue Sharing	21.0	0.1	1,104.7	4.2	2,067.4	6.2	2,080.0	5.7	2,541.7	7.2
Internal Source	237.8	1.1	1,126.7	4.3	2,010.5	6.0	3,335.8	9.2	3,641.2	10.3
Foreign	948.6	4.5	71.2	0.3	10.5	0.03	10.5	0.03	1.9	0.01
Public Participation	8.0	0.04	12.7	0.05	2.6	0.01	3.7	0.01	0.4	0.001
Total	**21,085**	**100**	**26,146**	**100**	**33,277**	**100**	**36,265**	**100**	**35,444**	**100**

Source: SUTRA FY 2017/18– FY 2021/22, authors' estimate using information from Palikas and FCGO's consolidated financial statements, FY 2017/18–FY 2019/20

Interestingly, internal sources have emerged as an important source of funding for LLs in health, increasing from a 1% allocation in FY 2017/18 to 10% in FY 2021/22. However, public participation in LL health budgets is negligible. Similarly, the share of foreign funding of health budgets has been decreasing.

5.3.6 Percentage Allocation of Health Budget at Local Level by Line Item/Economic Code

Table 5.3.6 shows health budget allocation at local level by type of grant. Over the years, the majority of the health budget at LL has been allocated under salaries and wages, followed by programme activities. It is interesting to observe that the share of capacity building has also decreased in the LL health budgets. This implies two things: either allocation in capacity building is actually decreasing, or there is an error in budget coding at the local levelLL. Over the years, the share of medicine purchases in LL health budgets has remained constant, at 5% or less.

Table 5.3.6: Percentage Allocation of Health Budget at Local LeveLL by Economic Code (Amount in NPR millions)

Economic Code/ Line item	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Wages & Salaries	11,120	53	10,027	38	12,596	38	12,646	35	14,282	40
Support Services	1,312	6	849	3	1,634	5	2,053	6	1,970	6
Capacity Building	276	1	301	1	171	1	178	0	235	1
Program Activities	2,564	12	11,229	43	8,817	26	10,506	29	10,987	31
Medicine Purchases	799	4	424	2	1,508	5	1,526	4	1,726	5
Social Service Grants and Social Security	2,441	12	413	2	1,192	4	1,180	3	783	2
Subsidy for Institutions	82	0	170	1	693	2	762	2	838	2
Inter-governmental Fiscal Transfer	883	4	198	1	646	2	871	2	441	1
Capital Construction	1,207	6	2,001	8	4,696	14	5,328	15	2,781	8
Capital Goods	402	2	533	2	1,325	4	1,214	3	1,402	4
Total	**21,085**	**100**	**26,146**	**100**	**33,277**	**100**	**36,265**	**100**	**35,444**	**100**

Source: SUTRA FY 2017/18–FY 2021/22, authors' estimate using information from Palikas

5.3.7 Percentage Allocation of Health Budget at Local Level by Chart of Activities

Table 5.3.7 shows health budget allocation at local level by chart of activities. Over the years, the majority of the health budget at local level has been allocated to administration, HR and office management, followed by the RMNACH and nutrition programme.

Table 5.3.7: Percentage Allocation of Health Budget at Local Level by Chart of Activities (Amount in NPR m)

Chart of Activities (Health Cluster)	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation	Budget	% Allocation
Administration, HR & Office Management	10,590	66	13,089	62	15,486	51	16,667	46	20,578	55
RMNCAH & Nutrition	3,019	19	3,147	15	4,619	15	4,738	13	5,647	15
FCHV & Community Health Programmes	990	6	1,631	8	1,333	4	1,323	4	1,768	5
Communicable, Infectious Disease, & Epidemic Control	187	1	535	3	632	2	467	1	583	2
Non Communicable Diseases & Human organ transplant	5	0	48	0	108	0	155	0	504	1
Eye & Other Health Services	77	0	70	0	80	0	103	0	132	0
Social Health Protection Services	155	1	68	0	194	1	291	1	428	1
Laboratory and Diagnostic Services	6	0	61	0	143	0	261	1	341	1
Academy and Hospitals	0	0	3	0	80	0	40	0	45	0
Health Education and Information	121	1	105	0	221	1	348	1	382	1
Ayurveda and Alternative Medicines	167	1	354	2	638	2	886	2	226	1
Free drug purchase, drug regulation and supply chain management	553	3	1,567	7	1,508	5	2,594	7	3,560	10
Health Research and Surveys	-	-	-	-	1	0	0	0	3	0
Physical Infrastructure Development and Improvement	203	1	513	2	3,771	12	4,302	12	1,473	4
COVID-19 response		-		-	1,806	6	4,015	11	1,554	4
Total	**16,072**	**100**	**21,192**	**100**	**30,620**	**100**	**36,189**	**100**	**37,224**	**100**

Source: SUTRA FY 2017/18–FY 2021/22, authors' estimate using information from Palikas

The budget for "free drug purchase, drug regulation and supply chain management" has increased over the years, from 3% in FY 2017/18 to 10% in FY 2021/22. In FY 2019/20, Palikas received 6% of the budget for COVID-19 response activities, increasing to 11% in FY 2020/21, and going back down to 4% in FY 2021/22. It is worth noting that this is an analysis of the identified activities, and does not not include information on activities funded through the Local Level Disaster Management Fund, which includes a COVID-19 fund.

Chapter 6: Analysis of FMoHP Budget FY 2021/22

This chapter provides a detailed analysis of the budget allocated for FMoHP only. It captures the budget upto FY 2021/22 and expenditure upto FY 2020/21. FMoHP's financial monitoring report (FMR), verified with the FCGO's Financial Management Information System (FMIS), is the source of expenditure and the final adjusted budget. It should be noted that the budget mentioned for FY 2019/20 in the last BA produced in 2021 report differs from the budget in this report because the adjusted budget is used in the this BA report. This practice applies across this report.

6.1 FMoHP Budget and Expenditure by Capital and Recurrent Classifications

Table 6.1 shows that there is almost a two-fold increase in the volume of the capital budget, from NPR 7.4 billion in FY 2017/18 to NPR 15.1 billion in FY 2020/21. This increase reflects GoN's policy commitment to build health infrastructure. The percentage allocation of the capital budget actually decreased from 22% in FY 2017/18 to 14% in FY 2021/22, which is may be due to increased resources required for COVID-19 vaccinations. At the same time, the recurrent budget increased almost 8 percentage points from 86% in FY 2016/17 to 78% in FY 2021/22.

Table 6.1: Budget and Percentage Expenditure by Capital and Recurrent (Amount in NPR billions)

Budget Type	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Capital	7.4	90.8	8.6	68.4	9.3	77.5	15.1	49.5	13.9
Recurrent	26.0	79.6	20.8	89.6	29.7	80.5	47.1	72.3	87.1
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

The data suggest that absorption of the recurrent budget is better than that of the capital budget, except in FY 2017/18,[11] peaking at 90% in FY 2018/19. One of the reasons could be because a significant proportion of the recurrent budget is used for administrative expenditures, including salaries and allowances, whereas the capital budget is subject to procurement delays. In FY 2020/21, only half of the capital budget could be absorbed and only 72% of recurrent budget was spent, which could be mainly due to COVID-19. Compared to FY 2019/20, budget absorption in FY 2020/21 decreased further.

6.2 FMoHP Budget and Expenditure by GoN and EDPs

Table 6.2 shows the share of GoN and EDPs in FMoHP's budget and expenditure. Between FY 2017/18 and FY 2021/22, government contribution to FMoHP's budget fluctuated between 77% and 38%. This sharp drop was followed by a recovery to 52% in FY 2021/22. The share of EDPs in FMoHP's budget was below 23% in FY 2017/18, and increased to 33% in FY 2018/19. This was mainly because EDP budgets continue to fund/reimburse FMoHP's activities only, while government sources were channeled as conditional grants to PGs and LLs. In FY 2020/21, EDPs' share in FMoHP's budget increased to 62%, mainly to respond to COVID-19. Still, 48% of FMoHP's budget was supplied by EDPs in FY 2021/22.

[11] In FY 2017/18 there was almost 91% absorption of the capital budget. This is due to an additional NPR 1 billion for building construction expenditure being provided by the Ministry of Urban Development to FMoHP.

Table 6.2: Budget and Percentage Expenditure by Source of Fund (Amount in NPR billions)

Budget Source	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
GoN	25.5	84.5	19.4	88.7	28.8	78.5	23.8	71.8	52.5
EDPs	7.8	74.2	9.9	73.1	10.2	83.4	38.5	63.6	48.5
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

Government budget absorption for the last two years has remained at 85% and above, with around 79% absorption in FY 2019/20. At the same time, EDP's budget absorption has shown significant improvement, at almost 84% in FY 2019/20, which is the highest ever recorded. This could be due to improved reporting practices from EDPs, mainly the capture of direct funding. In FY 2020/21, FMoHP and EDP absorption declined compared to previous years, which can be attributed to COVID-19 response.

6.3 FMoHP Budget and Expenditure by Administration and Programme

Table 6.3 shows FMoHP budget allocated under administrative and programmes. In FY 2017/18, almost 10% of FMoHP's budget was allocated under administration, which went down to 4% in FY 2018/19. This is mainly because salaries and other administrative expenses have been allocated to PGs and LLs through conditional grants. However, an increase in the administrative budget is observed in FY 2019/20 and FY 2020/21 at 8%, which however decreased to 4% in FY 2021/22.

Table 6.3: Budget and Percentage Expenditure by Administrative and Programme (Amount in NPR billions)

Budget Heading	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Admin	3.2	87.4	1.3	80.6	3.2	65.1	5.2	49.2	4.1
Program	30.1	81.5	28.1	83.5	35.8	81.1	57.0	68.3	96.9
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

Until FY 2018/19, FMoHP's administrative and programme absorption was more than 80%. However, since FY 2019/20, both administrative and programme budget absorption has been decreasing, with administrative budget absorption as low as 49% and programme budget absorption at 68% in FY 2020/21. This can be attributed to the effect of COVID-19.

6.4 FMoHP Budget and Expenditure by Government, Pool Fund and Direct Funding

The GoN's Red Book mainly covers government funds and contributions from EDPs in the form of direct and pooled funds. Table 6.4 shows that there is no clear trend for the share of pool and direct funding in the FMoHP budget. Until FY 2019/20, direct funding remained at 11% and below, until a sudden jump to 46% was observed in FY 2020/21 followed by a dip to 37% in FY 2021/22. Pool fund contributions remained at 11% of the FMoHP budget for FY 2021/22.

Table 6.4: Budget and Percentage Expenditure by Government, Pool and Direct Funding (Amount in NPR billions)

Budget Source	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
GoN	25.5	84.5	19.4	88.7	28.8	78.5	23.8	71.8	52.5
Pool Fund	4.4	82.1	6.6	83.5	6.1	83.2	9.7	43.5	11.5
Direct fund	3.4	63.8	3.3	51.9	4.1	83.7	28.7	70.4	37.1
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

It is important to note that expenditure reporting under direct funding, which used to be weak, has dramatically improved. In FY 2020/21, absorption of direct funds appeared to be equivalent to GoN's absorption.

6.5 FMoHP Budget and Expenditure by Organisational Level

Until FY 2016/17, DoHS took up a major part of the FMoHP budget. Since FY 2017/18, budget allocation within FMoHP cost centres like DoHS, DDA, the Department of Ayurveda (DoA) and Centers has been slowly decreasing, which is mainly because the majority of health activities have been devolved to the local level, and later to PGs.

The budget to FMoHP as a spending unit appears to have drastically increased, from NPR 4.2 billion to NPR 74.3 billion, between FY 2017/18 and FY 2021/22. In FY 2021/22, FMoHP as a spending unit took up almost 74% of the FMoHP budget, followed by DoHS (11%) and insurance (7%). Compared to FY 2019/20, percentage budget allocations for hospitals and academy decreased in FY 2021/22. The budget for DoA has increased, from NPR 0.6 billion in FY 2017/18 to NPR 0.2 billion in FY 2021/22. This is mainly because the majority of the DoA activities have been devolved to LLs.

Table 6.5: Budget and percentage expenditure by FMoHP Organisations (Amount in NPR billions)

Organisations	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
FMoHP	4.2	84.9	10.7	75.5	13.9	69.1	33.2	52.5	74.3
DoHS	18.4	80.2	7.3	84.8	7.2	78.5	7.3	68.0	8.7
DDA	0.1	76.4	0.2	71.1	0.2	47.7	0.2	59.1	0.2
DoA	0.6	83.7	0.4	71.8	0.4	74.5	0.2	63.8	0.2
Centres	3.0	67.7	1.7	78.2	1.7	75.6	1.9	78.7	1.8
Hospitals	2.5	94.5	2.4	99.4	3.8	94.2	3.4	90.0	2.9
Health Insurance Board	1.8	73.5	3.4	82.1	5.2	89.6	7.5	98.1	7.5
Council	0.11	99.9	0.11	100.0	0.11	83.6	0.16	46.4	0.2
Academy	2.6	99.9	3.2	99.8	6.5	89.9	8.4	82.2	5.2
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

Compared to hospitals, which have been able to sustain more than 90% absorption throughout, the budget absorption of the Council and Academy has declined. However, significant improvement have been noticed in the absorption capacity of the Health Insurance Board. In FY 2020/21, among FMoHP's spending units, the Health Insurance Board was highest in absorbing the allocated budget

(98%), followed by hospitals (90%), whereas the Council recorded the lowest absorption (46%), followed by FMoHP (53%).

6.6 FMoHP Allocation and Expenditure by EHCS, System Support and Beyond EHCS

Essential health care services (EHCS) are a priority for FMoHP, and account for a majority of its budget. This is in line with NHSS recommendations. The systems' component are recorded between 10% to 21%. Over the years, the percentage allocation of EHCS has fluctuated between 63% and 44%. Between FY 2020/21 and FY 2021/22, "beyond EHCS" recorded a sudden rise in the share of FMoHP's budget from 43% to 45%. At the same time, system components[12] had the lowest allocation in FMoHP's budget, at 10%.

Table 6.6: FMoHP budget and percentage expenditure by EHCS, beyond EHCS and systems support (Amount in NPR billions)

	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
EHCS	20.0	76.6	17.5	86.5	17.3	81.9	27.3	74.7	63.2
Beyond EHCS	6.5	94.0	6.6	78.8	17.9	85.8	26.6	75.1	19.1
System Components	6.8	86.6	5.3	78.8	3.9	42.2	8.3	13.5	18.7
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**9.4**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

In FY 2021/22, both EHCS and "beyond EHCS" had the lowest absorption at 75%. Compared to FY 2018/19, budget absorption for system components went down dramatically, from 79% to 42% in FY 2019/20 to 14% in FY 2021/22. This can be attributed to the diversion of the budget to the COVID response.

6.7 FMoHP Allocation and Expenditure by Priority Programme

Table 6.7 shows the FMoHP budget in NPR and the percentage of the budget spent by the different levels of priority programmes. Priority 1 programmes are those with the highest priority assigned by the National Planning Commission (NPC). Over the years, Priority 1 programmes have been allocated more than 75% of FMoHP's budget. In FY 2018/19, GoN abolished the P3 priority level.

Table 6.7: FMoHP budget and percentage expenditure by programme priority (Amount in NPR billions)

Priority	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
P1	26.6	79.2	22.9	79.7	30.3	76.0	53.6	63.3	94.5
P2	6.0	94.9	6.5	96.5	8.7	92.9	8.6	88.1	6.4
P3	0.7	79.8	-	-	-	-	-	-	-
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

Compared to FY 2018/19, the share of P1 programmes in FMoHP's budget increased from 77% to 86% FY 2020/21 and absorption decreased from 79% to almost 63%.

[12] System components include decentralised service delivery, private/NGO sector development, sector management, health financing/ resource management, logistics, human resource development and information system management.

6.8 FMoHP Budget and Expenditure by Line Item

Table 6.8 shows the budget allocated and percentage spent on the main budget line items. The data show that, for the budget allocated between FY 2017/18 to FY 2021/22:

- grants to hospitals have almost doubled since FY 2017/18, from NPR 14.6 billion to NPR 37.8 billion in FY 2021/22;
- the budget for capital construction has doubled between FY 2017/18 and FY 2021/22, from NPR 6.2 billion to NPR 13.2 billion;
- the budget for wages and salaries and capacity building has decreased since FY 2021/22;
- compared to FY 2020/21, the budgets under medicine purchases and programme activities increased in FY 2021/22, with the budget for the former more than quadrupling. This is mainly due to the purchase of COVID-19 vaccines.

Table 6.8: FMoHP Budget Line Budgets and Percentage Expenditure by (Amount in NPR billions)

Broad Line Item	FY 2017/18		FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22
	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget	% Exp	Budget
Wages & Salaries	1.6	78.9	0.6	89.0	0.5	97.1	0.9	89.4	0.8
Support Services	1.2	73.8	0.5	79.5	0.7	67.6	2.6	16.5	0.6
Capacity Building	0.7	74.0	0.2	76.2	0.1	36.0	0.1	35.5	0.1
Programme Activities	3.3	61.1	1.0	60.3	1.0	39.6	2.3	64.6	4.2
Medicine Purchases	4.5	64.2	3.5	87.0	5.8	77.3	9.9	79.6	43.6
Grants to Hospitals	14.6	89.4	14.9	92.8	21.6	83.6	31.3	74.8	37.8
Capital Construction	6.2	93.3	7.6	69.8	6.2	72.6	13.1	47.2	13.3
Capital Goods	1.2	78.2	0.9	56.1	3.2	87.0	2.0	65.4	0.6
Total	**33.3**	**82.1**	**29.4**	**83.4**	**39.0**	**79.8**	**62.2**	**66.7**	**101.0**

Source: Red Book, FY 2017/18–FY 2021/22

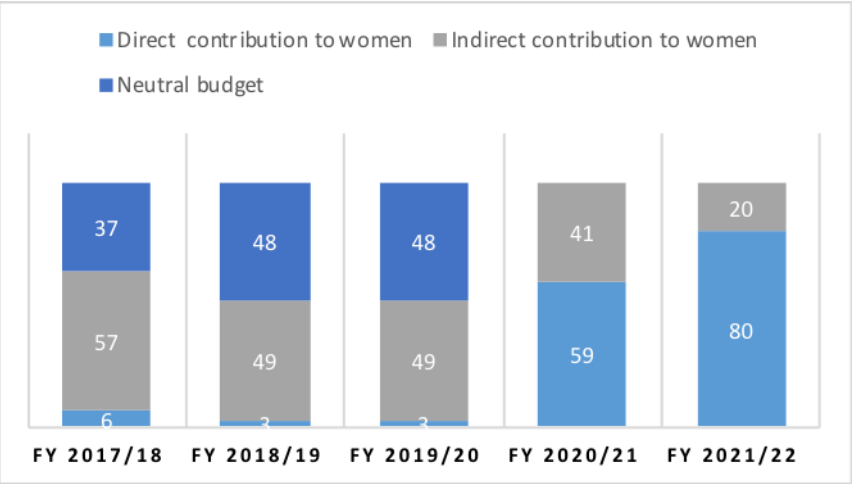
In FY 2020/21, FMoHP's overall expenditure performance was at its lowest, at 66.7%, compared to the previous three fiscal years. The main reason for this could be the onset of COVID and HR mobility across all spheres of government. The weakest performing line item was support services (16.5%), followed by capacity building (35.5%) and capital construction (47%). This could be mainly because training/workshops, service contracts and capital construction could not be implemented due to COVID-19. Hospital grants had a good rate of absorption that declined to 75% in FY 2020/21. In FY 2019/20, the top performer in terms of expenditure is wages and salaries (89%), followed by grants to hospitals (75%) and capital goods (65%).

6.9 FMoHP Budget Allocation for Women-focused Activities

FMoHP classifies its activities according to the Red Book categories of directly or indirectly contributing to women's health and these are well incorporated into the e-AWPB. The largest proportion of the FMoHP budget is taken up by programmes indirectly contributing to women's health (Figure 6.9). This is because the budget is aimed at both men and women of all ages and those living in different geographies. FMoHP includes a budget for curative, disease control, prevention, and promotional services. The budget of the Family Welfare Division (FWD) and some others are considered programmes directly contributing to women's health. Since FY 2017/18, FMoHP's share of budget directly contributing to women declined sharply from 6.3% to 2.5% in FY 2019/20. This is

mainly due to devolution of basic health services to LLs. The majority of basic health services include programme activities that directly contribute to women's health. In FY 2021/22, the neutral category was no longer valid and the share of budget directly contributing to women increased to 80%.

Figure 6.9: Percentage allocation of FMoHP's budget by contribution to women's health

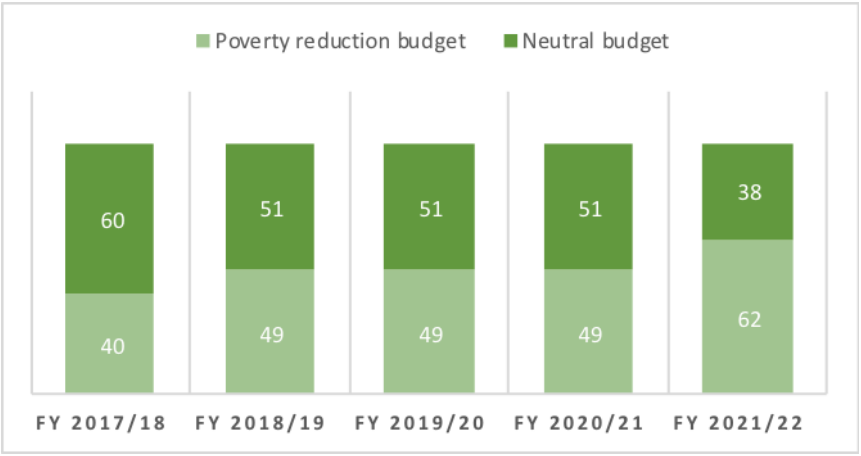


Source: Red Book, FY 2017/18–FY 2021/22

6.10 Budget Allocation by Poverty Reduction

The analysis looked at FMoHP's budget for poverty reduction. FMoHP refers to the Red Book to define activities contributing to reducing poverty. Figure 6.10 suggest that over the years, FMoHP's poverty reduction budget has increased from one third in FY 2016/17 to almost half in FY 2020/21. It should be noted that this just gives an indication and further work is required to accurately define the proportion of the FMoHP's budget that contributes to reducing poverty.

Figure 6.10: Percentage allocation of FMoHP budget by contribution to poverty reduction



Source: Red Book, FY 2017/18–FY 2021/22

6.11 Audit and Clearance

Table 6.11 shows the audit queries against the total audited amount under FMoHP.[13] Audit queries against audited expenditure is has increased, from 4.77% in FY 2018/19 to 7.69% in FY 2019/20. This

[13] *Does not cover autonomous hospitals, or PG and LG level analysis of audit queries.*

is mainly due to staff mobility, ambiguity in budget implementation guidelines and a lack of clarity in the procurement plan.

Table 6.11 Audit Queries against the Audited Expenditure (Amount in NPR thousands)

SN	Audit of Year	Audited Amount	Audit Queries	
			Amount	Percent (%)
1	2017/18	31,323,000	1,494,412	4.77
2	2018/19	19,637,600	1,321,766	6.73
3	2019/20	23,961,600	1,842,314	7.69
4	2020/21	Audit ongoing		

Source: OAG Annual reports

The audit for FY 2020/21 is ongoing and will be finalised by mid-April 2022.

6.12 Cumulative Audit Queries and Clearance

Table 6.12 shows total audit queries and their clearances over the years. It only includes FMoHP's audit queries and clearance. The table shows that the cumulative audit queries clearance has increased, from 36.88% in FY 2012/13 to 51.51% in FY 2015/16.

Table 6.12 Cumulative Audit Queries and Clearance (Amount in NPR thousands)

SN	Up to Fiscal Year (FY)	Cumulative Audit Queries	Clearance		
			FY	Amount	%
1	2017 Mid-July	3,639,688	2017/18	1,508,562	41.45
2	2018 Mid-July	4,773,332	2018/19	1,985,658	41.60
3	2019 Mid-July	4,282,086	2019/20	473,423	11.65
4	2020 Mid-July	5,261,456	2020/21*	1,122,959	21.43

*Source: Audit Queries Clearance Evaluation and Monitoring Committee Annual reports, *Audit clearance ongoing*

However, audit clearance has decreased since FY 2016/17. This could be due to structural changes, the functions of different governments, and transfer of account officers and office chiefs. Special attention should be given to clearing the cumulative audit backlog that has been observed due to structural transitions. In FY 2019/20, audit clearance was very low, mainly due to the COVID-19 pandemic.

This analysis shows that FMoHP received increased budget in comparison to the previous FY 2020/21. Additionally, due to the low absorptive capacity, FMoHP has surrendered budget to MoF for the COVID-19 response and redistributed budget to SNGs for conditional grant activities. However, absorption is low compared to the previous year. The budget allocation pattern shows an increasing trend in the capital budget. Further analysis is required to analyse to rationalise the need for increased infrastructure budget in health sector.

Chapter 7: Conclusion and Way Forward

7.1 Conclusion

The recent evidence on UHC suggests that lower and middle-income countries should spend at least 5% of their GDP on health, which translates to USD 86 (NPR 9,630) per capita. This analysis confirms that GoN health spending as a share of the GDP is far less (2.4% in FY 2020/21) than the desired level. The slight increase in GDP spending on health (compared to 2.2% in FY 2019/20) could be due to the COVID-19 response. Similarly, the health sector budget as a share of national budget (8.6% in FY 2021/22) falls short by 1.4% in achieving the NHSS target of 10% by 2022. Nonetheless, it is encouraging to observe per capita expenditure doubling from NPR 1,082 in FY 2014/15 to NPR 1,973 in FY 2020/21 (in constant terms). One of the key factors behind this was additional resource allocation to health from PGs and LLs. However, this analysis suggests that the current investment in health is not sufficient to achieve UHC or the health-related SDG targets by 2030.

Since FY 2017/18, a share of the health budget has been allocated to SNGs in the form of conditional grants. A large majority of the health budget remains at the federal level. More than three fourths of the health budget is allocated to SNGs under the programme heading. RMNACH and nutrition, FCHVs and community health programmes are major headings under which budget is allocated to SNGs through conditional grants. Government sources are the predominant source of funding health conditional grants. By NHSSP outcome indicator, almost all the budget for physical infrastructure development and improvement, health research and surveys, social health protection services, laboratories and diagnostic services, the academy and hospitals are allocated to the FG.

At the SNG level, provinces have been spending between 0.3% and 2.9% of GDP on health, which translates to NPR 384 to NPR 3,338 per capita spending in health in real terms. The health sector allocation against provincial budgets is between 5.8% and 10%. Over the years, the health budget has been increasing at the SNG level, and it is encouraging to observe that internal sources are emerging as an important source of funding. This is a positive message in terms of increasing the fiscal space for health. Federal conditional grants for LLs are also important. Most of the health budget is allocated under programme heading in PGs, and under salary and wages in LLs.

This analysis confirms that SNGs have started allocating health sector budgets using resources other than conditional grants, such as matching grants, special grants, revenue transfer and internal revenue. This suggests that there is fiscal space for health which can be tapped if appropriately utilised. Nepal's commitments in achieving UHC and the SDGs by 2030 largely depend on a dominant share of public funds. In the absence of well-functioning planning, budgeting and expenditure tracking systems, even increased resources for the health sector will not contribute in achieving the UHC and SDGs, although it is argued that that the conditional grant in health is a temporary modality until SNGs have built independent capacity to plan for their own health indicators. At the same time, most of the health conditional grant remains with the FG. There are no specific policy directives that provide the basis for determining the volume of health conditional grants to SNGs, which has led to issues of both allocative and technical efficiency. The concern of under and over allocation, including duplication, is the most cited challenge for health conditional grants. More importantly, it is time to discuss an exit plan for the conditional grant modality at the PG level as more than 60% of the health budget is financed through internal source. In the absence of proper policy guidance on health planning and budgeting at the SNG level, an opportunity to realize SDG targets could be missed.

Nepal has practiced a sector wide approach (SWAp) in health since FY 2005/06. One of the intentions of SWAp is to improve the budgetary commitment from the government. GoN has been increasing the share of the health budget over the years, although in FY 2019/20 some reduction was observed, mainly as a result of low revenue generated due to COVID-19. However, there was a slight improvement in FY 2021/22. In general, the absorptive capacity of the health sector has improved over the years, although it declined in FY 2020/21 due to COVID-19, and in FY 2021/22 the absorption was low (73%) compared to the national absorption rate (78%).

Over the five years of federalism, the FMoHP budget has tripled, from NPR 33.3 billion in FY 2017/18 to NPR 101 billion in FY 2020/21. This can be attributed to the COVID-19 response. However, the increase in budget for COVID-19 does not correlate with the increment in budget for COVID-19-related activity at the SNG level. The budget to FMoHP as a spending unit seems to have drastically increased, from NPR 4.2 billion to NPR 74.3 billion, between FY 2017/18 and FY 2021/22. Grants to hospitals have almost doubled since FY 2017/18, from NPR 14.6 billion to NPR 37.8 billion in FY 2021/22. This raises important questions regarding whether the current planning and budgeting process favours federalism. Despite a huge budgetary allocation, the absorptive capacity of FMoHP has declined, from 82% in FY 2017/18 to 67% in FY 2020/21. In reality, the budget absorption capacity for FMoHP has been weak over the years, given the fact that FMoHP surrenders some budget and some activities are reallocated to fund conditional grant activities in the provinces. Since the beginning of federalism, almost all the EDP budget channelled through the treasury has continued to fund the activities of FMoHP. More than 62% of the FMoHP budget was funded through EDPs in FY 2020/21, and this stood at 48% in FY 2021/22. This also provides an important basis to discuss the modality of EDP support in Nepal's health sector. The policies and programme of federal, provincial and local governments are not sufficiently aligned with their budgets. Nepal's health system still needs to practice the essence of federalism for which a dialogue need to be initiated. Support for this initiative will be needed from all levels of government, policy makers, programme planners, implementers and academia, as well as EDPs.

7.2 Way Forward

The Constitution of Nepal mandates health as a fundamental right of the people (GoN, 2015) and the National Health Policy 2014 aims to deliver these rights by ensuring equitable access to quality health care services for all (GoN, 2014). The evidence of other countries suggests that institutionalising the budget formulation process alone is not enough to respond to health needs. It should be coordinated with other important elements of overall public financial management reform, including MTEF, budget tracking system, cash management, financial information and progress reporting systems. The classification and organisation of a budget are centrally important issues when preparing sector budgets. Budget classifications serve to present and categorise public expenditure in finance law and thereby "structure" the budget presentation. They provide a normative framework for both policy development and accountability. While budget execution rules influence how money flows to the health system, the choice of budget classifications often pre-empts the underlying rules for budget implementation and thereby plays a pivotal role in actual spending. This BA of the health sector for the first five years of federalism has highlighted some key concerns in health federalism, which if timely addressed could support proper implementation. The following major policy areas should be further discussed at all level of governments, with FMoHP taking the lead role to kickstart the process:

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

- A costed national health financing strategy needs to be formulated through intensive and comprehensive discussions with provincial and local governments. This analysis revealed that provincial and local governments have increased their budgetary commitment in the first five years of federalism. Thus, a health financing strategic framework that is relevant to all spheres of government needs to be formulated.

- A conditional grant transitional plan should be prepared to sustain achievements and prevent widening disparity in health care delivery. It should clearly outline where additional support can be sought in securing required resources by provinces and Palikas that require the most resources. It should be noted that PGs and LLs 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 equality to health care delivery. At the same time, a discussion should be initiated around capacitating PGs to plan for conditional grant activities for their Palikas. This should facilitate the resolution of planning and budgeting issues with regard to health conditional grants.

- A new national health sector strategy needs to be developed based on a comprehensive analysis of the policies, guidelines and standard operating procedures used across the health sector. Clear outcome and output indicators related to disaster response, epidemics, public financial management and public procurement should be reflected in the new NHSS. It should be able to provide clear indicators and targets for the health sector at the SNG level, including targets for budget allocation.

- A comprehensive policy framework and standard operating procedures that support the preparation of budgets under equalisation, matching and special grants that is acceptable and applicable to all spheres of government need to be developed and endorsed. A specific institution with clear terms of reference at FMoHP and province level would help in initiating and institutionalising the process. In the future, this practise can be harmonised at local level.

- An electronic financial management information system that is able to track and consolidate health budget and expenditure at all spheres of governments is essential. Moreover, the tracking tool should be able to provide information on key health markers, such as gender and social inclusion (GESI), and maternal and child health. This type of system is important to capture actual government spending in health and also ascertain total health expenditure. An already existing FMIS tool such as TABUCS can be updated to capture income, budget and expenditure at all levels of government.

- FMoHP needs to shift from incremental line item-based budgeting to a goal-oriented performance-based or programme-based budgeting system. FMoHP needs to develop a better understanding of the efficiency of its different programmes and increase allocations for cost-effective interventions. An immediate step would be to institutionalise the existing performance-based grant agreement being piloted by FMoHP. A performnce based grant agreement policy with a monitoring framework that is applicable across all government hospitals is needed. The steering and technical committees can help to monitor the process of PBGA implementation and also determine the scope of scalability in both public and private hospitals. They will also standardise methodology, processes, indicators and agreements.

- The practice of delayed approval of annual health budgets because of the delay in sending budgets to SUs (especially in the provinces) remains a key challenge in the devolved context. As a result, there is a risk of failing to maintain financial discipline and providing timely health services to people. FMoHP should ensure complete implementation of the annual budget calendars which may help address the issue.

References

ADB (2021). Macroeconomic Update: Nepal. Asian Development Bank, Manila, Philippines.

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

GoN (2017). 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 (2015/16-2020/21). 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.

Mcintyre, D., Meheus, F. and Rottingen, J. A. (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.

FMoHP (2014/15-2018/19). Annual Work Plan and Budget. Federal Ministry of Health and Population, Kathmandu, Nepal.

FMoHP (2014/15-2017/18). Financial Monitoring Report. Federal Ministry of Health and Population, Kathmandu, Nepal.

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

FMoHP (2018). Transaction Accounting and Budget Control System. Federal Ministry of Health and Population, Kathmandu, Nepal.

MoF (2014/15-2016/17). Economic Survey. Ministry of Finance, Kathmandu, Nepal

MoFAGA (2018/19). Health Conditional Grant. Ministry of Federal Affairs and General Administration, Kathmandu, Nepal.

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.

ANNEX

Methodology elaborated

Overall

- Consolidated Financial Statements, FY 2017/18–FY 2019/20, Government of Nepal, Financial Comptroller General Office, Anamnagar, Kathmandu, Nepal.
    - Province and Local Government – Treasury Position: provides only total income and total expenditure of the provinces and the local governments.
- Intergovernmental Fiscal Transfer, FY 2017/18–FY 2021/22, Government of Nepal, Ministry of Finance, Singha Durbar, Kathmandu, Nepal.
    - Province and Local Government – Equalization, Conditional, Complementary, and Special Grant: provides only total budget figures by provinces and the local governments.
- Conditional Grant of Health Sector, FY 2017/18–FY 2021/22, Government of Nepal, Ministry of Finance, Singha Durbar, Kathmandu, Nepal.
    - Province and Local Government – provides budget allocation by activity level by provinces and the local governments.

Federal Government

AWPB

- FY 2017/18–FY 2021/22: Activity-wise Budget Entry
    - Line Ministry Budget Information System (LMBIS).
- FY 2017/18–FY 2021/22: Expenditure
    - Red Book, Ministry of Finance, Singha Durbar, Kathmandu, Nepal.
    - Financial Management Report (FMR) for the health sector expenditure.

Provincial Government

- AWPB
    - FY 2017/18–FY 2018/19: Sub-National Treasury Regulatory Application (SuTRA).
    - FY 2019/20–FY 2021/22: Provincial Line Ministry Budget Information System (PLMBIS).
- Activity-wise Expenditure
    - FY 2017/18–FY 2018/19: Transaction Accounting and Budget Control System (TABUCS) in Madhesh and Sudurpaschim Provinces. Remaining province expenditure was estimated based on the Consolidated Financial Statements and Provincial Red Book.
    - FY 2019/20: Provincial Government's Red Book and FY 2020/21: PLMBIS.

Local Government

- AWPB and Expenditure of health sector: Sub-National Treasury Regulatory Application (SuTRA)
    - FY 2017/18: 196 Palikas
    - FY 2018/19: 406 Palikas
    - FY 2019/20: 753 Palikas
    - FY 2020/21: 753 Palikas
    - FY 2021/22: 740 Palikas (as of October 20, 2021)
- The health sector budget and expenditure were estimated for the remaining Palikas for FY 2017/18 and FY 2018/19. The FCGO Consolidated Financial Statement (CFS) report, disaggregated into internal income and intergovernment fiscal transfer (excluding revenue sharing) was used for the estimation of missing data.
- In FY 2021/22, the health sector budget was estimated for the 13 Palikas based on the Palika budgets from previous years.