Health Sector

BACKGROUND

1. 1 Introduction

The overarching goal of development efforts in Nepal is poverty reduction as reflected in His Majesty's Government of Nepal's (HMGN) Poverty Reduction Strategy Paper (PRSP). Improving the health of the nation is a valid end in itself as well as a requirement for economic development. Evidence shows that increased investment in health has its most important economic effects on human and enterprise capital through a variety of pathways. Thus, investing in health is a key way out of poverty.

HMGN is committed to bringing about tangible changes in the health sector development process. The Second Long Term Health Plan, 1997-2017 (SLTHP) aims to provide equitable, gender sensitive and high quality health care for all the Nepalese people, especially the poor, women and other vulnerable groups. This is in line with the Poverty Reduction Strategy Paper and the Tenth Plan. The health sector's vision is:

"A health system in which there is equitable access to co-ordinated quality health care services in rural and urban areas, characterised by: self-reliance, full community participation, decentralisation, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population".[1]

1. 2 Overview of NDF 2002 and progress made

Despite the ongoing conflict and a number of bottlenecks in the country; the health sector has made significant progress since NDF 2002. The Ministry of Health (MoH) together with its External Development Partners (EDP), INGOs and the private sector collaborated to achieve commitments made during NDF 2002. The concept of categorisation of health care services as priorities one, two, and three was made and will have long term impacts all sectors of the population and consequences for resource allocation. Progress was made in the following key areas:

A. Policies / Strategy

1. "Health Sector Reform – An Agenda for Change" developed and approved
2. signed oEDPs, as well assharmonisationon analysedthe plan'shas been the xpenditure madeCommunity- based health insurance mechanisms aimed at the poor in selected districts are being pilot tested
3. A proposal for a master plan of Social Health Insurance in Nepal has been prepared in collaboration with the MoH and the International Labour Organisation.
4. Qualified 500 Maternal & Child Health Workers working in 500 Sub-Health Posts (SHPs) have been awarded ANM training scholarship by the MoH to be trained at high quality training centres under CTEVT
5. Policies on oral health, health care technology and health care waste management have been developed and are at various stages of implementation
6. The MoH has established a Management Change Unit, a Health Economics and Financing Unit and a Health Sector Reform Unit in order to facilitate the reform process
7. Policy analysis on health sector decentralisation has been completed and 1,072 SHPs have been handed over to local bodies
8. Private Hospital Services Regulatory Act was submitted to parliament but could not be passed as the parliament was dissolved. Efforts to get it approved by Royal ordinance are being made

B. Reproductive Health, Child Health and HIV/AIDS

[1] Second Long Term Health Plan, 1997

1. Gradual expansion Intra Uterine Contraceptive Device (IUCD), Voluntary Surgical Contraception (VSC) and other Family Planning methods service outlets
2. Provision for Safe Abortion Care made through the amendment of Nepal's Civil Code; Training guidelines have been formulated and are being used at both government and NGO facilities N
3. Nepal Medical Standard vol. II published for quality assurance in FP services
4. Micro nutrient supplementation for pregnant women introduced in 9 districts
5. Infant and young child feeding strategy finalised
6. EPI, nutrition and community based IMCI programs have been further strengthened
7. A neonatal health strategy was developed and has been approved by HMG
8. Five year (2002 – 2007) strategic plan as well as operational plan for HIV/AIDS finalised & implemented

C. Sector Management / others

1. Community drug program expanded to 32 districts.
2. Service delivery through private sector introduced.
3. EDPs co-ordination meeting taking place regularly to assist with harmonisation.
4. Needs based/ decentralised capacity building process has been initiated in order to enhance the local capacity of health workers and management committees.
5. Distance learning through electronic media initiated.
6. Existing rules and regulations have been reviewed and revised to make health service more effective.
7. Hepatitis B and anti rabies vaccine (ARV) services introduced free of charge.
8. Two new district hospitals in Syangja and Humla have been opened and made operational. The number of districts without hospitals has come down to 4 (Rolpa, Dolpa, Mugu & Kalikot).
9. Effective Tuberculosis treatment (DoTS) is available to 90% of the population.

Polio is virtually eradicated and certification from the Maternal and Neonatal Tetanus elimination program is almost completed. The Leprosy Elimination Program, 2003 has also made good progress and has been rescheduled for 2005. Anti-retroviral HIV/AIDS treatment has been initiated in a number of locations and EDPs' support in the health sector was readjusted to address the conflict situation.

2. TRENDS IN HEALTH STATUS

2.1 Health status

Nepal is estimated to be carrying one of the greatest disease burdens in South Asia. The main causes of death and disability in the country are infectious, maternal, and perinatal and nutrition related illness. Table 1 sets out the burden of disease in terms of overall mortality and in Disability Adjusted Life Years (DALYs). In the case of Nepal half of all deaths are caused by Group I category diseases, and half by a combination of Group II and III category diseases. Over two thirds of all DALYs are caused by Group I related problems and lead to the most deaths among poor communities. The on-going high prevalence of poor health is one of the main reasons why the poor remain poor.

Table 1: Comparison of "Deaths by Cause" and DALYs Lost by Cause[2]

Cause of Death	Cause-specific Deaths as % of All Deaths	DALYs Lost as % of All DALYs Lost
Group I: Infectious diseases and maternal, perinatal and nutritional problems	49.7%	68.5%
Group II: Non-communicable and	42.1%	22.8%

[2] Ministry of Health and World Bank, 1997, Burden of Disease Study

congenital problems		
Group III: Injuries and accidents	6.9%	8.7%
Unclassified	1.0%	0.0%

Source: Second Long Term Health Plan 1997-2017, pp 25, Ministry of Health, 1999

Communicable diseases, maternal mortality ratio (MMR of 539/100.000) and child health conditions account for two thirds of the disease burden. The emergence of HIV/AIDS has serious implications in terms of medicine and health care supply needs and has necessitated a major social mobilisation program to encourage safe behaviour. There is also the emergence of Japanese Encephalitis and re-emergence of Malaria, Kala-azar, and Tuberculosis.

The highest risk groups are children under five, particularly girl child. More than 50% suffer chronic malnutrition and stunting, forever crippling their potential for growth, development and productivity.[3] Although children under five years represent only 14% of the population, they account for over 50% of the total DALYs lost from all causes. Women aged 15 – 44 years experience 26% higher loss of DALYs than men in the same age group. Much of this excess loss is due to pregnancy and childbirth related problems.

Table 2: Current Health trends and expectations[4] [5]

Indicators	1991	1996	2001	2007 *	2017*
Infant Mortality Rate	108	79	64.4	45	34.4
U5 Mortality Rate	162	118	91.2	72	62.5
Maternal Mortality Ratio	515	539	539	300	250
Total Fertility Rate	5.1	4.6	4.1	3.5	2.5
Life Expectancy	54	57	60.4	65	68.7

Source: HMG's 10th Five Year Plan, DHS 2001& 2nd Long Term Health Plan
* Projected figures

Table 2 suggests that the overall health status of the Nepalese population improved in the nineties. The infant mortality rate (IMR) declined by 40% (from 108 to 64.4/1000 live births) and the fertility rate fell from 5.10% to 4.10%. Improvements in the overall health status is partially attributable to those changes contributed by other sectors which have improved living standards, education, agriculture, housing, water supply & sanitation, transportation, forestry and women's development.

As a result of the changing demographic and epidemiological profile of the country, non-communicable diseases like cardiovascular diseases, cancer, mental, oral health problems, and road traffic accidents are also increasing. With the increase in the life expectancy of the population, the number of elderly is also on the rise. Currently, over 6% of the population is over the age of 60 years. To address this, geriatric care facilities are needed.

Table 3: Regional socio-economic and health comparisons[6] (series from 2000 & 2001)

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[3] Nepal Micronutrient Survey, 1998.
[4] HMG's 10th Five Year Plan, DHS 2001
[5] 2nd Long Term Health Plan
[6] Note: HDI (Human Development Index) is a composite index wherein 1 represents the highest and 0 the lowest level of human development encompassing GDP per capita, literacy rates, school enrolment rates and life expectancy. GDI (Gender Development Index) uses indicators similar to the HDI's but compares the relative achievements of men and women

	Nepal (HDR)	Bhutan	India	Sri Lanka	Bangladesh
Population (million)	24.1	2.1	1033.4	18.8	140.9
GDP per capita (PPP, 2001)	1310	1412	2840	3180	1610
Gini Index	36.7%	NA	37.8%	34.4%	33.6
Human Development Index (HDI) 2001	0.499	0.511	0.590	0.730	0.502
GDP rank less HDI rank	8	5	-12	19	-
Gender Development Index (GDI)	0.479	NA	0.574	0.726	0. 496
Human Poverty Index (As %)	41.9%	-	33.1%	18.3%	42.6%
Per Capital Health Exp. (PPP 2000) US$	64	64	71	120	47
Audit Literacy Rate (>15 Yrs)	42.9%	47%	58.0%	91.90%	40.6%
Male	60.5%	-	69.0%	94.5%	49.6%
Female	25.2%	-	46.4%	89.3%	30.8%

Source: UNDP, Human Development Report 2003.

As seen from table 3, the socio-economic & health indicators in Nepal are low compared to other countries in the region with similar levels of socio-economic development.

2.2 Health disparity

Despite some gains in the overall health of the Nepalese population, wide health disparities still exist throughout the country. This is most evident between urban areas (life expectancy, 71 years) and rural areas (life expectancy, 58 years). The situation is particularly bad in hilly and mountainous areas, where access to health care is poor. For example, the average life expectancy for Kathmandu is 74.4 years, whereas it is only 37 years in Mugu. Approximately 21.8 % of the total population of the country is still dying before they reach the age of 40[7]. Similarly, health care technology and information technology are still lacking in the rural and remote districts which poses big challenge in accessing the health services.

Table 4: Mortality by Area of Residence

Area of Residence	Infant Mortality Rate	Under 5 Mortality Rate
Urban	50.1	65.9
Rural	79.3	111.9
Mountains	112.0	157.4
Hills	66.2	93.9
Terai (Plains)	80.8	112.8

Source: DHS 2001.

Although the life expectancy of women has improved in recent years, women's health is still not satisfactory. Gender disparities are striking during childhood and reproductive years. Over 90% of maternal deaths occur in rural areas with only 9.8% occurring in urban areas.[8] 75% of pregnant women in Nepal are anaemic, which not only contributes to maternal deaths but also adversely affects the entire growth and development of children.

Health service utilisation by marginalized groups within the population is low and evidence shows health disparities among various ethnic groups are wide.

[7] op cit. Ref 2

[8] Maternal Mortality and Morbidity, 1998

3. HEALTH SERVICE DELIVERY

3.1 Infrastructure

The 1991 Health Policy established one sub-health post in each VDC and one primary health care centre (PHCC) in each electoral constituency. The number of health institutions increased nearly four-fold from 1,098 in 1991/92 to 4,110 in 2002/03. Currently there are 3,132 sub-health posts, 705 health posts, 190 PHCCs/ Health centres and 83 hospitals throughout the kingdom. To date, there are 48,047 village-based Female Community Health Volunteers. Nepal's basic health infrastructure is linked all the way to the villages. In addition, the public, private and NGO sectors are providing preventive, promotive and curative health services. Similarly, 287 ayurvedic health facilities and one homeopathy and unani hospital are providing alternative health care options within the public sector.

At present the hospital bed to population ratio is 1 bed to 1,753 people. The public hospital beds to private sector hospital beds (Medical Colleges, NGO run hospitals and Private hospitals) ratio is 4:6 and the majority of private sector hospitals are concentrated in urban centres.

Efforts to provide essential drugs throughout the year at the community level are underway through the community drug program, but communities are expressing some mixed reactions to this scheme. In the majority of districts with CDP, funds have been accumulated, but it is necessary to work on practical exemption criteria in order to give access to the real poor.

To date, primary health care institutions only have concentrated on essential drugs use programs. Larger health care institution shave not. To improve the efficiency and effectiveness of this, it is equally important to introduce the essential drug use program in larger health institutions as well.

3.2 HRH Management

Staff vacancies and absenteeism are common – only 85% of sanctioned posts are filled and only 70% are manned. The shortage of physicians and dentists has lessened in recent years with the establishment of medical institutions in private sectors, but shortages in some categories of health personal persist and the total number of staff (30,214) in proportion to the population is low. The overall distribution of staff in terms of the mix of skills shows a deficiency in the middle technical grades. The MoH has recently started upgrading MCH workers by providing ANM scholarships to 500 VDCs. The plan is to place ANM in all VDCs of the kingdom to improve maternal health. As the MoH seeks to raise the skill level of its human resources and increase efficiency, opportunities to reduce the percentage of unskilled and semi-skilled labour in the total work force will be explored.

The MoH, as it moves to improve the efficiency and quality of health services, will need to introduce new policies and operational mechanisms to improve its ability to systematically manage the planning deployment, utilisation and development of its staff. In other words, the MoH will need to take a proactive position on human resource development (HRD). This is reflected in the MoH's Strategic Plan for Human Resources for Health, 2003-2017.

3.3 New role of MoH for Health Sector Reform

The Nepal Health Sector Strategy of 2002[9] has provisions for the review of current organisational arrangements. In contrast to its current role in service delivery, the MoH and central departments will need to move towards more decentralisation and private public partnerships. In order to do this the MoH

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[9] MoH, Health Sector Strategy: An Agenda for Change (Reform), 2002

will take on strategic planning, policy development, regulation, facilitation and financing responsibilities rather than the service delivery responsibilities. The contracting out services, such as safe motherhood in district hospitals, x-ray and laboratory diagnostic services, and security and cleaning services, will be accelerated.

3.4 EDPs support

There are more than a dozen major EDPs working in the health sector. Presently, many EDP-assisted projects lack clear linkages with national strategies, and the approach to external assistance remains fragmented. EDPs account for 40% of the health budget – whilst most expenditure is reflected in the Red Book, 90% of this is executed by the EDPs directly.

3.5 Expanding role of Private sector

The private sector, including "for profit" institutions and non-governmental organisations (NGOs) provide 60% of the total beds in the country. There are over 250 NGOs operating in the health sector, although about 60% work in the Central Region and only 8% work in the under-served Far- and Mid-Western Regions. The private sector ranges from sophisticated hospitals in Kathmandu to traditional healers and unqualified practitioners in the rural areas. Private care is becoming increasingly expensive and therefore most poor do not access this sort of healthcare. The quality of care available in the private sector however, is uncertain as no regulations and/or quality assurances exist; thus risks can be high and quality of care in relation to cost, low.

3.6 Effect of Conflict on Delivery of Health Services

The present conflict presents new challenges for the delivery of health services. First, while the provision of health services is generally non-contested, it is a challenge in some areas. Secondly, there are circumstances where both Maoists and security forces challenge health workers. Third, the continuation of the conflict may erode health gains as the rural poor's livelihood worsens. Finally, the conflict has increased the health care needs of victims from all sides; thus there is a need to increase medical supplies accordingly, especially in conflict areas.

The MoH will engage through proper channels to ensure conflict victims' right to access health care is met, including that of health workers to provide health care to all in need. Similarly free movement of health personnel and essential medical supplies has to be ensured by all concerned.

3.7 Areas of Co-operation & Collaboration

There are many areas where collaboration/co-ordination between HMG/MoH & EDPs is necessary to improve the health status of the population. Collaboration/co-ordination is needed at the community level, central/regional level, and at HMG/N and EDP policy level. It is worth noting that the Health Sector Strategy stresses the need for public private partnership (PPP) for health. All these scenarios demand close multi-sectoral collaboration in carrying out health activities. This in turn demands a clear understanding of the role and tasks to be performed at various levels along with the monitoring of achievements (See Annex 2). However, for the sake of brevity, only the major tasks that need to be addressed by HMG/N and EDPs are discussed here.

Tasks, that HMG/Nepal can accomplish independently:

- Revision of health policy (1991) and legislation
- Improved service delivery including the referral system
- Decentralised management of health institutions
- Formulation of comprehensive policy on decentralisation in Health Sector (clearly defining the role of the centre, region and district, as well as the private sector and NGOs)
- Infrastructure development (especially sub-health posts and health posts)

- ?? Improved drug supply system
- ?? Continued reform of Health Sector Management in relation to good governance, transparency, and human rights
- ?? Effective implementation of essential health care services
- ?? Development of guidelines, protocols and manuals as required
- ?? Develop norms, standards & accreditation systems for quality assurance in health care

Task, that HMG/Nepal can perform with support from EDPs:

- ?? Develop Human Resources for health including training, orientation, skill building
- ?? Provision of essential equipment and instruments
- ?? Provision of essential drugs, vaccines, contraceptives and other medical supplies
- ?? Capacity building for health financing including prepaid and insurance schemes
- ?? Behaviour change communication
- ?? Establishment of geriatrics health services
- ?? System for addressing global emergencies (e.g. SARS; Avian flue etc.)
- ?? Physical infrastructure development (district hospital and primary health care centres)
- ?? Implementation of health insurance schemes in selected areas
- ?? Improvement to environmental health (e.g. slum area, personal hygiene; water, Sanitation)
- ?? Disease control such as TB, Malaria, Kala-azar & HIV/AIDS
- ?? Prevention & management of trauma & accidents
- ?? Standardisation of traditional medicine

Tasks which need exclusive support from EDPs:

- ?? Establishment of IT in health services and related training (tele-medicine and tele-education)
- ?? School health programmes
- ?? Introduction of new vaccines such as JE, Hib
- ?? Mental health and oral health programmes
- ?? Tobacco control programme
- ?? Urban health programme
- ?? Disaster management strategies
- ?? Safe blood transfusion program

4. HEALTH FINANCING AND FINANCIAL MANAGEMENT

4.1 Economic and Social Benefits

Nepal is one of the poorest countries in the world with 86% of its population living in rural areas (CBS 2001). The Human Poverty Index (HPI) which measures the proportion of the population living on less than a dollar a day is about 38% in the country as a whole. The poorest areas are the Western Mountains, Mid-Western Mountains, Hills and Terai, and Far-western Mountains and Hills. Generally, mountains and Terai populations are poorer than hill area populations. The HPI for the rural areas is 41.4 compared to 23.9 for the urban areas.

A large proportion of the poor live far away from health facilities; 57% of households belonging to the wealthiest income group can reach a health facility within half an hour, whereas for poorest groups the figure is only 29%. The difference in utilisation of health services is reflected in per capita health expenditure, where the richest households spend 8.7% and the poorest households spend 3.2% of their household expenditure on healthcare.

There is growing evidence that strategic investments in the health sector contribute substantially to the economic development of a country. International studies suggest that each 10% improvement in life expectancy is associated with an increase in economic growth of about 0.3% to 0.4% per year, other

growth factors being the same[10]. The child mortality rate (risk of dying under five per 1000 live births) is also a highly significant[11] predictor of economic performance. This is illustrated by Nepal's high child mortality rate, which is matched by low per capita income of about US$ 250. Globally, it is estimated that an investment of US$ 34 per person per year is required in order to ensure the delivery of essential health care to all in need in order to stimulate economic development and reduce poverty.[12] Apart from the benefits from improved health status, investments in sustainable financing mechanisms could also help to alleviate the financial costs of poor health and also reduce time of work for those suffering from illness and their caretakers. Investment in the health sector strategy, for instance, is estimated to provide economic returns of 30% - 40%.

4.2 Health sector funding

Health services are financed in two main ways: through out of pocket user charges and from public expenditures. Although National Health Accounts are not yet produced on a regular basis, estimates suggest that private spending is at least $10 per capita whilst total public spending remains at just over $5 per capita. The current pattern of health expenditures leads to a highly inequitable distribution of health system utilisation and continued ill health. In the private sector the key issue is that funding is both inequitable and, frequently, ineffective. In the public sector the main issue is that finance has historically favoured urban areas while both demand and supply side barriers impede access amongst the rural poor.

4.3 Private (Out of pocket) spending

The regressive nature of user charges makes them an inferior mechanism for financing most health services since they impact most significantly on the unhealthy when their income is lowest: user charges are in effect a tax on ill-health. The result is that either households must shun health services when sick or risk impoverishment by paying for services. Evidence suggests that both occur. The probability of using a private hospital when sick amongst the richest quintile is double that of the poorest households[13]. At the same time out of pocket costs represent a substantial burden. A recent survey of household costs for maternal health care, for example, found that the average cost of a normal vaginal delivery at a health facility was more than 3.5 times the monthly household cash income for the poorest households[14]. Organisations such as WHO have consistently advocated for more pooled finance where out of pocket payments are channelled through insurance or pre-payment schemes[15].

In addition to the impact of user charges on equity, it is also likely that much private spending is ineffective or inappropriate. There is, for example, well-documented evidence of large-scale over-prescription of antibiotics by private pharmacies[16]. Problems are exacerbated by the lack of effective regulation of the private sector. Developing mechanisms for channelling an increasing proportion of private funding into services that are both effective and permit pooling could have a substantial impact on the performance of the health system.

4.4 Public expenditure on the health sector

In 2001/02 public spending per capita on the health sector was approximately NRs. 400 or US$ 5.1[17]. Around 50% of this spending is financed from central government revenues, 40% from contributions of

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[10] Evidence quoted in Sachs, J. (2001). Macroeconomics and Health: investing in health for economic development. Geneva, World Health Organisation.
[11] World Bank, World Development Report, 1993.
[12] Sachs 2001, ibid.
[13] Hotchkiss 1998, ibid.
[14] Borghi, J., T. Ensor, B. D. Neupane and S. Tiwari (2004). Coping with the burden of the costs of maternal health care. Kathmandu, Nepal Safer Motherhood Project, Options funded by DFID.
[15] WHO (2000). The World Health Report 2000, health systems: improving performance. Geneva, World Health Organisation.
[16] Wachter, D. A., M. P. Joshi and B. Rimal (1999). "Antibiotic dispensing by drug retailers in Kathmandu, Nepal." Tropical Medicine & International Health **4**(11): 782-788.
[17] HEFU (2003). Public expenditure review of the health sector. Kathmandu, Health Economics and Financing Unit, Ministry of Health, HMG Nepal.

EDPs and the remainder from State Owned Enterprises (SOEs), autonomous bodies, municipalities and district and village development committees. Most of this funding is allocated through the Ministry of Health (80%) but the Ministry of Finance, Defence (treatment of military and their families) and Supplies (supplying iodised salt to the public) also receive significant allocations (table 5).

Table 5: Health Spending by Line Ministries [18]

Line Ministries	Percentage of Total National Health Spending 1999/2000	
	1999/2000	2001/2002
Ministry of Health	85	82
Ministry of Finance	9	13
Ministry of Defence	2	2
Ministry of Supplies	2	1
Ministry of Home Affairs	1	1
Ministry of Education	1	1

Source: FIMS, FCGO 1999/200-2001/2002-Public Expenditure Review of the Health Sector, MOH, 2003

Over the past five years government allocations to the MoH have increased to around 5% of total government spending and are expected to rise further to 5.5% by 2005/2006. The fact that the allocation to MoH is rising faster than the Government's total budget can be taken as an indication of the Government's strong commitment to health. Ministry of Finance and National Planning Commission has adopted a policy not to reduce the budget allocated for Priority 1 projects (See Annex 1).

Table 6: Allocation of Government expenditure on health by priorities (NRs in million)

Priority Order	1999/2000		2000/2001		2001/2002	
Priority 1	2,511	58.0%	2,415	50.1%	2,538	49.9%
Priority 2	389	9.0%	417	8.7%	500	9.8%
Priority 3	1,406	32.7%	1,984	41.2%	2,048	40.3%
Total	**4,306**	**100.0%**	**4,816**	**100.0%**	**5,086**	**100.0%**

Source: FIMS, FCGO 1999/2000-2001/2002, Public Expenditure Review of the Health Sector, MOH, 2003

Table 6 is derived from functional allocation (regular and development) of the expenditure on health. Health Sector programme prioritisation began in NDF 2002 which was done retrospectively but needs revision of programme headings.

Table 7: Program Budget of Ministry of Health (NRs. In million)

Priority	2002/03 (2059/60)			2003/04 (2060/61)		
	HMG	**EDPs**	**Total**	**HMG**	**EDPs**	**Total**
P1	542	919	1461	601	1003	1605
%	42.2	68.0	55.4	42.84	69.11	56.20
P2	145	25	170	531	443	974
%	11.3	1.9	6.5	37.84	30.51	34.11
P3	597	407	1005	271	5	276
%	46.49	30.14	38.11	19.31	0.39	9.69
Total	1285	1351	2637	1403	1452	2856

Table 7 gives a better picture while using the programmes budget approach for analysis. Gradual increment in priority 1 programme and decreasing trend in P3 programmes is obvious. Two scenarios have been projected here in view of current political situation, absorptive capacity, need of introducing

[18] FIMS, FCGO 1999/200-2001/2002-Public Expenditure Review of the Health Sector, MOH, 2003

new programmes and expansion of quality health services focusing the underprivileged and marginalized population.

4.6 Areas of Cooperation & Collaboration:

Note : As this section is devoted to financing aspect, I suggest to take this section under section 3 as 3.6. Its placement here between the costing and financing topics is a bit misplaced editorially.

There are many areas where collaboration/coordination between HMG/MoH & EDPs is necessary to improve the health status of the population. The collaboration/coordination might be in the community level, at the central/regional level, among HMG/N and EDP level. Besides, the Health Sector Strategy stresses on public private partnership (PPP) for health. All these scenarios demand for close multi-sectoral collaboration in carrying out health activities. This in turn, demands for a clear understanding of role and tasks to be performed at various levels along with monitoring of achievements (See Annex 2). However, for present purpose, only the major tasks that need to be addressed by HMG/N and the EDP are discussed here.

Task, that HMG/Nepal can do on its own:
Revision of health policy (1990) and legislations
Improved service delivery including referral system
Decentralized management of health institution
Formulation of comprehensive policy on decentralization in Health Sector (clearly defining the role of Centre, Region, District as well as Private sector and NGOs)
Infrastructure development (especially Sub Health Posts, Health Posts)
Improved drug supply system
Continue reforming Health Sector Management in view of good governance, transparency, human rights
Effective implementation of essential health care services
Development of guidelines, protocols and manuals as per need

Task, that HMG/Nepal can perform with support from EDPs:
Develop Human Resources for Health including training, orientation, skill building
Essential equipment and instruments
Essential drugs, vaccines, contraceptives and other medical supplies
Capacity building for health financing including prepaid and insurance schemes
Behavior change communication
Establishment of geriatrics health services
Addressing Global Emergencies (e.g. SARS; Avian flue etc.)
Physical infrastructure development (district hospital and primary health care centers)
Implement Health Insurance in selected areas
Environmental Health (e.g. slum area, Neat Hygiene; Water, Sanitation)
Disease Control such as TB, Malaria, Kala-azar & HIV/AIDS
Road Safety

~~Tasks, which need exclusive support from EDPs~~
Establishment of IT in health services and training (telemedicine and tele education)
School health programme
Introduction of new vaccines such as JE, Hib
Mental Health and Oral Health Programme
Tobacco control
Urban Health
Natural Disaster Management

4.5 4.7 Costs of EHCS and the Financing Gap

?? One of the problems faced in estimating the resource gap is the underlying uncertainty in the costs of implementing the NHSP-IP's EHCS package. A range of estimates exists. An MDG costing report, which illustrates the higher end of the range, suggests US$ 12 per capita will be

needed for EHCS. At the lower end of the range, a World Bank commissioned report that conducted a more detailed zero-based costing of the NHSP-IP's prioritised EHCS program estimated costs to be around US$ 5.5 per capita. Globally, US$ 34 per capita is recommended for a minimum set of essential health care (Commission on Macroeconomics and Health).

?? Reasonable estimates of the unit costs of already successful EHCS services can be obtained from current expenditure data, although very few cost studies have been done to date. The cost of the complete EHCS package is being worked out. The funding gap for essential health programme is as below:

Table 8: Funding Gap for EHCS based on 2002/03 budget

Description	Required Resource	Available Resource	Resource Gap
Public Exp. In NRs. In million	20880	9302	11578
Public Expenditure In US $ in million	286	127	159
As a percentage of GDP	3.2	2.2	1
Per Capita Expenditure on Public Health	900	401	499
Per Capita Public Expenditure on Health	12.0	5.3	6.7

Source: HEFU, MoH

?? In the absence of a complete picture of resources and costs for EHCS during the medium term, it might be desirable at present to use US$ 12 per capita as the basis for calculating the resource need

?? The estimated unit cost of US$ 12 indicates a need of around US$ 910 million for 4 years. This shows a resource gap of approximately US$ 200 million per year. The resource gap is shown as below in Table 8

4.5.1 Assumption on calculating funding gap

Certain assumptions have been made while calculating the funding gap, these are namely:

?? Over 70% of available resources have been spent on EHCP, the same ratio will be used in the future

?? Costs in between MDGs costing gap (NPC) and EHCP costing gap (WB)

?? Government allocates 9% of its expenditure on health to close gap

for detail calculations see annex 4

4.5.2 Funding Gap for Health Sector (Scenario 1)

Scenario 1 has been calculated on the basis of US$ 12 per capita as recommended by WHO to fulfil the target set in the MDGs. It is expected that this scenario would be applicable when there is a conducive environment for development as resources increase substantially. Similarly, the management approach and policy reform of the MoH (centre, region and districts) would be further adjusted as discussed under section 3.3. This would require additional funding.

Table 9: Estimated funding gap for Health Sector (in million US$)

Description	2003 (base year)	2004	2005	2006	2007	Total
Total fund required	**669**	**769**	**885**	**1017**	**1170**	**3841**
Available fund (HMG + EDP)	**510**	**587**	**675**	**776**	**893**	**2931**
Funding gap	**159**	**182**	**210**	**241**	**277**	**910**
Percentage	**23.77**	**23.67**	**23.73**	**23.70**	**23.68**	**23.69**

4.5.3 Funding Gap for Health Sector (Scenario 2)

Scenario 2 has been calculated on the basis of US$ 5.1 per capita as recommended by the study conducted under the support of World Bank taking the year 2000 as base year. In this scenario the projection is made on incremental basis. The anticipation is that even in the ongoing conflict situation the projected resources can be utilised efficiently, as the current funding gap is too wide.

Table 10: Estimated funding gap for Health Sector (in million US$)

Description	2003	2004	2005	2006	2007	Total
Million NRs	**12,704**	**13,888**	**15,050**	**16,388**	**17,517**	**75,546**
Million US$	**176**	**193**	**209**	**228**	**243**	**1,049**
NRs per Capita	**514**	**550**	**583**	**621**	**651**	
US $ per Capita	**7.14**	**7.64**	**8.10**	**8.63**	**9.04**	
Share of GDP	**2.5%**	**2.6%**	**2.7%**	**2.8%**	**2.8%**	

Table 9: Resource Need and Meeting the Gap

Description	Required resource	Available resource		Resource gap
		Government	EDPs	
P1				
P2				
P3				
Total				

See Annex 1 for P1, P2 and P3 Programs

To be elaborated on amount of Foreign Aid received, expenditure pattern and problems encountered.

The implications of the tables (Scenario 1 & 2) given above entails the:

- Need for increased budget allocation for health
- Need for increased EDP funding support
- Need for increased private & NGO sector involvement
- Need for redirecting increased resources to reach the poor in rural and remote areas
- Need for the MoH should carry out a series of cost studies, both of current services and “best practices” to provide a more empirical basis for estimating the cost of a complete by working with the program managers.
- Need for the MoH to address need for community-based health insurance schemes with increased and well-targeted subsidies to pay the premiums of the poor as part of the overall health insurance and poverty alleviation program in the country.

5. ADDRESSING THE MILLENIUM DEVELOPMENT GOALS

Against the above backdrop of the current health sector situation in the country, Nepal remains committed to the MDGs as set out in HMG’s PRSP and its fiscal framework. Of the eight MDGs, three are directly related to health. The MDGs are incorporated into health expectations by 2017 (i.e. within the lifetime of the 2nd Long Term Health Plan).

The health related MDGs aim to (between 1990 – 2015):

- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS Malaria and Other Diseases

These MDG's can be met. Progress is largely due to the successful control of communicable diseases. Vaccination coverage has improved significantly over the last 10 years. The percentage of children age 12-23 months who have been fully immunised by 12 months of age increased from 37% in 1991 to 60% in 2001. Most of the gain was achieved from 1996 when coverage increased from 43%. Between 1996 and 2001, coverage with all three doses of DPT increased from 51 to 71% while complete polio coverage increased from 48 to 90% of children. The incidence of diarrhoea fell considerably in the last decade to 2.3 per child per year episodes in 2000 from 3.3 in 1990.

However, as there is already good coverage of immunisations, further reductions of child mortality through immunisation alone would be difficult. The 65% of the existing infant mortality (64 per 1000 live births) is attributed to deaths of newborn babies within the first 4 weeks of their lives (39 per 1000 live births). Such, high level of neonatal mortality is largely due to lack of easy access to basic maternal and neonatal health care by all those in need.

Evidence show that effective and affordable interventions prevent up to 80% of maternal and neonatal deaths. What is missing, however, are the resources and the will to scale up the already proven interventions, particularly in rural areas where 86% of Nepalese live. Addressing a major scale up in utilisation of skilled attendance at birth (currently only 13%) along with the essential obstetric and neonatal health care interventions is essential in order to impact on the two MDGs relating to child and maternal mortality.

Five areas have been identified in response to the HIV/AIDS epidemic namely vulnerable groups; young people; treatment, care & support; epidemiology, research & surveillance; and management & implementation of an expanded response. The currently available global fund for HIV/AIDS is under implementation.

Table 10: MDG Target between 1990 and 2015

Indicator	1990	2000	2015
1. Under 5 mortality			
Under 5 mortality rate (per thousand live births)	161.6 (1989)	91 (2001)	54
2. Maternal Health			
Maternal Mortality Ratio	850 (1988) 515 (1991)	539 (1996)	213 or 129
% deliveries attended by health provider (doctor/nurse)	7.4 (1991)	12.7	100
Contraceptive prevalence rate	24.1 (1991)	38.9 (2001)	58.2 (SLTHP)
3. HIV/AIDS, Malaria and TB Halt and Reverse the Spread of HIV/ AIDS, Malaria and other disease by 2015			
HIV prevalence rate among adults (15-49 years)	0	0.29 (1999)	0.29 *
Number of malaria cases per 100,000 people	115 (1992)	29 (1997)	26 *
Number of TB cases per 100,000 people	92.3 (1995)	106 (1998)	90 *

Source: HMGN/UNDP Progress Report Millennium Development Goals 2002
* suggested figures

Nepal's maternal mortality ratio (MMR) of 539 per 100 000 live births[19] is one of the highest in the region[20]. Ninety percent of maternal deaths occur in rural areas[21]. 67% of maternal deaths occur at home, while 11% die on the way to a health facility. Evidence shows that maternal mortality is higher if trained personnel do not attend deliveries. The leading cause of maternal death in such cases is due to postpartum bleeding. Nutritional anaemia during pregnancy (75% pregnant women are anaemic, Nepal Micronutrient Status Survey, 1998) is also a major contributor to maternal death. The other equally important factor of the existing high level of maternal death in rural communities is the lack of essential life-saving medical interventions available within 24 hours to women in such conditions. A WHO study shows that globally, women from the poorest households with income less than US$ 1 a day are at least 300 times more likely to die of maternal deaths than their better-off sisters.

A massive scaling-up of community-based essential obstetric care, including good contraceptive services and safe abortion care, through community-based skilled health personnel and referral services is essential if we are to attain the MDG on improving maternal health. Investing on maternal health also means saving a countless number of newborn babies. The estimated cost for providing an integrated package of life-saving safe motherhood interventions is about US$ 134 million for the period of 2003–2007.

In the absence of effective interventions, HIV/AIDS will rise to much higher levels and will become difficult to reverse by 2015, as mentioned in the MDGs.

The incidence of malaria has decreased dramatically from 115 per 100,000 of the population in 1992 to 29 in 2000, though the available annual statistics seem to fluctuate.

The tuberculosis programme is effective. The rate of TB cases is 71% and the cure rate is 90%. The treatment success rate used by WHO (includes cure and treatment completed) is now 87%.[22]

6. THE POLICY ENVIRONMENT – NEPAL HEALTH SECTOR STRATEGY

6.1 Nepal Health Sector Strategy

In response to ensuring equitable access to quality health care for all as reflected in the policy objectives of the Tenth Five-Year Plan, PRSP and the MDGs, the MoH has developed 'Nepal Health Sector Strategy: An Agenda for Change (Reform)'. The Strategy summarises key reforms relating to how the country could handle the challenges of meeting the health and welfare needs of all, especially the poor, women and other vulnerable groups. The Cabinet has already approved the strategy.

The key features of the Health Sector Strategy are:

- Ensure universal access to essential health care services by using cost-effective interventions;
- Establish Public-Private-NGO Partnerships in the delivery of quality health care services;
- Decentralisation of the health system for fair and efficient delivery of health services;
- Obtain better value for out-of-pocket expenditure on health by devising pre-paid alternative health financing mechanisms;
- Provide access to services out side essential health care services; and
- Monitor sector performance through the use of logical framework, particularly in achieving the health component of the MDGs and PRSP.

[19] Nepal Family Health Survey 1996, Ministry of Health, Kathmandu. 1997.
[20] WHO SEARO Regional Health Report, 1997.
[21] Maternal Mortality and Morbidity Study, HMG,MOH, 1998
[22] Annual Report, NATIONAL TUBERCULOSIS CONTROL PROGRAMME, NEPAL, 2059/60, (2002/2003), HMGN, Ministry of Health, Department of Health Services, National Tuberculosis Centre Thimi, Bhaktapur).

6.2 Health Sector Development: Moving To A Sector-Wide Programme

In order to operationalise the HSS reform strategies by moving to strategic sector-wide planning, budgeting, management and monitoring, the MOH and the EDPs have jointly formulated the Nepal Health Sector Strategy Implementation Plan (NHSP-IP). The NHSP-IP is the operational guideline for achieving the goals and visions of the Health Sector Strategy as set out in the Tenth Five-Year Plan, PRSP and the MDGs. A shared vision agreed priorities and a commitment to work together exists between the MoH and the EDPs. This commitment has been expressed through the signing of a 'Statement of Intent' to guide partnerships for health sector development in the country. The agreed partnership principles are as follows:

- ?? The EDPs will ensure that all the assistance given by them in the sector will be fully consistent with the Health Sector Strategy: An Agenda for Reform.
- ?? Harmonisation of EDPs support in annual planning, review and reporting shall be encouraged. Financing of the sector shall be in accordance with each agency's mandate, financing mechanisms, and procedures.
- ?? Develop and maintain a climate of transparency, openness and accountability and share relevant information with all partners to facilitate their contributions to health sector development.
- ?? Work together in partnership to build consensus between the MoH and the EDPs on actions needed to support MoH's efforts to achieve the common vision.

Based on health care needs and an estimate of financial resources likely to be available, the MoH and EDPs agree to develop a prioritised spending framework. This framework will guide the allocation of all resources available from HMG and the EDPs.

The implementation of the NHSP-IP will commence in 2004 and operate till 2009 with a review after 3 years to allow for amendments in accordance with the 11th Plan.

The NHSP-IP has two main features:

a) to increase coverage, especially for the poor and women and to raise the quality of essential health care services (EHCS). These will impact on all Nepal's health related MDGs; and
b) to implement sector wide principles and reforms across the whole sector including financing, planning, management and implementation.

The primary focus is delivery of cost effective essential health care services nation-wide prioritising family planning, safe motherhood and neonatal health, child health, communicable disease control and outpatient care. These services address the diseases that account for 70% of Nepal's burden of disease. The expected outputs and new strengthening actions by each output are given in Annex 3.

In order to implement the NHSP-IP effectively, it was further agreed that a formal Health Sector Development Forum is established under the chair of the Health Secretary. The purpose of the Forum is to ensure the effective delivery of a joint framework for planning, programming and monitoring by all development partners in support of implementing the Health Sector Strategy of HMGN.

All EDPs will ensure that their projects and financing are incorporated within the NHSP-IP and thus contribute in a planned way to the HSS. In addition, monitoring and evaluation of the whole sector will be integrated with a single common system of annual review, planning and budgeting.

In this context, the First Joint Annual Review of the Nepal Health Sector Program: Implementation Plan was carried out from 15–26 March 2004. All the major stakeholders participated in the joint review. During this review various issues were discussed including donor harmonisation, decentralisation, Public Private Partnership and effective implementation of the NHSP-IP. Explicit recommendations were made in the form of joint planning of the Annual Work Plan and Budget (AWPB) and joint monitoring of activities, along with finalisation of costing of EHCS – IP. The final report of the Review of NHSP-IP is pending.

7. KEY ISSUES FOR POLICY ACTIONS: THE CHALLENGES

7.1 Sector Management Actions

- Ensure significant scaling up of the numbers of skilled health workers at service delivery points by providing scholarships for every VDCs. This is critical, especially in reducing maternal mortality (only 13% of deliveries are attended by skilled attendants) and child mortality.
- Reform the role of the MoH, Department of Health Services and other departments to reduce the centralisation of sector management resulting in inefficiency and a lack of responsiveness to local needs.
- Address the barriers faced when seeking care, in particular the costs involved. A deepening appreciation of household costs and strategies to minimise costs is required, especially for the extreme poor.
- Strengthen planning processes through reform and organisational development to ensure they are better integrated into the financial planning, management and monitoring process.
- Develop and implement a strategy to work with the private sector as well as effective regulatory mechanisms to assure quality care is delivered.
- Create an intersectoral co-ordination mechanism.
- Develop and implement decentralizations strategy. This will address (i) deconcentration with the health sector as well as (ii) preparation for and implementation of devolution to DDCs where and when the political climate is accommodating.
- Establish alternative financing mechanisms i.e. "maternal & child health fund" for the extreme poor, especially for purchasing essential obstetric and child care services from the private and public sectors including emergency transportation.

7.2 EDPs and HMGN relations

Working procedures for harmonisation among EDPs and HMG as intended in the Statement of Intent are being worked out.

It has been generally agreed to prepare a code of conduct for all partners. Similarly, integration of planning budgets by HMG/ MoH and EDPs and facilitating coherent sector management must be stressed. Gradual undertaking of various supported activities/programs by HMG is also being worked out.

7.3 Health Sector Decentralisation

MoH will develop a comprehensive strategy for decentralisation. A focal unit for decentralisation in the MoH is of urgent need as is a clear description of responsibilities. Despite the ongoing efforts of handing over sub-health posts and health posts to communities, decentralisation still remains a challenge in the current context of the country. While there has been considerable action at the community level as a result of the hand over of health institutions, there is a danger that progress made at this level will distract attention away from the core issue due to lack of strategy. Therefore attention needs to be focused on the main objective, devolving the entire health system.

Given the social, economic and political diversity of local systems in Nepal together with the differences in local capacity, the MoH should prepare for devolution through a hybrid system. This would mean:

- A deepening of the present system of deconcentration by transferring more resources and responsibilities to the district health office and regional health directorates
- Gradually increasing the responsibilities of the DDC, municipality, and VDC

Consideration will be given in the course of decentralisation as to how the sector-wide approach to programme support will fit with decentralised health care delivery. Issues to be considered in this respect include:

?? How EDPs should assume a more strategic role in the sector while ensuring continued service delivery and supporting capacity building at the district level.

?? How pooled funds from DFID and IDA can best be used to support both national development and district implementation.

?? Assigning the Health Sector Reform Unit the ultimate responsibility for decentralisation strategy and leading the process of decentralisation forward.

8. CONCLUSION

The progress made after the NDF 2002 is satisfactory despite the ongoing conflict and resource gap in the country. Though the health sector at large is not much affected, the recent trend indicates some concern for the smooth delivery of health care services. The MoH, with its sector partners, is committed to adjust its policies and working modalities to address the challenges.

?? An additional US$ 910 million in funding is needed to implement the health sector program as presented. In order to meet the MDGs and Nepal's own health goal, this existing resource gap should be mobilised from all concerned partners involving government, external development partners, NGOs and the private sector.

?? 70% of the proposed health sector allocations should be spent on priority 1 health programs with increased resources focused on rural and remote areas.

?? The estimated US$ 180 million resource gap for 2004/05 (2061/62) is urgently needed to jump start health sector reforms with a sharp focus on protecting the poor from the diseases of poverty and for contributing to poverty reduction.

ANNEX 1

Prioritised Health Programs and activities

S.No.	Program/Activities	Priority Indicators
1.	Child Health	
	1.1 Expended Program for Immunisation - Regular Immunisation program - Hepatitis B - National Immunisation Day	 P1 P2 P1

	1.2 ARI/CDD - Strengthening ARI program - CDD program	 P2 P1
	1.3 Nutrition - Nutrition program - Vitamin A and Micronutrient supplement - Growth monitoring	 P2 P1 P3
2.	Family Health	
	- Family Planning	P1
	- Safe Motherhood /RH	P1
	- FCHV	P2
3.	Epidemiology + Disease Control	
	- Communicable Disease	P1
	- Vector Borne Disease Research & Training	P2
	- Emergency Preparedness and disaster management	P1
4.	TB Control Programme	P1
5.	Leprosy Programme	P1
6.	HIV/AIDS/STD	P1
7.	Environmental and Occupational Health - Hospital Waste Disposal - Others	 P2
8.	Substance Abuse	P3
9.	Urban Health	P3
10.	Oral Health	P2
11.	Accident Prevention	P2
12.	Hospitals	
	1. Teku Hospital	P1
	2. Bir Hospital	P1
	3. Kanti Children's Hospital	P1
	4. Sahid Gangalal Heart Centre	P3
	5. Maternity Hospital	P1
	6. Patan Hospital	P2
	7. Mental Hospital	P3
	8. Bhaktapur Hospital	P1
	9. Eye Hospital and Research Centre - Eye Hospital - BPK Ophthalmic Centre - Netra Jyoti Sangh	 P2 P3 P3
	10. BPKIHS, Dharan	P3
	11. BP Memorial Cancer Hospital, Bharatpur	P3
13.	Development of Health Infrastructure - Ambulance - PHCC/HP Construction - Hospital Construction - Health Inst. Renovation and maintenance	P3
14.	Homeo	P3
	Ayurveda - Naradevi Hospital - Department of Ayurved - Ayurveda Chikitsala	P2
15.	Department of Drug Administration	P2
16.	Unani Hospital	P3
17.	Western Regional Hospital	P2
18.	District Health Institutions - District Hospital - Primary Health Care Centre and Health Centre - District Public Health Office, HPs, SHPs	P1
19.	Zonal Hospitals	P2

20.	Organisation and Management	
	1. MoH	P2
	2. MIS	P1
	3. DoHS	P2
	4. NHEICC	P2
	5. RHDs	P3
	6. NHTC	P1
	7. Medical & Inst. Supply	P1
	8. Health Laboratory	P1
	9. Integrated Supervision	P2
	10. Post-graduate Medical Education & Co-ordination Committee	P2
	11. Research	P3
	12. Community Drug & Health Insurance	P1
	13. Institutional Capacity Building in the context of Decentralisation (center, region, district and below)	P1
	14. Health Poverty Alleviation Fund (safety net)	P1

P1 = high P2 = medium P3 = low

ANNEX 2

Suggested Indicators for Monitoring of NDF 2004

	2058/59	Target 10th Five Year Plan	MDG Target Nepal	Suggested Target by 2006
Availability of EHCS	70	90	-	80%
Pregnant women attending ANC	16	25	-	20
Delivery conducted by trained HW	12.7	18	100	25
CPR	39.3	47	58.2 (SLTHP)	45
TFR	4.1	3.5	-	3.7
Neonatal Mortality Rate	39	32	-	35
IMR	64	45	-	50
U5MR	91	72	54	75
MMR	539 (1996)	300	129	325
Malaria Cases (API)	55/100,000 (Annual Rep.)		28	35
TB Cases	135/100,000 (HDR)		70	90
HIV	0.29 (1999)		0.29	0.52 (current prevalence)

ANNEX 3

Health Sector Strategy : An Agenda for Change (Reform)

OUTPUTS:

Output One: Prioritised EHCS
?? Costing of and resource allocation for EHCS
?? Redefine institutional arrangements for delivering EHCS
?? Develop systems for priority access for poor and vulnerable groups
?? Strengthen Outpatient Services
?? Additional Behaviour Change and Communication (BCC) activities

Output Two: Decentralised health management
?? Introduce Local management of Sub-Health Posts
?? Create Hospital autonomy and initiate resource mobilisation

Output Three: Private and NGO sector developed
?? Formally establish committees or workgroups for specific program areas to co-ordinate the work of government, EDPs and I/NGO groups
?? Establish district level Health Co-ordinating Committees.
?? Up-date Inventory of existing Private/NGO/Public involved in health sector, by district
?? Define an appropriate Public/Private/NGO/ mix for each district
?? Set quality standards and regulatory mechanisms for private and NGO delivery.

Output Four: Sector Management
?? Strengthen joint MOH/EDPs annual planning, programming, budgeting and monitoring cycle
?? Strengthened ongoing MOH/EDPs programmatic collaboration
?? Strengthen Sector Management at the Central Level
?? Strengthen Regional and District Management
?? Capacity Building at central and district levels
?? Systematic assessment of institutional and organisational arrangements.
?? Re-definition of roles throughout the health system.

Output Five: Financing and resource allocation
?? Identification of health sector priorities and re-allocation of resources to priority services.
?? Alternative financing arrangements, such as community health insurance, explored.
?? MOH to develop national guidelines for user fee practices and other payments in public facilities
?? Drug financing mechanisms strengthened to support increased and equitable availability of essential drugs

Output Six: Management of physical assets
?? Products selection and quality improved
?? Commodity distribution improved
?? Drug financing mechanisms strengthened
?? National Drug Policy better implemented
?? Logistics Management Information System (LMIS) strengthened
?? Disaster relief commodities management strengthened
?? Quality and safety policies and systems to be established

Output Seven: Human Resource Development
?? The MoH will reform its HRD unit and locate it in an appropriate place
?? The MoH will improve its personnel management
?? In-service training co-ordination and quality will be improved
?? New training for identified needs
?? Better co-ordination between the Ministry of Education (MoE), MoH and CTEVT for pre-service education.

Output Eight: Integrated MIS and QA Policy
?? Develop and establish integrated Management Information System
?? Establish and implement Quality Assurance (QA) Policy

As these eight expected outputs cut across the on-going programs (many of which are EHCS) and they are mutually reinforcing, the innovative part of which would be to implement actions using their linkages. In that the implementation of the NHSP-IP entails doing "the same business, but differently". This is an important operational challenge requiring attitudinal change among managers and partners of health sector programs.

NHSP-IP focuses on the delivery of the ECHS (a P1 priority). It sets the framework for one single sector strategy, plan and budget (pending). All EDPs support (current and future) will be co-ordinated through the programme.

ANNEX 4

Detail calculation of the funding gap

Funding Gap in health sector in 2003	Gap						
	Required Funding	Available fund	Gap	Source			
Public expenditure	**20880**	**9302**	**11578**	: Requirement, source: EHCP WHO Per capita expenditure US$ 12			
in US $ in Million	286	127	159	: Available fund source:public expenditure			
As a percent of GDP	3.2	2.2	1				
Per Capital Public Expenditure on Health NRS	900	401	499				
Per Capita Public Expenditure on Health US$	12.0	5.3	6.7				
Funding requirement to Essential Health Care Package NRS million	**14825**	**6604**	**8220**				
Donor contribution in Essential Health Care Package in million	7264	3689	3575				
Government contribution in Essential Health Care Package in million	7561	3295	4266				
Per capita EHCP Expenditure NRS	**639**	**285**	**354**				
Per capita EHCP Expenditure in US$	**8.52**	**3.80**	**4.72**				
Private expenditure in NRS million	**48720**	**31007**	**38593**				
Household in NRS million	31668	20154	25086				
For profit and not for profits in million	2436	1550	1930				
Per capita private expenditure in NRS	2100	1336	1664				
Per capita private expenditure in US$	28	18	22				
Total expenditure on Health in NRS in million	**69600**	**40309**	**50171**				
Total expenditure on Health in US$ in million	928	537	669				
Per capita Total Health Expenditure in NRS	3000	1737	2163				
Per capita Total Health Expenditure in US$	**40.0**	**23.2**	**28.8**				

Funding Gap	**2003**	**2004**	**2005**	**2006**	2007	Total	
Public expenditure	11578	13315	15312	17609	20250	66485	
in US $ in Million	159	182	210	241	277	911	
As a percent of GDP							
Per Capital Public Expenditure on Health	499	574	660	759	873	2866	
Per Capita Public Expenditure on Health	7	8	9	10	12	38	
Funding requirement to Essential Health Care Package	8220	9453	10871	12502	14377	47205	
Donor contribution in Essential Health Care Package	3575	4111	4728	5437	6253	20530	
Government contribution in Essential Health Care Package	4266	4906	5641	6488	7461	24496	
Per capita EHCP Expenditure	354	407	469	539	620	2035	
Per capita EHCP Expenditure in US$	5	5	6	7	8	27	
Private expenditure in NRS million	38593	44382	51040	58696	67500	221618	
Household in NRS million	25086	28849	33176	38152	43875	144051	
For profit and not for profits in million	1930	2219	2552	2935	3375	11081	
Per capita private expenditure in NRS	1664	1913	2200	2530	2909	9552	
Per capita private expenditure in US$	22	26	29	34	39	127	
Total expenditure on Health in NRS in million	50171	57697	66352	76304	87750	288103	
Total expenditure on Health in US$ in million	669	769	885	1017	1170	3841	
Per capita Total Health Expenditure in NRS	2163	2487	2860	3289	3782	12418	
Per capita Total Health Expenditure in US$	29	33	38	44	50		