A STATUS PAPER ON HEALTH SYSTEMS SCENARIO IN NEPAL

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Introduction

Nepal is one of the least developed countries in the world. Its GNP per capita income, at US $ 219 reflects poverty and underdevelopment. About 90 percent of the total population reside in the rural areas. Most of them live in conditions of extreme poverty and social deprivation. Poverty, mass illiteracy and ignorant has become roadblock to health development in Nepal. Its people receive less than US $ 3.0 per head for health expenditure and only 15 percent of them have access to modern health care service. Fertility, infant mortality and population growth rates remain very high and life expectancy is low. The present health scenario of Nepal is very bleak, and the health status of its people can be described as extremely poor. The poor health status of people reflects the inadequate management and poor operation of the health system in the country.

Nepal's government has accepted health service as essential for human life and several significant efforts have been made toward achieving the goals of primary health care. For the development of health systems, attempts made in the past have had some improvement in the people's health status; however, major health indicators of Nepalese people have shown that their health status is for below as compared to other developing countries. Malaria, tuberculosis, leprosy and vaccine preventable childhood diseases have been controlled to great extent. However due to inadequate financial resources, lack of institutional capacity, lack of consistency between policy and programme, and managerial problems, people have not obtained expected health services from extended health institutions. Despite growing burdens of diseases and challenges, HMG/MoH has to make commitment towards bettering the public health status by reforming existing health systems.

Every country has its own national health systems that reflect its history, its culture, its socio-economic development and political commitment. Nepal has also own national health systems which aim at improving and maintaining the health of the people. The health systems in Nepal are a blend of health care services operating in both public and private sectors even in folk sectors. Medical pluralism and multiple health system coexist simultaneously in the country. As far as the government is concerned the existing health system has accepted in its fold the following.

- The Allopathic or modern system of medicine
- The Traditional Ayurvedic system of Nepal.
- The Homeopathic system of medicine.
- The Unani system of medicine.

The four categories of health systems are limited particularly urban and development areas and inaccessible to the majority of people. In the popular sector, people have been long adopting different types of preventive as well as curative means of health systems. Indigenous and traditional health care systems are still popular among the local people. Nepalese people are general under influence of different types of healing systems. In broadest sense, health systems of Nepal can be divided into four broad categories:

a) The Home Based System.
b) The Traditional Faith Healing System.
c) Traditional Ayurvedic, Homeopathic and Unani Systems.
d) Modern Allopathic System.

a) Home Based System

In the most cases, illness is managed at home using household's resource, knowledge and belief. People's health care practices are largely based on this system. It is widely believe that about 90 percent of all illness episodes are managed within home based health system. Although home based health care system is the largest part of the health systems, its is the least studied and poorly understood. It can be regarded as matrix containing several levels; individual, family, social networks and community beliefs and activities. It is particularly based on laymen management and popular culture arena in which illness is first defined and health care activities initiated (Kleimnan, 1980). In Nepal almost all households, at least at the initial stage of sickness, utilize the fairly wide stock of inter-generationally transmitted as well as new acquired knowledge sick back to good health. Limited access to and relatively low quality of, public health institutions and the prohibitive costs of modern health service force most household to relay on home remedies based on faith healing and the use of local herbs (NESAC, 1998).

b) Traditional Faith Healing System

Faith healing and folk medicine widely exist in every nook and corner of Nepal. There are various forms of traditional healing systems existed by practitioners of the arts such as Dhami, Jhankri, Jharpuke. It constitutes of almost entire health care systems of local community. In general, the failure of home remedy to cure the sick invites intervention from community level healers. Local healers use traditional knowledge and techniques of faith healing including herbal remedies to treat the sickness. Often specialized in particular techniques and which specialist is consulted in a functions of illness itself (Stone, 1976). The number of faith healers in very large, which can itself be taken as an indication of the legitimacy of the system. It is estimated that at least 400,000 to 800,000 faith healers of various categories provide health care to the local people. The majority of the sick persons in the rural areas

who eventually visit the health post had first consulted a traditional healer (UNICEF, 1992). Majority located in the remote village areas they are the most often the first health care providers to the community and the herbs they use in healing process have real medical value. If properly mobilized could greatly contribute to the health care system of the country.

c) Traditional Ayurvedic, Homeopathic and Unani Systems

The Ayurvedic system is the most ancient as well as traditional system of healing which has been widely practiced in south Asia since ancient times. Although this system is considering to be traditional, it bases itself on a well developed system of the physiological characteristics of sick person, symptoms of sickness and detailed pharmacological knowledge of herbs and their processing techniques. Ayurvedic medicines are inherent of Nepal and are suitable for Nepalese people because trees or shrubs and tubers with health properties exist in mountains and hills. The only trouble is that arts of traditional practitioners become old and limited in certain families. Most Ayurvedic healers work within the private domain. Ayurvedic system in the public sector in performed through one central Ayurvedic hospital with 50 beds, one 15 beds local hospital, 172 dispensaries in 55 districts and a central drug manufacturing unit, Baidhyakhana (MoH, 1997).

Homeopathy was introduced Nepal as early as 1920 as a natural healing system. It is largely a private sector initiative which encompasses approximately 500 practitioners and 100 clinic (MoH, 1997). In public sector there is only a national Homeopathy Hospital established 27 year ago. This hospital is providing treatment to the patients with chronic respiratory problems, diarrhoeal diseases, skin diseases, jaundice and so on.

The Unani system also exists in Nepal but it has extremely limited access to the people. Most people are unknown about it. At the government level, Unani treatment is available within the homeopathy hospital of Kathmandu. This hospital is providing the treatment services to few people through out-patient department (OPD)

Alternative system of medicine: Other various form of alternative systems of medicine have been seen in Nepal. Because of growing heap of side effects of allopathic medicine and failure to care some chronic diseases, people are attracted toward alternative medicines. There may be categorized as Naturopathy, Acupuncture, Hypnotherapy, Magnetic or Copper therapy, Japanese methods and other therapies. Nowadays, of these, naturopathy is becoming popular in Nepal. In the system of naturopathy diseases are cured through the use of air, water, soil, exercise, Yogashan and dieting. It is believed that around 100 AD, people of Nepal practiced natural therapy in the form of mud, water and herbs which later was

modified to herbalism or traditional system of medicines. In the public sector there is neither hospital now institute for providing naturopathic services. However, more than two dozens of naturopathy hospital and treatment centres are providing services in selected areas of Nepal through private initiatives.

c) Allopathic or Bio-medical System

The missionaries were the first to introduce allopathic system of medicine in Nepal. Modern allopathic public health system was institutionalized by establishing the Bir Hospital in Kathmandu at the end of 19th century (1885). After establishing the central hospital in the capital a number of other small hospitals were opened in administrative headquarters of districts of periphery. However these so called hospital at the periphery were nothing more than dispensaries (Sapkota, 2054). By 1995 B. S., there were 39 small-scale allopathic hospital with a total of 623 beds and 29 dispensaries.

When organized, national level, public efforts initiated for the development of modern health service in the mid 1950, it continued to dominate the entire health system. A large-scale malaria control programme was launched in 1955; the leprosy and tuberculosis control projects were initialed in 1966; the small pox eradication programme was launched in 1968; and a family planning and maternal and child health board was established in 1968 (CBS, 1989). In 1977 the successful smallpox project was converted to the expanded programme for immunization. Other vertical programmes such as the nutrition support and diarrhoeal diseases control programme were integrated with EPI in 1980. Gradually small scale public hospitals were established at various regional and district centers. Similarly public health offices were established in the districts. At present 5 central hospitals, 11 zonal hospital, 64 district hospitals, 13 health centres, 120 primary health centers, 736 health posts and 3,187 sub-health posts are functioning in Nepal (DHS, 1998). Approximately 90 hospitals and nursing homes were also established under private initiative.

Selected Health and Related Indicators

As health is multi-dimensional in nature heal status of people is influenced by numerous factors. Moreover, the health status of populations is but reflection of the socio-economic development of the country and is shaped by a variety of factors; the level of income and standards of living, housing, sanitation water supply, education employment, health consciousness, health facilities, accessibility and affordability of health care delivery services. Health and socio-demographic indicators reflect the existing situation of health and health systems of the country. Indicators depict in following table provide an insight about the health in Nepal.

Table 1: Selected Health and related Indicators of Nepal and United States of America

S.N.	Indicators	Nepal	U. S.
1	**Demographic indicators**		
	Total population	22847000	274028000
	Annual growth rate	2.6	1.0
	Population Dependency Rate (Per 100)	83	52
	Fertility Rote	4.5	2.0
	Contraceptive prevalence Rate	30	71
	Crude Death Rate	35.4	--
	Life expectancy at Birth		
	Male	58	73
	Female	57	80
2	**Socio-economic Indicators**		
	Per Capita Income (US $)	210	21541
	Absolute Poverty (%)	50	
	Health Expenditure of GDP	5.0	14.0
	Unemployment Rate	14	4.1
	Adult Literacy Rate	38.0	99
	Male	55.7	99
	Female	20.7	99
3	**Health Indicators**		
	Infant mortality Rate	83	7
	(Per 1000 live births)		
	Child mortality rate (under five)	117	9
	Maternal mortality Rate (Per 100,000)	550	12
	Chronic malnutrition	49	2
	Daily calorie supply	2155	3350
	Percentage of population access to health	15	--
	service	6442	--
	No of person per hospital beds.	5	245
	No of doctor per 100,000 population	25	878
	No of Nurses per 100,000 population		
	Burden of diseases	69	--
	Group I diseases	23	--
	Group II Diseases	9	
	Group III (Injuries and Accidents)		

Sources: Nepal Human Development Report 1998, Human Development Report 1999, World Health Report 1999, Health in Nepal- Realities and Challenges (RECPHEC, 1996)

As per the 1991 census, the total population of the country were 1,84,91097. The population is currently estimated to be 2,28,47,000 and growing at the rate of 2.7 percent per annum. Fertility and crude death are high being 4.5 per women; crude death rate 35.4. Life expectancy at birth remains very low (57.5) and is estimated at 58 years for male and 57 years for female. Tragically, Nepal is the only country in the world where life expectancy of female is less than males. In the U.S. life expectancy at birth for female is seven years greater than that of male. Contraceptive prevalence rate (CPR) is 30 percent. Nepal's population is likely to grow at annual rate of about 2 percent in the foreseeable future. This would double the population in 35 years, putting enormous pressure on the country's meagre health services.

Nepal is one of the poorest countries of the world with per capita income of just US $ 210 and it ranks 121St among 133 countries. Half of the total population lives below absolute poverty. Unemployment rate is high at 14 percent. The rate of unemployment is found to be highest in Terai followed by the hills and mountains. The scale of under employment is higher still- approximately on behalf of the total labor force works for less than 40 hours a week (NESAC, 1998). Literacy rate has been increasing very slowly. The current rational adult literacy rate is estimated around 38 percent. The literacy rate of adult female and male is 20.7 and 55.7 percent respectively. These low educational levels pose a critical challenge for health and socio-economic development in the country.

Health indicators are generally worse in Nepal. Current mortality rate for infant (83 per 100,000 live births) and children of under 5 (117) still remain high. An estimated 99,000 under five deaths occur in Nepal each year. Nepal has one of the highest maternal mortality rate in the world (550 per 100,000 live births). High infant and maternal morality is product of inadequate safe motherhood practice, poor maternal health, unhygienic traditional birthing practices and health care system. Malnutrition affects 70 percent of ages of under 5. Around half of the children of under 5 years suffer from chronic malnutrition. Over 35 percent of the total population of Nepal consume less than the estimated minimum calorie requirement. An average calorie intake of Nepalese people is 2155 kg calorie. A majority of people do not access to public health facilities and services. It is estimated that only 15 percent of Nepal's populations access to modern health services. However, approximately half of the household could access a health post within a travel time of 30 minutes about out of five households consulted modern health practitioners during illness (CBS, 1997). Regarding hospital facilities under government sector there are 6442 people per bed. Likewise five doctors are responsible for 100,000 population. In the U.S. there are 245 medical doctors for providing medical service to 100,000 population. There are incomparable health indicators of Nepal and the U.S.

Infectious diseases, maternal and perinatal ailments and nutritional deficiencies are the leading cause of illness and death in Nepal. But the lack of adequate vital registration data and diseases surveillance systems makes analysis of burden of diseases difficult. A source of reliable data on sickness is the united mission hospital located in the central, western and eastern regions serving more than 300,000 outpatients a year. Based on data from these hospitals, World Bank estimated the burden of diseases for Nepal in 1996. Group I diseases (infectious diseases, maternal and perinatal ailments, and nutritional deficiencies) accounted for 69 percent of Nepal's diseases burden. Group II disease (degenerative and non communicable diseases) accounted for 23 percent of the disease burden. Nine percent of the disease burdens was attributable for Group III (injuries and accidents). Above mentioned socio-demographic and heath indicators reflect the poor health of population.

Organizational Structure of the Health Care Systems

Until the 1950s and early 60s health care system were based on medical care of hospital in the urban centers. Virtually no health service delivery system existed outside the Kathmandu. At that time modern health system was in rudimentary stage. After establishment of Ministry of Health significant efforts were attempted to organise and develop health system. The ministry of health was established in 1956, mainly to eradicate smallpox and to control malaria. These two priorities were organised as separate disease control vertical programme. At late 1960s family planning and maternal and child health (FP/MCH) project and, leprosy and tuberculosis control programmes were initiated. A system of public and personal health care through a network of district hospitals and health posts became the priority of the government in the wake of the historic Alma Ata Declaration in 1978. In the early 1980s additional activities such as the goitre control project, nutrition support programme, diarrhoeal disease control programme, project for control of blindness were initiated. Similarly significant steps were taken by successive government to expand the public healthy network from central to community level and efforts were made to make health services available to all people. The sub-health post is being established in every V.D.C. The health system at national level and regional level consist of the ministry of health and 5 regional directorates.

Ministry of Health

The Ministry of Health plays a leading role in improving the health of the people including mental, physical and social well being, for over all national development with increased the participation of the private sector and non-

government institution in the implementation programmes. The Ministry i responsible for effective delivery of curative serving disease prevention, healt promotive of activities and establishment of a primary health care system. Th ministry of Health has two divisions: The central administration division and polic planning, Foreign aid and monitoring division. At the central level, the ministry c Health has three department viz. Health Services, Drug Administration an Ayurved.

There are four councils under ministry of health namely Nepal Medica Council (NPC), Nepal Health Research Council (NHRC), Nepal Ayurvedic Counc (NAC) and Nepal Nursing Council (NNC). These councils provide suggestions t the MoH for formulations of policies and the implementation of plans.

Department of Ministry of Health

There are three major departments of MoH at central level which are as follows:

1. Department of Health Services
2. Department of Drug Administration
3. Department of Ayurved

Department of health services

The overall purpose of DHS is to deliver preventive and curative healt services through out the kingdom of Nepal. The department of health service i entrusted with the responsibility of mobilizing necessary resources and developin physical infrastructure, developing necessary manpower and properly utilizing ther according to policy formulation by Ministry of Health to provide health services an make them a accessible to general population. It has seven divisions and 5 centers.

Divisions of DHS

i. Planning and Foreign Aid Division
ii. Family Health Division.
iii. Child Health Division.
iv. Epidemiology and disease control Division.
v. Logistic Management Division.
vi. Health Institution and Manpower Development Division.
vii. Leprosy Control Division.

National Centers of DHS

1. National Health Training Centre.
2. National Health Education, Information and Communication Centre.
3. Nepal Tuberculosis Centre.
4. National Centre for AIDS and SID Control.
5. National Public Health Laboratory.

At the regional level, there are five regional health services directorates one in each development region of Nepal, there in a provision for regional training centre, regional laboratory, regional medical store, regional TB centre and Regional hospital. Each regional health service directorate has following sections and sub-section to effectively run the programmes and activities. Administration section, Financial Administration Section, Planning and Monitoring Section, Disease Control sub-section, Maternal and Child Health sub-section,, Epidemiology and Disaster control sub-section, Health Education and Institution Development sub-section and the indent and procurement coordination sub-section. There is provision for district health office, district hospital each district of the kingdom. However, out of 75 districts, there are 61 district health office, 64 district hospital and 14 district public health office.

Department of Drug Administration

The Department of Drug Administration (DDA) was establishment in 1979 under the ministry of Forest of soil conservation to carry out the functions relating to control of drug under to the Drug Act 1978. Later in 1983 it was transformed to the Ministry of health . As per Act, DDA is responsible for prohibiting pharmaceutical products as well as false or mistaking information relating to efficiency and use of drugs. It is also responsible for management and distribution of drugs. DDA regulates and control the production, marketing distribution, export, import storage and utilization of those drugs which are not safe and important. DDA has following sections: Training and Drug information section, Drug Registration and license section, and planning and monitoring section. DDA's activities have been severely limited to the central level because of lack of manpower and facilities.

Department of Ayurved

Ministry of Health has Department of Ayurved at central level to facilitate the development and expansion of the Ayurvedic system in Nepal. Homeopathy, Unani and Naturopathy also come under this department. The Ayurved Dept. has given the responsibility of providing health service to the people through the use of Ayurvedic

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Department of Ayurved

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and other alternative medicine. There is a main producer of Ayurvedic medicine, Singh Darbar Vaidyakhana, which works under the direction of this department. Ayurvedic department also regulate and control the activities of other medical system like Homeopathy, Unani and Naturopathy. There is only one homeopathic dispensary and hospital with 20 beds which has been providing homeopathic treatment service in Nepal. Unani dispensary is the only one institution within kingdom of Nepal to provide curative service through Unani system. According to recent information, there are 2 Ayurvedic hospitals, 34 District Ayurvedic Health Centres and 181 dispensaries providing curative service to the people of the country.

Infrastructure

Hospital and hospital beds

According to information of HurDIS/DHS-MoH, there are 94 hospitals including missionaries and teaching hospitals in Nepal. There are only 83 hospitals operating under government sectors. The hospitals in Nepal have been broadly classified into central, regional, referral (zonal) and district level hospitals. At central level in Kathmandu there are number of hospitals: one central hospital (Bir Hospital), 4 specialized hospitals (Kanti Children's Hospital, Maternity Hospital, Eye Hospital, Tropical and Infectious Hospital) and a teaching hospital run by Institute of Medicine, Tribhuvan University. At next tier there is only one regional hospital in Pokhara, Kaski. There are 11 referral (zonal) hospitals where specialist services are available. Only 64 of country's 75 district now have a district hospital each with less than 50 beds and three post of doctors (rarely are all three posts filled). District hospitals do not have any specialized services and providing only very limited surgical and obstetric care. By and large they function as out-patient units. Table 2 furnishes information relating to the distribution of hospitals and hospital beds by development region.

Table 2: Distribution of Hospital and Beds by Development Region

Development Region	No. of Hospital	No. of Beds
Eastern Region	17	410
Central Region	23	1851
Western Region	18	443
Mid-Western Region	15	280
Far-Western Region	10	220
Total	83	3204

The urban orientation of health services is evident from the fact that out of 3204 beds in 83 hospitals, about 1800 beds are located in Kathmandu Valley.

Hospital care is thus heavily biased in favour of the urban population and the relatively privileged minority living in the central region, particularly Kathmandu Valley.

Health Centre, PHC, Health Post and Sub-health post

In terms of service delivery, the main points of entry for health care in the rural areas are the sub-health post and health posts. HPs and SHPs provide basic health care service to the rural livings. They have been expanded to most of Village Development Committee of Nepal. At present there are 3187 Sub-health posts, 736 health posts, 120 primary health centres and 13 health centres. According to the institutional framework of DHS/MoH, the sub-health posts function as the first contact for basic health services. However, the SHP is the first contact point from the institutional perspective only. In reality the SHP is a referral centre of the volunteer cadres of TBAs and FCHVs as well as activities such as PHC, EPI, outreach and home visiting services.

Private Hospital and Nursing Homes

After restoration of democracy in 1990, private hosp tals and nursing homes have been mushrooming in the urban areas of the count . Currently 90 private hospitals and nursing homes are providing curative health ervices to the minority people living in the urban areas of the country. Of total 9 nursing homes, 69 are located central region particularly in Kathmandu Valley.

Rapid population growth, lack of proper care in public hospitals and changes in family living in the urban areas have resulted in growing demand for such services. Now days nursing home has become a big business for doctors of the city areas and almost all nursing homes are opened for profit. Responsibility for supervision of private hospitals and nursing homes rests largely on Department of Health Services-MoH. But due to the lack of supervision and control of MoH/HMG, except few, most of them are not well established and well equipped and often offer poor and inadequate medical services to their clients. There is no rule and regulation for charging the clients. They are more prone to attempt to maximize profit by minimizing expenditure and making unnecessary charge.

According to current information available, 29,398 health workers including AHW, Nurses, paramedics and allied health workers, public health, traditional health staffs and non-specific are working in different parts of the country. According to Nepal Medical Council, there are 26096 registered medical doctors, but MoH/HMG employs only 3.5 percent (923) doctors of the total doctors. The ratio was one doctor per 21205 population in 1996. According to the Human Development Report 1999, there are 5 docters per 100000 people. The docter-population ratio is lowest (1:2701) in the Kathmandu district and highest (1:179,621) in remote hill district, Rolpa. There is one health centre with one doctor to provide treatment services to the people of Rolpa. As hospital care is biased in favour of the urban population, Nepal's health manpower also shows such bias with 460 of Nepal' 923 doctors concentrated in the central region. Likewise, of 6023 nurses, 2163 nurses are working in the hospital of central region under government sectors. Maldistribution of manpower is a significant problem in the health care delivery system. Doctors, physician and other health professionals tend to practice in urban and sub-urban areas. This is an acute problem, since illness tends to be more prevalent among rural population. Table 3 shows distribution of human resource by category by Region.

Table 3: Total number of Human Resource by Category by Region

Development Region	Staff Category						
	Doctor	Nurses	Paramedics and Allied Health workers	Public Health	Traditional Health Staff	Non-Specific	Total
Eastern	160	1283	2494	42	87	1952	6,018
Central	460	2163	3707	87	185	4041	10,643
Western	157	1226	2428	40	120	1909	5880
Mid-Western	85	804	1684	35	68	1369	4,045
Far-Western	61	547	1149	24	66	965	2,812
Total	923	6,023	11,462	228	526	10,236	29398

Besides doctors and nurses, there are number of paramedics and allied health workers, public health and traditional health (Ayurvedic, Homeopathic and Unani) staffs to assist in health delivery services of the country. The paramedical staffs and allied health workers consist of health assistant (HA), Auxiliary Health Worker (AHW), health laboratory technologist and technician, dietitian, medical record personnel, village health workers, Female Community Health Volunteers and

maternal and child health workers. There are other vertical project staffs that include EPI vaccinators, malaria field workers and TB and leprosy workers.

Financing in Health

At present there are several internal and external funding agencies that provide financing for health. The internal funding sources consist of the government, private companies and households. The external agencies consist of external development partners and donors of multilateral and bilateral agencies as well as international non-governmental organizations, and religious/philanthropic missions. Table 2 shows the level of total health expenditure by sources in 1994/95.

Table 2: Level of Total Health Expenditure by Source, 1994/95

Expenditure	In millions Rs.	Percent	Per capita
Private Source	8,278	75.65	407.20
Households	8,102	74.04	398.53
Private Enterprises	176.50	1.61	8.68
External Source	1,505	13.74	74.03
Donor / Development partners	1,360	12.43	66.93
INGO	101.29	0.92	4.98
NGO	43.03	0.39	2.12

Source: Nepal Human Development Report 1998

In 1994/95 the total expenditure made by internal and external funding agencies in health sector amounted to Rs10.94 billion, equivalent to 5.3 percent of GDP. Household sources provide the largest proportion health expenditure while other sources accounted for much smaller level. Of the total health expenditure of Rs 10.94 billion for 1994, households accounted for over 76 percent. Development partners and international donors accounted for 14 percent and the government for 10.6 percent only. In 1994, per capita health expenditure was Rs 538.35 (US$ 11.0). Of this households spent nearly 400 rupees. The share of the government was 57 rupees and the share of developing partners and donors 67 rupees. Likewise, the contribution of INGOs and NGOs was around 7 percent and the share of the private sector was close to 9 rupees.

Public expenditure: The MoH enjoys the major share of the government' health budget constituting over 90 percent of public health expenditure. In 1996/97 a year when the share of public expenditure on health rose from 3.7 percent of total spending to 5.4 percent and per capita spending was only Rs 80.5 (US$ 1.6) per

capita. In the fiscal year 1999/2000 the HMG has released 5.1 percent of total health budget. Only 0.15 percent of total health budget has been allocated under health institution grant that also shares the some expenditure of Nepal Health Research Council and research activities. Recurrent (regular) budget spending on health care has represented about 45 percent of total public health care spending while development spending has represented about 55 percent of spending.

Public Health Care Spending Trends: The share of public health spending as a percentage of total primary health care allocation has fallen significantly from almost 80 percent in 1991/92 to about 60 percent in 1996/97 (Table 5). Over this period allocations for hospital rose. Around 40 percent of the government health sector expenditure continue to be allocated to the maintenance of hospitals and curative services. About 3 percent of health budget has been constantly allocated for traditional medicine. It is also estimated that spending on medication and equipment has fallen from 13 percent of recurrent health care spending in 1994/95 to just 9 percent in 1996/97.

Table 4: Trends in Budget Shares by Major Components in 1991/92-1997/98

Category	91-92	92-93	93-94	94-95	95-96	96-97	97-98
Primary health care	76.8	75.8	72.8	63.1	63.4	63.9	57.2
Health policy and management	5.7	4.5	4.4	3.8	3.2	2.5	2.5
Hospitals	14.6	16.3	20.0	30.3	30.0	30.6	37.5
Traditional Medicine	2.9	3.1	2.8	2.9	3.4	3.0	2.8
Total	100	100	100	100	100	100	100

Sources: Budget document (Red Books) various years

External sources: A large part of the country's development expenditure is met through international assistance. About 55 percent of total development expenditure in 1992/93 was financed through external assistance. About 51 percent of the total official development assistance to Nepal in 1995 came from bilateral sources and 4.1 percent from multilateral sources to the health sector, a proportion of total government expenditure on health ranged from 36 percent in 1991/92 to 49 in 1994/95. And in 1999/2000, 40 percent of total health budget is estimated to be met through external assistance.

Exact figure on aid disbursement by individual programme in not available. Aid dependency in health sector varies from 6 percent in health education to 100 percent in the goitre control programme. Primary health care activities; EPI,

FP/MCH, CDD, Malaria control, FCHV, SHP, AIDS/STDs control, goitre and cretinism and other activities together constitute around 80 percent of total health sector aid 1993/94. Non-primary health care or the health services constitute less than 15 percent. Thus high level of donor dependency makes the health sector vulnerable to changes in external aid flows; raising issues of sustainability.

Private enterprises: The financial investment made by the private sectors, in recent years, has been substantial. The share of health services delivered by the private sectors through nursing homes in urban areas has been growing. Expenditure made by private hospitals and nursing homes in 1994/95 amounted to Rs 37.67 million. The combined expenditure figure for the private sector including nursing homes, hospitals, private sectors including nursing homes, private diagnostic centres, private pathological laboratories in the health sector was estimated to be 130.69 million in in 1994/95.

Private household expenditure: Health expenditure accounted for 6 percent of the total household expenditure (CBS, 1996). Household expenditure for health include made by households for drug and health services available at hospitals, health post, clinic, mobile clinic, private nursing home and pathology, pharmacies and other traditional medical outlets. Household expenditure in health was estimated to be around 8.102 million in 1994/95. A large proportion on health is spent on accessing government health care outlets and for the procurement of drugs prescribed by such outlets. Slightly more than one-third of all household health expenditure is spent on private sectors.

Absorptive Capacity: In general absorptive capacity is measured in term of the foreign aid utilization rate against the commitment made in a stipulated period of time. Also it is measured in terms of spending performance against the allocated budget in a particular fiscal year. Nepal's absorptive capacity seems to be unsatisfactory. About 40 percent of the external resource remained unutilized during the period of 1989/90 to 1994/94. There is no single year in which the government has been able to fully utilize the budget amount; spending performance has always lagged for behind (Shrestha, 1995).

Health Insurance: Insurance is purchased contract in which the purchaser (insured) is protected from loss by the insurer's agreeing to reimburse for such loss. Health insurance has become an almost indispensable to the structure of financing medical care in developed countries like United States of America. The health insurance industry has become big business in the U.S. and health insurance finances America's personal health care expenses. Paying for health care services in the U.S. is, by and large, made by third party payment, health insurance. In Nepal the patient directly pays health care providers. Currently concept of implementing the health insurance programme is growing among the health policy planners. However, some

INGOs and NGOs have introduced medical or accidental insurance to protect their employees against loss from accidents or severe illness. In government sector, there is a provision for demanding treatment cost, but they can obtain only amount equivalent to the salary of one and half month of respective employee. Health insurance programme is planning to be implemented as pilot programme in the areas inspired by local communities during the period of ninth five year plan.

Issues in Health Systems

Until 1950, there were just a people of hospitals and very few doctors to provide health care services to the people of Nepal. Virtually no modern health service delivery network existed outside Kathmandu. Rural people solely depended on traditional and folk medicine for the treatment of illness. Since then considerable progress has been made in various aspect of health service delivery. However, it is still inadequate to meet the growing needs of the present population. Furthermore, the health care system is itself plagued with certain inherent weakness which need timely corrective action.

It is estimated that health care delivery system in Nepal reaches barely 15 percent of the total population. Access to health care in acutely constrained by the rugged terrain, limited health infrastructure, and lack of financial resources. The doctor population ratio is 1:21646- very low by international comparison even for low income countries. Further more, most doctors and health facilities are concentrated in the urban areas of Central, Eastern and Western development regions. At the same time most private sectors and non-government organizations involved in health care systems are located in the central region, particularly Kathmandu valley, around one-fourth of the 685 health post surveyed had inadequate infrastructure and these facilities lacked of proper furniture and equipment. Likewise many facilities suffer from a chronic shortage of specific medications. Because of distribution and supply problems, essential drugs are sometimes unavailable for four to six months of a year.

Major factors contributing to the ineffectiveness of modern health system are the problem of staff vacancies and absenteeism and absence of outreach health care. The problem of staff vacancies and absenteeism is acute in rural health facilities. Physician in district rarely visits health posts. FCHVs and village health workers an responsible for providing basic care to the villagers but they are not competent to provide the health services. Inadequate infrastructure and inadequate human resource management have become major concern for both the quality of care and for system capacity to meet services needs. Inadequate coverage, under-utilization

and lack of an outreach component are not so much a reflection of deficient policies but of inefficient management. The current policies relating to primary health care are adequate and appropriate, while the management of the various reflect there policies. It is extremely weak in term of motivation, training proper implementations of existing of structural constrain in Nepal's political against drug early solution to these problems.

The policy of coordination and integration assumes that efficiency can be achieved by combinating the service actives of the various project. The process of integrating various primary health care programmes remain weak and process of integration of the vertical programme remains unsolved. The planning and coordination, capabilities of most are inadequate, skills in planning and program development, management and situations analysis are lacking. Collaboration and coordination with Governments agencies and other stockholders is limited. Moreover, the national health programme has been greatly handicapped by inadequate coordination of donor resources within a frame work of generally accepted and prioritized intervention planning, budgeting, operation and monitoring mechanism have yet to be decentralized adequately to the regional district and outreach levels. However, the government is now accelerating the process of integration with some success but a number of issues still remain to be resolved.

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