CHAPTER-I

INTRODUCTION

1.1 Background

Public expenditure is the most important instrument of the fiscal policy. It plays an important role in achieving higher rate of economic growth. The main source of finding public expenditure is the public revenue. Public expenditure can cause significance variation in income, output and employment of the country. Public finance today is conceived as the most exciting branch of economy. It deals with the coming in and going out of public part of the resources along with its distinct impact on the economy.

Public expenditure is one of central instruments through which government influence economic events. Public expenditure refers to the expense made by the public authority i.e. central government and other local bodies to carter the demand of the public. It is for protecting the citizens and for promoting their economic and social welfare. (Goode, 1984) defines "government expenditure for goods and services may be thought of as means of supplying services; that decision makes desire to have provided in appreciably different quantities of qualities from what enterprises would supply through the market." Public expenditure; i.e. government should invest properly in the field of income generation in under developed countries like Nepal where the mixed economy is still alive and private sector is not much competent. The involvement of government is seen through the fiscal policy.

Public expenditure is one of the major dimensions of fiscal policy. According to C.V. Brown and P.M. Jackson (1980) say, "Total public expenditure is the sum of the expenditure on current and capital accounts of the public sectors and is equal to the sum of consolidated public sector receipts". In other words, public expenditure is the expenditure made by local and national agencies as distinct from those private individuals, organizations or firms.

In Nepal, the economic planning started in 1956. Since 1956, the country has completed 11^{th} plan. Public sector outlay has increased subsequently in every year. The actual growth in expenditure is not observed in the real team because inflation over the same period has increased very quickly. Recurrent expenditure has increased faster than the capital expenditure.

It is the act of public expenditure, which is responsible to of on the means for it. Economic development demands co-operation from both public and private parts.

Private co-operation for economic development process is crucial. Direct public expenditure on industry, commerce, and aggregate economic development can feed up the economic development by its suitable policies. Co-operating private participant by providing the transportation, communication, health, education and other social program in the economy is necessary. The growing popularity of planning and budgeting in underdeveloped as well as the developed countries have importance (vital role) to public expenditure promotion and planning the peace of economic development.

The improvement in health status of the people requires allocating the public resources for the health sector and spending them in such as way that it should ensure easy and affordable access of the health services to the people. The primary goal of public health is to produce healthy manpower for economic development of the country and ensure the access to health. The size and quality of public spending on the health sector plays a crucial role in the social equality and poverty reduction. It is imperative to examine critically the public health spending and to provide evidence for redesigning health policy and improving budget performances. Health, in every sense is the fundamental factor of development. “Improvements of health contribute to the productivity by raising the quality of the people and these outlays yield a continuing return in the future” (Meier.1990). No country can achieve sustainable economic development without substantial investment in human capital i.e. health education and sanitation etc.

Thus, the government of the LDCs like Nepal is making valuable contribution towards increasing income and opportunity of employment in the country by increasing their expenditure on economic development. Public expenditure in the LDCs therefore plays vital role in raising the level of income and employment in the country.

1.2 Statement of the Problem

This study is primarily concerned on analyzing the structure and trend of public expenditure on health sector. Since 1956, Nepal has started planed process of economic development. But the basic issue of the country has remained the same. There are many causes to create the problems keeping the country in the poor condition like rapid population growth, massive poverty political instability agriculture, dominate economy etc. Growing population put pressure on the

government for the provision of the greater social services (health, education and sanitation etc). In the health sector, there will be made more physical buildings, more furniture, and more doctors and to well health services are to be provided.

Though the budget speech comes every year, the government sets the goal of economic development and growth. After the first annual budget in 1952, this process has become a routing practice in Nepal. However even fifty-six year of experience in Nepal has not been able to achieve a satisfactory economic growth. They can be judged from various development indicators for instance, population below poverty line, illiteracy rate are still very high and thirty six percent of GDP is covered by agricultural, which is still depending on weather.

According to budget and the spending system of the government, there is a deviation in budget and the actual spending of the government. The actual public expenditure can be attributed to a few factors. Firstly, resources may not have been allocated realistically and at times, there seems to be very ambitious allocation of the resources. Secondly, the government has not been able to develop the mechanism to utilize the allocated resources to the extent desired on various programmers.

1.3 Significance of the Study

Economic growth and development is possible through the good health. The Gross Domestic Income is one of the measuring indexes of economic development and growth to get improvement on HDI. It is necessary to improve on health which results from the sufficient expenditure in health sector. All economic activities i.e. production, consumption are affected directly or indirectly by people's health condition. Hence health should remain well to all because it serves as backbone in the economic development of a country. That's why it is possible through the public expenditure.

Health and economic development are highly interrelated. It is confusing to identify which is the cause and which is the effect. The general view is that economic growth and development results from the good health. i.e. economic growth and development through the impact on per-capita income and is the determinant of good health.

In Nepal, most of the people are not yet getting health facilities where to get health facility is basic right of the people. There is great challenge to the nation to give proper health facility to the citizens. For the fulfillment of that issue, government

has been allocating the budget increasing trend and making implementing the various plan and politics. This study is concerned with a budget allocation of the government of Nepal and donation given by the donors, in health sector. So, this study focused on what amount of public expenditure expenses and what are the outputs benefited to the citizens.

1.4 Objectives of the Study

The main objectives of the study are as follows:

1. To examine the trend and pattern of public expenditure in the health sector.
2. To study the extension of health service in Nepal.

1.5 Limitation of the Study

1. This study is based on the published secondary data and information.
2. This study would cover the period from it F.Y. 1990/91 to F.Y. 2009/10.
3. This study is specially limited on expenditure analysis in the health sector.

1.6 Organization of the Study

This study has divided into five different chapters. Chapter one is related to background of the study and statement of the problem, significance of the study, objective of the study and limitation of the study. Chapter two is concerned with the review of the literature and describes theoretical concept about public expenditure and health activities in Nepalese context. Chapter three is the methodology chapter which consists of definition of different variables used in this study. Chapter four deals with the trend and pattern of government expenditure related to public health expenditure. Chapter five is the last chapter where the summary, conclusion and recommendation of the study are mentioned.

CHAPTER-II

LITERATURE REVIEW

2.1 Review of Literature

The purpose of literature review is to find out what research studies have been conducted in field of survey and what remains to be done. The literature review on this topic are many research papers, survey articles, literature has been given below.

2.2 Theoretical Context of Public Expenditure

2.2.1 Classical Views on Public Expenditure

This classical economist always believed in the existence of the full employment in the economy. They had a strong belief that if the resources are fully employed then the government intervention is not necessary. Thus the classical economists developed arguments to justify the role of government and thus defined that area of public wants.

Government expenditure consists of spending on real goods and services purchased from outside suppliers, spending on employment in state services purchased form administration, defense and education, spending on transfers payments to pensioners, the unemployed and the disable spending on subsidies and grants to industries and payments of debts interest.

The normative orientation of public expenditure reached a higher stage through the seminal articles by Samuelson in the early 1950's. These articles viewed the concept of sure public goods as something which people desired but which could not be provided through the normal market mechanism. Because the way the goods and services are provided ensures that they will be equally consumed by citizens. That is no one can be excluded from enjoying service provided whether he pay for it or not. Samuelson work together with a larger independent formulation by Musgrave (1959) has given rise to the large and growing literature on the theory of public goods. In short, classical economists had no faith in the government activities. According to their view, the main theme of the public finance was simply to make the best of a bad lot and to allocate the burden of taxes as fairly as possible among the members of community.

2.2.2 Keynesian Views on Public Expenditure

Keynesian theory shattered the basic foundation of the classical doctrine, when the former asserted that the competitive process of free enterprises economy does not necessarily ensure an effective demand such as to absorb all productive resources at full employment, supply doesn't operate its own demand and the economy may attain equilibrium at underemployment level.

Froyen puts in his book macroeconomics: Theory & policies. Keynes economics developed against the background of world depression of the 1930 the length and the severity of decline in economic activity that occurred that time were unprecedented the unemployment rate rose from 3.2 percent of the labor force in 1929 to 25.2 percent 1933, the low point for economic activity during the depression. Unemployment remained at over 10 percent throughout the decade. Real gross national product (GNP) fell 30 percent between 1929 and 1933.

Keynes regarded the inevitability of a positive fiscal policy. At a level of an income corresponding to full employment, the gap between total income and total consumption is so high in mature economy that private investment is inadequate to fill it. If unemployment is to be avoided the gap must be filled either by government expenditure or by increasing the prosperity to consume. But in a capitalize economy which is characterized by wide inequalities in the distribution of income and institutional factors which make for a high propensity to save the propensity to consume cannot easily be raised enough to have a significant effect upon employment falls on the public expenditure designed to narrow the gap between income and consumption at full employment. Further in Keynes view, a depression in an advanced industrial economy occurs due to the deficiency of aggregate demand. Thus, during a depression, when the aggregate spending is inadequate to achieve full employment, the government must increase spending directly by undertaking public works programs on a large scale and indirectly by inducing people to spend more.

2.2.3 Wagner's Hypothesis

The 19th century economists Adolf Wagner adds new dimension to the concept of public expenditure. Most of his works have been published in German language. His law was based upon historical facts. Wagner presented his former 'Law of increasing state activity" pointed out the growing importance of government activity and expenditure as an inevitable feature of progressive state. He put his hypothesis on

test by examining the industrialization process in various countries such as Britain U.S. Germany, Japan and France.

The basic cause of the relative growth of government expenditure according to Wagner is “social process”. This factor necessitates in addition to the position of economics goods, including the provision of certain “Social products” like communication and education. As real per capita income grow, investment in these “social products” tends to increase which helps to push up the magnitude of government expenditure. As the economy is continuously expanding, government expenditure will also tend to continuously expand.

Among the factors making for charges in the private sector which influence public expenditure decision particular mention may be made of the four factors discussed below.

a) Income Effect

One of the major factors which determine the demand for goods and services including public goods and public services is the magnitude of the flow of real income occurring to the members of the community. As this income increases the effective demand for all kind of goods and services are increases. No special problems arise in this relation between higher incomes and higher demand in the case of goods and services provided through the market mechanism. The relationship here is obvious and straight forward higher incomes induce and increased demand for such kind of goods and services and the market responds to the increased demand through increase supply of goods and for increased process for these goods.

b) The Population Effect

A second factor which has made increase public expenditure is the secular growth of population. With the growth of population and increased in the flow of real income occurring to individuals the place of urbanization has also increased at a rapid rate. This has necessitated and increasing rate of outlay on the provision of public services and urban amenities through public expenditure allocation.

c) **The Urbanization Effect**

Increasing rate of urbanization, however is a major factor accounting for an ever growing rate of public expenditure. There is also the possibility of external effects of

an expenditure becoming more and more widely diffused as consequence of the increase in the size of the urban community.

d) The Technical Effect

Another development in the private sector of the economy which has been instrumental in bringing about increase in public sector activity is the nature and extends of technological innovations. Many of these innovations have been the cause of substantial increase in external effects necessitating there by increased expenditure by public sector institution.

Conclusion is that the increase in the real per income technological process, growth in population, rapid urbanization are the main cause of the rapid growth in the public expenditure for the provision of public goods and services in the economy.

2.2.4 Peacock Wiseman Hypothesis

Peacock and Wiseman analyze the process of growth of public expenditure in terms of three separate but related concepts of the displacement, inspection and concentration effects.

a) Displacement Effect

It was during the period of emergencies or of major social disturbances such as war and depression effect by which the previous low level of expenditure were displaced by a new and higher level of expenditure during the emergences.

b) Inspection Effect

Association with his displacement effect is the inspections effect, which helps to review the higher levels of public expenditure forced on the public sector institutions at the time of emergency. This effect refers to the phenomenon whereby as a direct consequence of the social emergency, public expenditures comes to encompass within in preview economic and social activities which might have been the province of private sector concern prior to period of crisis.

c) Concentration Effect

In the secular growth of public expenditure in Great Britain peacock and Wiseman discovered the influence of another factor which they call the concentration

effect. It refers to the evolution of the expenditure undertaken at different level of the government and its tendency to be concentrated at the national or central level of the government. The usually happens when a country is experiencing economic growth.

2.2.5 Colin Clark: Critical Limit Hypothesis

Colin Clark put forth what he calls the 'Critical limit' hypothesis regarding tax tolerance. Colin Clark based his hypothesis on the interwar data of several western countries. He has argued that inflation inevitably occurs when government expenditure financed out of taxes and other receipts exceeds 25 percent of the aggregate national income. This has been alleged to be true even under circumstances when the budget remains in balance. Public expenditure beyond a stipulated level will causes inflation only if there doesn't exist initially sufficiently unused capacity of carter to the increased demand and if the additional public spending to release resources necessary to meet the requirement of increased public expenditure.

Theory holds that by increasing taxes and restricting credit, it is possible to cut down expenditure of the private sector and thereby to accommodate increased public expenditure by releasing sources from private use. Therefore when it is asserted the public expenditure beyond a specified limit will generate inflation it seems to imply that resolution of private expenditure and account of personal consumption and private investment is either possible or undesirable. If any of these contentions is conceded, it will be true that additional public expenditure will cause inflation in the economy.

2.2.6 Productivity Lag Hypothesis

The 'Productivity lag' hypothesis sometimes called 'Baumel's disease is based on the proposition of productivity differentials Baumel (1967), while distinguishing progressive and non-progressive sectors in the economy, maintains that to keep the same output level in the non-progressive sectors in the economy, maintains that to keep the same output level in the non-productive public sectors, labor input has to be increased tremendously. As a result public sector expansion takes place at the cost of private sector. It follows that productive gains are less likely to be experienced in the public sector than in private sector and hence there will be inherently greater labor intensity in the public sector compared with private sector.

2.3 Review of Related Area in Nepalese Context

Singh (1977): In his book 'The fiscal system of Nepal' studied the expenditure pattern of Nepal government during the period of 1956/57 to 1976/77. He found that Nepal government budget show that between 1956/57 and 1962/63 (except 1961/62) revenue was not sufficient to meet even regular expenditure. Since 1963/64, there had been enough to meet development expenditure. Both regular and development expenditure had been rising fast. According to him, investment in the public sector establishment of regional growth centers and decentralizing of administration in a number of case maintenance expenditure social service expenditure increases in salary and dept. Similarly, Upadhyay (1981): Studied 'the impact of trend of public expenditure on GDP'. He found the volume of development expenditure was increasing rapidly though of the country and there by the standard living the per-capita income.

He also analyzed the resource allocation practices and observed that large amount of public expenditure was centered to the development region in the study period of 1972/73 to 1977/78. He concluded that the resource allocation practices were only growth promoting rather than balanced regional development. He noticed the volume of development expenditure increased during his study period out contributing to low rate of economic growth. Consequently, the standard of living along with per capita income did not increase as per expectation. His finding was that government expenditure mainly was confined to the infrastructure of development rather than the basic needs of people.

In the same way, Basnet (1983): Studied 'the problem of resource gap and analyzed the trend of public expenditure'. He found that the growth rate of development expenditure. It is much higher than the growth rate of regular expenditure of the total expenditure. Economic services alone consume more than 50 percent of it. He found that the share of total expenditure to GDP has increased from 7.9 percent in 1970/74 to 14.08 percent in 1980/81. The share of regular expenditure to GDP has also increased from 3.4 percent to 4.8 percent in1980/81. About 75 percent to 80 percent of the total expenditure is allocated always for meeting the requirement of economic services and economic administration and planning.

Likewise, Shrestha (1986): Studied 'a significant incensement in the government expenditure during the period of 1961 to 1982'. The dominant scenario, as she observed, was the foreign aid consisting of grants and loans rather than the

resource mobilization within the country. She figured out that government spending on an average at the constant price of 192/93 was Rs. 467.07 million yearly during the period mentioned above in the same period, she observed an increase in the per capita GDP was Rs. 2.7 million and the government spending was raised by Rs. 45.4 million in the study period. She noticed a little influence of government expenditure on country's GDP despite the increasing rate of government expenditure.

Khanal (1988): Studied 'the growth pattern and impact of public expenditure different sub-sector of the Nepalese economy'. He studied the log liner regression model to examine the pattern and growth public expenditure using a demand factors. He found that revenue alone doesn't pay an important role in the expansion of regular expenditure but an increase in development expenditure has far-reaching implication for expansion of regular expenditure.

In order to examine the macro-economic impact of public expenditure in different sub sector of the Nepalese economy, Khanal developed a structural macro model of the economy. Khanal's macro-exercise produces a number of interesting result but an auto correlation problem, an under specified model and an under size sample all suggest show that social service comprising mainly education and health tend to increase at faster rate than other services like economic administrative defense etc. That major expansion has taken place only after the 1970. The elasticity coefficient for total public expenditure, development expenditure, economic services and social has been found to be more then unity. Income elasticity's for a regular expenditure, defense service and administrative service have been obtained to be below unity (Khanal, 1988).

Upreti (1996): Analyzed 'the trend, pattern and impact of public expenditure during the period 1974/75 to 1991/92'. He found that the growth of public expenditure in Nepal has taken place rapidly than the growth of GDP of the country. The growth rate of development expenditure is almost equal to the growth of development expenditure. He found that that the large percent of development expenditure has been covered by foreign aid. This trend highlights the expenditure pattern in Nepalese economy that is unable to create more than 80 percent employment which has been provided from agriculture sector but on the other hand, the higher average growth rate of public expenditure to agriculture sector than non-agriculture sector has become unsuccessful to get more GDP growth rate from agriculture sector.

Khadka (1998): In his M.A. thesis, entitled 'role of public expenditure in economic development on Nepal', has made a remarkable study during the period of 1974/75 to 1994/95. The study had estimated the regression model using cross sectional data. The double log transformation model has been used in the study. During the period under consideration, the size of public expenditure has found to be extremely increasing. It has been observed that the internal revenue has mainly helped to increase recurrent and consumption type of expenditures. He has found the high dependence of development expenditure on external sources. The dependence of foreign aid adversely affects the growth rate of the economy through the sustainable increase in the capital output ratio. In the study period, the foreign aid covered 48.5 percent. Development expenditure is 31.6 percent of total expenditure on average. He has also pointed out the weakness in both macro and sect oral planning due to the absence of regional cost benefits analysis and program budgeting. The donor agencies have predominantly influenced in determining the sect oral programs.

World Bank (2000): On a study under the title 'Nepal: Public expenditure review' concluded that Nepal is not facing a fiscal collapse rather than the fiscal situation is quite stable. This study, however, showed inefficiency and mismanagement on public spending. Deficiencies in the budget planning, resource allocation and expenditure management process has been found a major factor contributing to low productivity. This study pointed out the institutional weakness for the insensitiveness of public spending in Nepal. The report present number of suggestion to improve the effectiveness of public expenditure projection, good governance and transparency, decisive action to formulate an auto-corruption agenda greater local ownership of the public expenditure program, build a partnership between local and central and public and private etc are major.

Pyakuryal (2004): Under the study title 'Nepal's conflict economy; cost, consequences and alternatives', has presented that Nepalese economy has lost its productive capital and sustained growth due to the government expenditure and revenue pattern. He found that ratio of regular expenditure of GDP in f FY 1996/97 was 8.6 percent but increased to 11.5 percent in 2001/02 on the other hand he found that ratio of development expenditure was decrease with 9.5 to 7.5 percent daring the same period. So, he recommended the explanatory fiscal policy is better that contract nary fiscal policy in war time.

Adhikari (2004): In a thesis entitled 'public expenditure in Nepal trend and determinants' concerns all about the trend and pattern of government expenditure during the time frame 1990/2000. He observed empirically that the determines of public expenditure during the period under review, both demands as well as supply side factors have contributed to rapid growth on the size of public expenditure. Under demand side factors that the public expenditure is highly responsive to GDP. He found that the elasticity coefficient of total expenditure, regular expenditure and development expenditure are 1.01, 1.45 and 0.64 respectively and concluded that the elasticity is grater then one in ease of total expenditure and GDP is the clear indication of the fact that not only demand side factors were influential in determining the size of public expenditure during 1990s. He observes that the overriding trend on the public expenditure reflects alarming situation with regard to fiscal discipline and the overall development program of the country. Following the restoration of multi party democracy system on early 90s, there was tremendous increase in the size of the public expenditure. The massive investment in each successive plan and annual budget for rapid expansion of economic and social infrastructure can be entitled for that increase. However, the massive public expenditure fails to aspirate the peoples' expectation to the country the country continuous to remain at low-level equilibrium trap.

Dulal (2007): In a dissertation entitled 'analysis of the pattern of public expenditure in Nepal, comes up with the following conclusion. "Regarding government expenditure behavior in the conflict economy, the government expenditure on regular expenditure and expenditure on defense has been increasing from the FY 2035/36 B.S. to FY 2060/63 ignoring some fluctuation. Oppositely, government expenditures on development purpose have been decreasing especially very in the conflict period pattern shows perfect application of P.W. hypothesis."

Shrestha (2009): In a research article entitled 'The composition of public expenditure, physical infrastructure and economic growth in Nepal' which asserts a mix of public spending could lead to a higher steady state growth rate for the economy. Based on the model, the empirical model suggests that expenditure on physical infrastructure is productive in Nepal, but its share is declining in slow growth of per capita income. In this context, it would be better to allocate more resources to develop physical infrastructure in Nepal, which is not only facilitates private

productive activities, but also generates employment in the economy for the mass an employment."

Nepal has history of health care services from traditional healing practice like Ayurveda (Herbal treatment) people in rural areas in Nepal still go for spiritual healing practice. Nepal is a country with an ancient and deeply rooted tradition in sprite processing and fifth healing for vast majority of ruler village this is the only means of health care. The introduction of new ideas about bacteria, infection and disease are contriving the gad-old beliefs in ghosts, witches and sprits immunizations drugs and medical treatment are odds with widely respected healing power of the Jhankari or local faith healer. More then half population are live in ruler specially mountain region, there are no infrastructure made properly .most of the old age people still believe on healing(Jhankari) . Jhankaris become doctor in these areas. Poor people say reach people only go to the hospital; we could not reach there due to the lack of money. The modern health practice was introduced during the malla regime. The year of 14th century. During Rana regime (1846-1915).few creative dispensaries wear available in country. But these were only for family member of Ranas .After fall of the Rana regimi , and restoration of democracy, since then health has been incorporating in the development plan of the country (Adhakari and Maskey:2003).

Nepal has experienced the inequalities in health services. Hospital are much more unequally distributed than other variables, the available is the number of hospital beds. The number of hospital beds is not evenly distributed with the proportion of the population in different regions of the country. Similarly, the doctors are not equally distributed in the different zones and the different regions of the country. Among the four indicators, the most wide uneven distribution can be seen on the part of doctors. The high gini coefficient shows the most uneven distribution of the doctors in different zones of the country i.e. 67.13 percent and the Gini coefficient of hospitals by taking the zonal wise distribution is only 4.64 percent. It indicates there is approximately equal distribution of hospitals in different zones of the country. The uneven distribution of doctors brought about a severe problem in the country. Only the hospital beds do not serve the general health of people, but equally, it is necessary apparatus, incentive and facility to operate this apparatus. So it is necessary to distribute the medical personal equally in different regions of the country to serve the people and to operate other available facilities, which has shown the high demand for medical doctors to provide good health service (Dhungel, 2004).

Thus, Nepal has faced growing demands for the extension of health service in the rural areas due to lack of health services, health resources and facilities. The rural population accounts for 85 percent of the nation's population. Rural people have higher risks of infection and disease, mental illness and nutritional deficiencies. Therefore, it may have higher needs for those amenable cares.

Ministry of Health and Population (2003), mentioned that in financial volume relatively little resources are targeted towards programs that benefit women of child bearing age such as family planning, safe motherhood and FCHVs. The share of reproductive health in total expenditure on health was 14 percent in 1999; it reduced to less than 3 percent in 2001/02 because of phasing out the population and family health sector. However, Nepal has higher MMR and morbidity, but unfortunately allocated amount is less inadequate to address the magnitude of the problem since there is less attention for women health for only women program is doubtful. It must be well documented only in the policy level, but less attention in implementation part as usual. Acharya (2003), analyzed the gender assessment in the health, education and agriculture sector. The study has found that women specific programs have been less focused than pro-women and other in health and education sector, as result, the classification of budget is also very nominal for women specifically. The study covered 1998/99 to 2000/01 of actual and allocated budget on both education and health sectors.

Public expenditure on health sector increased from NRS 3993 to 4626 in 2001/02, where the share of development expenditure increased remarkably from 29 to 40 percent. This indicates the less contribution of public expenditure in changing the health outcomes. In the total public finance on health the share of the central government is more than 50 percent, which shows and increasing trend. The central government (NG) contributed about 65 percent of public finance in 2002 while the share of EDPs was just over 32 percent in the form of direct and indirect spending (Ministry of Finance, Red books).

The private sector plays a key role in Nepal's health care system, and this NNHA provides the full evidence for this. As we see, almost two-thirds (62.5%) of Nepalese healthcare is directly financed by the private sector, so regulating the healthcare system has remained a major challenge in recent years. Regulating facilitation and co-ordination of the private sector's field optimum outputs in the

health sector. Public private partnership can play an important role for the improving the quality as well as containing the costs.

Reporting on the public expenditure on health as a percent of GDP in Nepal, WHO reports public expenditure on health has increased three fold. This increased pressure on the government budget for the extension and expansion of health care services with new technology, which need to spend more for the costs of health care. However, Nepal is still suffering with lack of equality in public spending on health by geographically (Rural and Urban), demographically and gender wise and economically (equality of source of finance, equality in distribution of benefits by income groups).

A significant change has been noticed in the coverage of health care service with the increase in the health expenditure. Vaccination coverage has improved significantly over the last 10 years. The Ministry of Health (2004) reported that total public expenditures on health increased form Rs. 3993 to 4626 million in the review period where the share of development expenditure increased marginally form 18 to 20 percent and that of regular expenditure increase remarkably from 29 to 40 percent. This indicates the less contribution of public expenditure is changing the health outcome.

The health expenditure shows more than 90 percent of total budget distributed in central level and less than 10 percent spent in district level (Ministry of Finance 2004). Thus the allocation of budget had very big gap between central and district level. Therefore, the district level also must have increased the budget similarly to central level. The development must be decentralized rather than centralized. However, it is little bit satisfactory in health expenditure in district level. (Source: Sakya Kusum: human resource development in Nepal: An analysis of education and health sectors.)

Health in Nepal is poor by international standard: especially disease prevalence is higher than in other south Asian Countries, leading disease and lioness include diarrhea, gastrointestinal disorders, goiter, intestinal parasites, leprosy and tuberculosis. Nepal also has high rates of child malnutrition (72 percent in 2001) and, under-five mortality (91.2 deaths per 1000 live births in 2001). According to United Nations data 2003, approximately 60000 persons aged 15 to 49 had human immunodeficiency Virus (HIV) and the HIV prevalence rate was 0.5% in spite of

these figures evidence suggests some improvement for example: Nepal's HDI was 0.504 in 2002, ranking Nepal 140 out of 177 countries up from 0.291 in 1975.

About 90 percent of the health expenditure is administered by Ministry of Health in Nepal (NESAC: 1998) though health sectors expenditure grew 3.47 percent in 1991/92 to 6 percent in 1996/97, but as a percent of GDP, this amount still accounts slightly more than one percent. About 40 percent of the government health sector budget expenditure continued to be allocated to the maintenance of hospital and curative health care. Despite some achievement in health sector, the level of deprivation is still extremely high improvement in the health services is highly unequally distributed across the regions, Rural, urban and income groups. The report stated that in the absence of prioritized set of health intervention inequalities in the status of health and inequalities in health related capabilities will widen.

NGO, play important roles in health development, the share of NGO, pay important roles in health development, the share of NGO, has been increased significantly in the last decade from 2 to 11 percent between 1994/95 to 2002/03. There is a scope of increasing coverage of EHCs by NGO. Therefore the government should regular facilitate and promote the roles of NGO in delivering the health care service to the poor and excluded groups.

After 1991, the role of NGO is appreciated by the government and the number of NGO has been increasing remarkably. The share of NGOs expenditures was only 2 percent of the in 1994/95 and it increased to 15 percent 2002/03 the survey listed 295 NGO reveals that NRs 3.6 billion spent by NGO on health care service in 2002/03 which near to the more then the central government spending on health (NRS. 3.5 billion). The share of international NGOs is the largest (73%) in the NGO expenditure on health Nepal with NRs. 2.7 billion (11% share of the) 2002/03 then NRs 1 billion was spent by us based and USAID supported INGOs on health care services in Nepal. Nepal NGOs expenditure on health was amounted to be NRS. 964 million in 2002/03, in percentage term the share of Nepali NGO and CBOs to total health expenditure (THE) was about 4 percent.

During the plan period the development expenditure had been decelerating by 1.1 percent annually. The share of development expenditure was proposed to be 56.2 percent of the total plan out lay but unexpected rise in regular expenditure force to limit it to 46.9 percent during the plan period. The targeted expenditure on economic services, infrastructure, social services and miscellaneous (administrative and

contingency) was 294, 36.3, 33.4 and 0.9 percent of the development expenditure respectively. The expenditure in unproductive sector especially a miscellaneous heading has exceeded the target, which the expenditure on productive sector like economic services and infrastructure has remained below the target (NPC, 2002).

Health in development plan was initated with the establishment of the department of health services in 1953 under the Ministry of Health and Population (MOHP). It was changed with the promotion and management of hospital and dispensaries. The first five –year development plan was launched on 1956, giving top priority to transportation and telecommunication. There were no specific targets set in the first four five – year development plans for health care , though prevailed the specific health programs like prevention and control of the disease like malaria. Small pox, tuberculosis, Leprosy, were undertaken. By the end of tenth five – year Plan (2062/ 63 B.S). there was 102 hospitals, 1176 health posts , 291 ayurvedic dispensaries , 2617 sub-health posts , and 207 primary health posts are made (Economic Survey : 2010)

National Health Policy

The first national health policy of Nepal was announced in 1991 with the principal aim of up grading the health standards of the majority of the rural population by extending basic primary health services up to the village level. It also aims to provide the rural people an opportunity to obtain the benefits of modern medical facilities by making services accessible to them. The motto of the policy is attainment of the highest possible level of health by all Nepalese people.

In Nepal 1990 dramatically shifted in the political regime from panchayanti system to Multi-party democracy system. The democratic government followed by the macroeconomic reform in the county (Khanal et al, 2005). The government for the first time introduced “Nepal Health Policy” in 1991 A.D. with an aim to “Upgrade the health standards of the rural population through the primary health care approach” (Adhikari and Maskey, 2003:104). The primary objective of the national health policy is to extend the primary health care system to the rural population so that they benefit from modern medical facilities and trained health care providers. The national health policy addresses the following areas:

a. Preventive Health service

Priority is given to programs that directly help reduce infant and child mortality rates. Services are to be provided in a integrated manner throughout the health system to sub health posts at the local level.

b. Promotive Health Services

The programs that enable people to live healthy lives will be given priority.

C. Curative Health Services

Curative health services will be made available at all health institutions: central regional, zonal and district hospitals; primary health care centers (PHCC), health posts (HP), and sub health posts (SHP) and at the health institutions at all levels of health care system. Mobile teams will be organized to provide specialist services to remote areas.

d. Basic Primary Health Services

Sub health posts will be established in all village Development Committees (VDCs). One health post in all electoral constituencies will be upgraded in a gradual manner and converted to a primary health care center.

e. Ayurvedic and other Traditional Health Services

Ayurvedic system will be developed another traditional health system such herbal, homeopathy, naturopathy will be encouraged.

f. Organization and Management

The organization and management of health facilities will be improved at the central, regional and district levels. This will include the integration of the district hospitals and the public offices into District Health Offices.

g. Community participation in Health services

Community participation will be sought at all levels of health care thought the participation of female community health volunteers (FCHV), traditional birth attendants (TBA) and leader of various local social organizations.

h. Human Resources for Health Development (HRH)

Technically competent human resources will be developed for all health facilities. Training centers and academic institutions will be strengthened.

i. Resource Mobilization in Health services

National and international resources will be mobilized and alternative concepts such as health insurance, user charges and revolving drug schemes will be explored.

J. Blood Transfusion Services

The Nepal Red Cross Society will be authorized to conduct all programs related to blood transfusion. The practice of buying, selling and deposition blood will be prohibited.

k. Health Research

Health research will be encouraged for better management of the health services. Making available one health post for every electoral constituencies and encouraging the private sector and NGOs in the health care services so that the rural people could benefit form the modern health care facilities.

The national health policy came up focusing on the health care of rural people however; its success was hindered by the lack of government commitment. The rough landscape of the country is another difficulty on the accessibility of services by those living in the mountainous region (Deslich, 2004:5).

Conclusions

In conclusion, the findings of various researches are largely different. This research has examined different researchers and analyzed their studies through different aspects. Mainly some researches are concentrated on social sectors, some are in the impact of public spending in various sector and some are concentrated in pattern and growth of public expenditure. In the context of Nepal, a very few empirical studies have been done. So, there are many causes to create the problems and keeping the country in the poor condition such as, massive poverty, the political condition, low per capita income, population pressure, agriculture dominate economy, low living standard, illiteracy, higher unemployment, technological backwardness, low participation of the private sector, decreasing the rate of foreign aid, low productivity, capital deficiency etc. If the government has provided these facilities, it would have solved easily.

CHAPTER-III

RESEARCH METHODOLOGY

Research methodology is used to solve the research problems in systematic way. The study focuses on the trend and pattern of public expenditure in health sector and the condition of Health resources.

3.1 Research Design

A research design is the specification of methods and procedures for acquiring the information needed. It is the overall operation pattern or framework for the project that stipulates what information is collected from which sources and by which procedures. Thus, a research design is a plan for the collection and the analysis of data. In this study, the trend of the government expenditure on health sector is basically analyzed by using descriptive method. The main concern is on what has happened and what is happening. On the other hand, analytical method uses previously available facts or information and analyzes these to make a critical evaluation of the material. This evaluation helps to analyze the government spending on health is utilized effectively or not.

3.2 Sources of Data

This research study is based on secondary data that are available in the published and unpublished form. The required data for the study are collected from different organizations. The data are mainly taken from the following sources:

1. Publication of NRB
2. Publication of Ministry of Finance
3. Publication of CBS
4. Economic Survey
5. A Hand Book of Government Finance Statistics
6. Human Development Report
7. National Health Accounts MoHp
8. Economic Review
9. Related Internet Web-sites

3.3 Methods of Data Analysis

The collected data from relevant sources is processed according to the need of the study. The available and collected data from various sources are collected, classified, grouped, tabulated and analyzed to meet the need of the study. Simple statistical tools are used for analyzing the data.

3.4 Statistical Tools and Variables

The variables of the study are as follows:

1. Total expenditure (TE): Total government expenditure during the specified year.
2. Regular expenditure (RE): Total consumption type of current expenses of government that is compulsion to expenses.
3. Development Expenditure (DE): Total capital expenditure of government during specified year. It can be considered as public expenditure as well.
4. Total Health Expenditure (THE): Total Government Expenditure on Health Service in Specified year.
5. Administrative Health Expenditure (AHE): It denotes the services such as; Minister of health, Department of Health, Regional health directorates and national program of population etc.
6. Curative Health Expenditure (CHE): The Expenditure includes the services such as; Hospital as Bir hospital, Patan hospital, with regional and Zonal hospitals etc.
7. Preventive Health Expenditure (PHE): It includes the services such as; AIDS and STD, TB, Leprosy, polio control etc.
8. Health resource development Expenditure (HRDE**):** It includes the services as; Training, Educating, lap and research etc.
9. Health management Expenditure (HME): Suggests the services as; Construction, Improvement, Repair, Mantonces and equipment supply etc.
10. Integrated health program (IHPE): Suggests the services as; spending with co-ordinating local governance and agencies

3.5 Human Health Resources

1. Doctor: The trained personal (MD, MBBS, Kaviraj, Vaidya) who directly or indirectly involve in the treatment of sick people in hospital.
2. Nurses: The personal who engaged in the services for sick people in the hospital.
3. Health Assistants: The assistants who involved in general treatment.
4. Health workers: General worker in health services.
5. Trained students, women and volunteers.

3.6 Health Services

1. Hospitals: Institutions providing medical and surgical treatment and nursing care for all and injured people.
2. Hospital beds: The beds where the injured people kept during treatment or got rest after treatment in hospital.
3. Health centers: Building containing various local medical services and doctor's practices.
4. Health posts: The places providing health services to the people.
5. Ayurvedic services centers: The places where the herbal treatment and herbal medicines are provided.
6. Sub-Health posts: Sub branches of health posts
7. Primary Health Centers: The medical centers primary treatment is done, etc

Chapter-IV

DATA PRESENTATION AND ANALYSIS

This chapter discusses the public expenditure on health service and status in the health sector. Analysis the health situation in Nepal; Covering the health status, health care services, Situation of health institutions and health resources and others. The health status includes the infant mortality Rate (IMR), Life expectancy (LE) at birth, Child mortality Rate (CMR), etc. The health care services present the various health institutes and availability of services such as; Hospitals, Hospital beds human resource group and other related to health service activities .The public expenditure presents the government spending in the health sector. This chapter analyzes the trend and pattern of total health expediter since 1990 in Nepal.

The improvement of health status of the people requires allocating the public resources for the health sector and spending them in such a way that it should insure easy and affordable access of health services to the people .The primary goal of public spending is to produce healthy manpower for not only economic development but also for overall sectors of the country. So, it shut be ensured the access health service to the people the size and quality of public spending on health sector play a curial role in the social equity and poverty reduction. More over in the economic development. It is essential to study critically the public health spending and to provide evidence for redesigning health policy and improving budget performances. This chapter attempt to over the status of public health spending and deficiency of health spending.

4.1 Analysis of Public Expenditure on Health

The public health expenditure has been analyzed by using the share of health expenditure on total public expenditure, Total development expenditure, Regular expenditure etc. That is shown below.

4.1 Share of Health Expenditure on Total Public Expenditure

The increasing share of health expenditure on the total expenditure except in some years shows that the government is increasing its attention towards the health care of the people however; the share is still low. It refers that the government is not providing the proper attentions and not conscious on general health problem. The Share of health Expenditure on total public expenditure has been presented on the table.

Table 4.1

Share of Health Expenditure on Total Public Expenditure

(Rs. in Million)

FY	Total Public Expenditure	Total Health Expenditure	HE as % of TE
1990/91	23533.6	660.6	2.8
1991/92	26418.2	918.1	3.5
1992/93	30897.7	1061.0	3.4
1993/94	33597.4	1065.6	3.2
1994/95	38795.4	1495.6	3.9
1995/96	46542.4	1714.6	3.7
1996/97	50723.7	2506.6	4.9
1997/98	56118.2	3125.1	5.6
1998/99	59779.0	2814.6	4.7
1999/00	66272.5	3451.5	5.2
2000/01	79.835.1	3519.7	4.4
2001/02	80072.2	3856.6	4.8
2002/03	84005.2	3652.0	4.3
2003/04	89442.5	3968.6	4.4
2004/05	102560.4	4597.5	4.4
2005/06	110888.9	5722.5	5.1
2006/07	133604.6	7440.7	5.5
2007/08	161349.9	9844.3	6.1
2008/09	219661.9	12731.4	5.7
2009/10	259689.1	15913.8	6.1

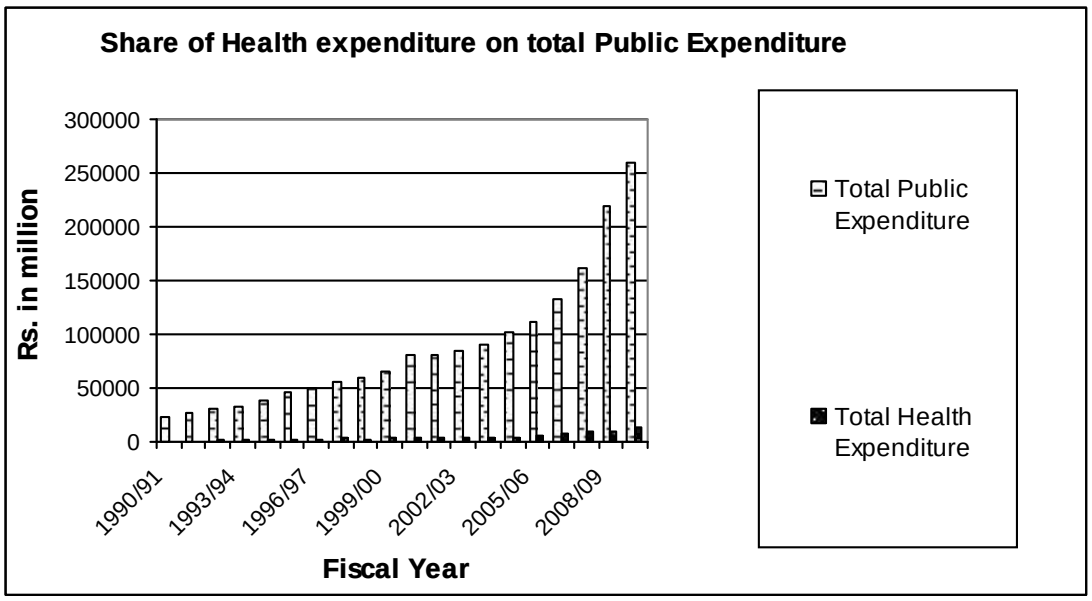
Sources: Economic Survey, Various Issues: Ministry of Finance

HE= Total Health Expenditure, TE = Total Public Expenditure

Table 4.1 shows the share of health expenditure on total public expenditure. In the FY 1990/91, the share of health expenditure on total expenditure was 2.8 percent in which total and health expenditure was Rs. 23533.5 and Rs. 660.6 million respectively. The share of health expenditure reached at 6.1 percent in the FY 2009/10 Total and health expenditure were Rs. 2596689.1 and 15913.8 million respectively.

The government is not able to allocate on the health sector. There might be various reasons. Some of them are increasing demand for government budget to resolve the ongoing conflict. During the last decade, low revenue collections in comparison increasing expenditure, low, disbursement of the health sector are major.

Figure No. 4.1



4.2 Composition of Health Expenditure

The increasing trend of regular health expenditure shows the government is allocating more amounts only for current expense and salary payment. As the increasing of regular expenditure, has not in creased in development expenditure. It indicates that government concentration to expand the health care services. The composition (trend and pattern) of the health expenditure has been presented on the table no. 4.2

Table no 4.2

Composition of Health Expenditure

(Rs. in million)

FY	Total Health Expenditure	Regular Health Expenditure	Development Health Expenditure
1990/91	660.6	293.9 (44.5)	366.8 (55.5)
1991/92	918.1	410.9 (44.8)	507.2 (55.2)
1992/93	1061.0	460.8 (43.4)	600.2 (56.6)
1993/94	1065.6	505.1 (47.4)	360.5 (52.6)
1994/95	1495.6	637.1 (42.6)	858.5 (57.4)
1995/96	1714.5	799.0 (46.6)	915.5 (53.4)
1996/97	2506.6	885.4 (35.3)	1621.2 (64.7)
1997/98	3125.1	1049.0 (33.6)	2076.1 (66.4)
1998/99	2814.6	1137.4 (40.4)	1677.2 (59.6)
1999/00	3451.5	1324.8 (38.4)	2126.7 (61.6)
2000/01	3519.7	2606.6 (74.0)	913.1 (26.0)
2001/02	3856.6	2957.3 (76.7)	899.3 (23.3)
2002/03	3652.0	3492.7 (95.6)	159.3 (4.4)
2003/04	3938.6	3826.4 (96.4)	142.2 (3.6)
2004/05	4597.5	4148.3(90.2)	449.2 (9.8)
2005/06	5722.5	4774.4(83.4)	948.1 (16.6)
2006/07	7440.7	6255.1(84.0)	1185.6 (16.0)
2007/08	9844.3	7409.5(75.2)	2434.8 (24.8)
2008/09	12731.4	10103.5 (79.3)	2627.8 (20.7)
2009/10	15913.8	12836.6(80.6)	3077.2(19.4)

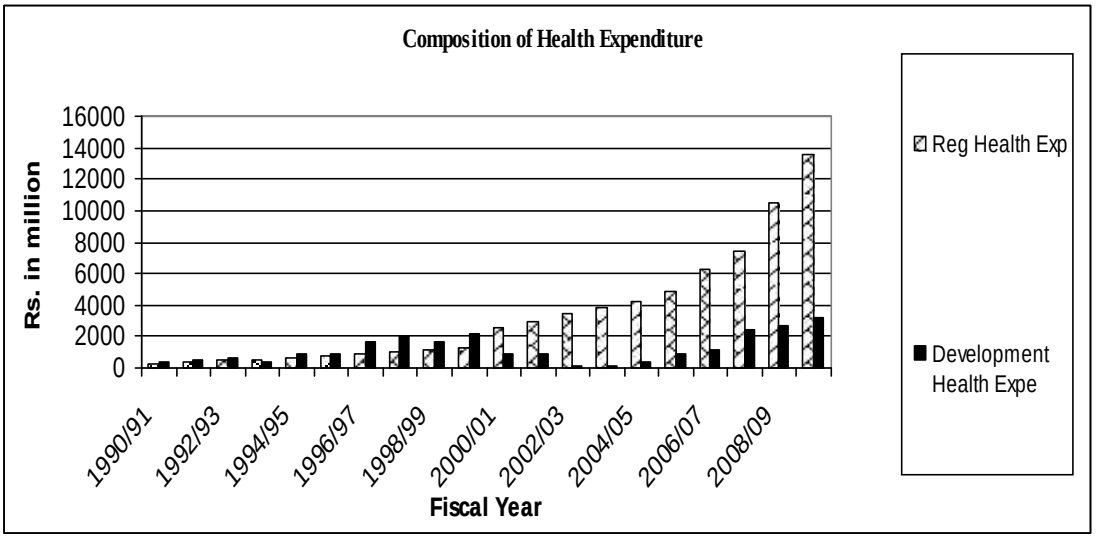
Sources: Economy Survey Various Issues: Ministry of Finances

Table 4.2 shows the terms of health expenditure (total, regular and development) in the FY 1990/91, the total health expenditure was 660.6 million in which regular and development health expenditure was Rs. 293.9 and 266.9 million respectively. In subsequent years, total and regular expenditure have been increasing in absolute amount. But the development expenditure has been increased slightly up to FY 1999/00, which started to decline gradually in the following year 2003/04. It was Rs. 142.2 million (only 3.6 percent of the total health expenditure) from FY

2004/05 it again started to increase. In FY 2009/10 it reached Rs. 3077.2 million in which total and regular expenditure Rs. 15913.8 and 12836.6 million.

Data indicates the government is not able to allocate sufficient budget on the health sector development. The increasing appointment of personal in health sector, excesses expenditure in ongoing conflict, low revenue collection love foreign aid and disbursement on health sector is the major reasons.

Figure No. 4. 2



4.3 Health Expenditure as Percentage of Total Development Expenditure

The fluctuating of health expenditure on the total development expenditure shows that there is no equal percentage of total development expenditure is allocated every year. Lower share of health expenditure on total development expenditure indicates that there was no more expenditure an infrastructure development related to the health service until FY 1999/2000 the share was quite higher. It means the overall development on health sector was going up. After then, it started to reduce from 1999/2000 to 2005/06. (That was Maoists insurgency period). For the fluctuation of share, there might be a problem of civil war. The Share of Total Development Expenditure Presented on the table 4.3.

Table 4.3

Health Expenditure as Percentage of Total Development Expenditure

FY	Total Development Expenditure	Total Health Expenditure	HE as % of TDE
1990/91	7574.1	660.6	8.7
1991/92	9905.4	918.1	9.3
1992/93	11484.8	1061.0	9.2
1993/94	12409.2	1065.6	8.6
1994/95	12265.1	1495.6	12.2
1995/96	21561.9	1714.5	8.0
1996/97	24181.1	2506.6	10.4
1997/98	27174.0	3125.1	11.5
1998/99	31047.7	2814.6	9.1
1999/00	34523.3	3451.5	10.0
2000/01	46485.5	3519.7	7.6
2001/02	49544.1	3856.6	7.8
2002/03	52024.3	3652.0	7.0
2003/04	55711.4	3968.6	7.1
2004/05	63310.4	4597.5	7.4
2005/06	66234.8	5722.5	8.8
2006/07	77122.3	7440.7	9.6
2007/08	64606.5	9844.3	15.3
2008/09	91498.8	12731.4	13.91
2009/10	127738.9	15913.8	12.45

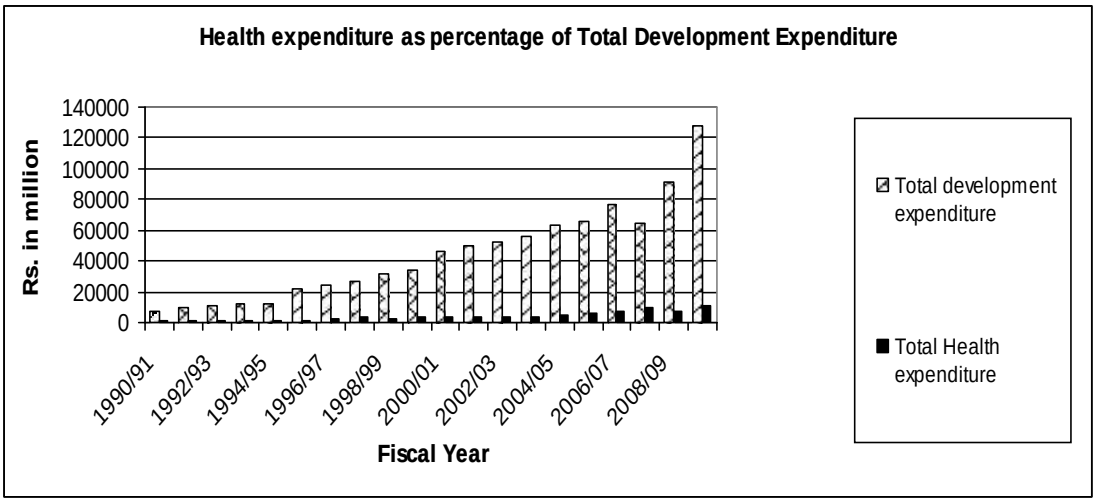
Source: Economy Survey, Various Issues.

HE = Total Health Expenditure, TDE = Total Development Expenditure

Table 4.3 Shows the share of health expenditure on total development expenditure seems fluctuation in 1990/91. The share of health expenditure on total development was 8.7 percent in which the total development and health expenditure was Rs. 7574.1 and 660.6 million respectively. The share is not constant rather its fluctuation according to the change of time. It reached higher up to 15.3 percent in 2007/08 and lower up to 7 percent in 2002/03 in which the total development

expenditure and health expenditure was Rs. 52024.3 and 3562.0 million respectively. It share in average is around 8 percent.

Figure 4.3



4.4 Regular health expenditure

Regular health expenditure is the consumption type of expenditure. It includes expense of health ministry to run its day to day activities, wages and salaries of the employees. It is name of various components, which are transfer traveling allowance, clothing and fooding, water and electricity, communication, fuel and oil, medicinal, program supplies and expenses etc. the pattern the regular health expenditure has been presentation in table 4.4 in to various functional component such as administrative, curative, preventive, integrate health program expenditure etc.

Table 4.4
Total regular health expenditure under different heads
(Rs. In Thousands)

FY	AHE	CHE	PHE	HRDE	HME	IHPE	OE	Total
2004/05	1663950 (40.12)	977677 (23.3)	726105 (17.5)	163821 (3.9)	186865 (4.5)	200239 (4.8)	239737 5(5.7)	4148394
2005/06	1858046 (38.09)	881720 (18.4)	1056666 (22.1)	294390 (6.1)	156695 (3.2)	287630 (6.0)	239441 (5.0)	4774488
2006/07	1988761 (31.7)	954944 (15.2)	1338791 (21.4)	213483 (3.4)	1006861 (16.0)	501640 (8.0)	250633 (4.0)	6255113
2007/08	2246225 (30.3)	1239879 (16.7)	1477569 (19.9)	293632 (3.9)	893004 (12.0)	1015625 (13.7)	243631 (3.2)	7409565
2008/09	2949104 (29.1)	1486568 (14.7)	2029664 (20.0)	336148 (3.3)	1057418 (10.4)	1808749 (17.90	435925 (4.3)	10103576
2009/10	3789814 (29.5)	1960828 (15.2)	2193922 (17.0)	525602 (4.0)	860769 (6.7)	3037209 (23.6)	468478 (3.6	12836622

Sources: Red Books and MoHp

AHE= administrative health expenditure

HRDE= human resource development expenditure

HME= hospital management expenditure

CHE=curative health expenditure

IHPE=integrated health program expenditure

PHE= preventive health expenditure

Table no.4.4 exhibits the pattern of total regular health expenditure under different heads. those categories has again been divided into different sub – categories, according to the table in FY 2004/05 the regular health expenditure was figured Rs.4148394 thousand which reached about Rs.12836622 thousand in FY 2009/10.Data reveals that the round figures where in increasing order, but with in the sub-categories, the Administrative health expenditure captured the remarkable sums starting FY 2004/05 Rs. 1663950 thousand to FY 2009/10 was reached Rs.371789814. Comparing to the starting FY 2004/05, it suggests decreasing data at about 10 percent. The expenditure during the period is highly focused on integrated health program categories. In the FY 2004/05 it was at Rs. 200239 thousand with in 4.8 percent, it increased rapidly and cut the height of Rs.3037209 thousand with the total expenditure of about 23.6 percent. The expenditure for the categories and curative health expenditure was in decreasing ordered which showed 22.32 percent but in the FY 2009/10 it went sharply down on 15.2 percent. The regular expenditure on preventive health expenditure remained constant unlike sum ups and downs during period. Likewise the expenditure on human resource development expenditure and hospital management expenditure showed fewer amounts in comparison to other expenditure under other heading have also constant rather up and down.

Figure No. 4.4

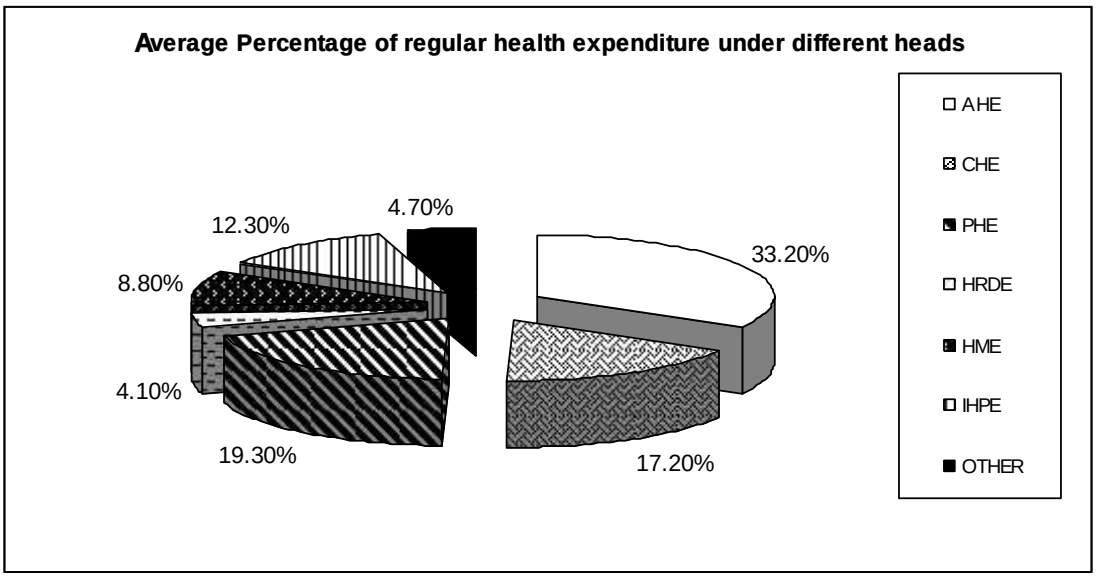


Figure 4.4 show that administrative Health Expenditure, curative Health Expenditure and preventive Health Expenditure received the large share of Expenditure. How ever other sector such as Human Resource Development, Hospital management and other Health expenditure received less than 5 percentages and nearly 4 percentage of total regular Health Expenditure during the year and the share integrated health program received average 12 percent of total regular expenditure respectively.

4.5 Development Health Expenditure

Development Expenditure refers to those developments of the ministry of health, which are liked with the expansion of the capital formation. It includes the expenditure on the land, furniture, vehicles, equipments and machineries, various infrastructure such as building construction etc. the development health expenditures are appropriate and designate to add the productive capacity of the country which would raise the level of living.

The main components of Development Health expenditure include Administrative, curative, preventive, integrated health program etc. the table of development Health expenditure under different major components have been presented in table no.4.5.

Table 4.5

4.5 Total development health expenditure under different heads (Rs. In Thousands)

FY	AHE	CHE	PHE	HRDE	HME	IHPE	OE	Total
2004/05	21992 (4.8)	155658 (34.6)	52106 (11.5)	23570 (5.2)	143977 (32.0)	36998 (8.3)	14926 (3.3)	449227
2005/06	27233 (2.8)	312407 (32.9)	49677 (5.2)	45519 (4.8)	339967 (35.8)	145272 (15.3)	28113 (2.9)	948188
2006/07	9095 (1.0)	458238 (38.6)	47459 (4.0)	76438 (6.4)	267240 (22.5)	308020 (25.9)	19117 (1.6)	1185607
2007/08	7791 (1.0)	790432 (32.4)	161243 (6.6)	104663 (4.2)	357838 (14.4)	982420 (40.0)	30422 (1.2)	2434809
2008/09	27274 (0.7)	999446 (19.0)	309707 (11.7)	86606 (3.2)	223765 (8.5)	1408612 (53.6)	72452 (2.7)	2627865
2009/10	11486 (0.6)	648950 (21.0)	44101 (1.4)	290620 (9.4)	94677 (3.0)	1902808 (61.8)	84599 (2.7)	3077242

Sources: Red Books and MoHp

AHE= administrative health expenditure

HRDE= human resource development expenditure

HME= hospital management expenditure

CHE=curative health expenditure

IHPE=integrated health program expenditure

PHE= preventive health expenditure

Table No.4.5 highlights the total development health expenditure under different heads. And the issues have again been divided in sub-issues respectively. According to the table the development health expenditure of FY 2004/05 was Rs.449227 thousands and topped the remarkable height in the FY 2009/10 with the round finger of Rs.3077249 thousands.

Date reveals the development expenditure on the issue health management expenditure showed sharply decreasing during the year being the starting FY 2004/05 was 32 percent to the FY 2009/10 at 3.0 percent. Likewise the expenditure on Administrative health expenditure was also started with Rs. 21992 thousands in FY 2004/05 and went down Rs. 11486 thousands in FY 2009/10. Which showed considerably decreasing order? Under minding the ups and downs during the period

the development expenditure of human resource development expenditure denoted increasing as it came with 5 percent of it and reached at the height of 9.4 percent at finishing FY 2009/10. The expenditure on the issue integrated health program expenditure has captured towering among sub-categories as it began FY 2004/05 with sun of Rs. 36998 thousands and peaked in FY 2009/10 Rs. 1902808 thousands as in 8.3 percent of the total expenditure to 60.8 percent.

While looking through the less of crisis the government spent much sum on integrated health program which suggests the co-ordination with local agencies and local government is focused.

Figure No. 4.5

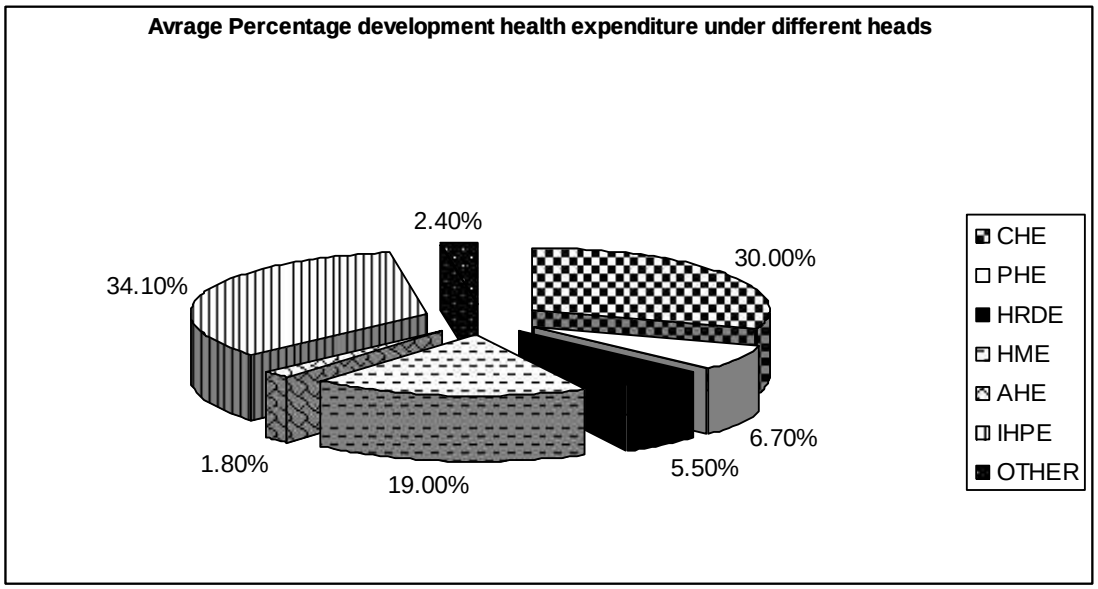


Figure 4.5 highlights some special characteristics. It is seem that integrated Health program and curative health expenditure hold a large share on total Development expenditure. The Expenditure on the hospital management received average 19 percentages, however at the same time at the spending under the administrative, preventative and other expenditure in an average nearly 4 percentage of total development expenditure.

The figure indicated that the government may want to make empowered the local government focused and decentralization.

4.6 Share of Health Expenditure on Social Expenditure

The more or less constant share of health expenditure on the social expenditure shows that the government has been paying attention equally in every

sector of social services. The share of health expenditure on social expenditure is second more with compare to other sector the government has prioritized attention on education sector. But health is also more sensible sector for the human resource development on the average; the share is only around 17 percent of social services. It shows that the government has not given much attention in health sector despite the fact that it plays significant role in the individual and national development. The trend of health expenditure seems not more fluctuation. The share of health expenditure on social expenditure presented on the table 4.6

Table 4.6

Health Expenditure as Percentage of Social Expenditure

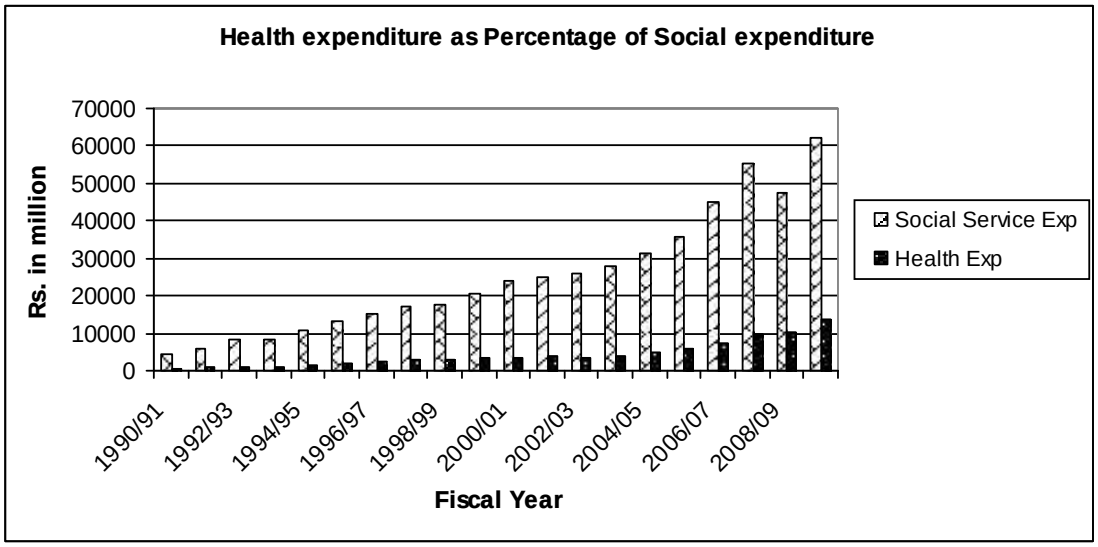
FY	**Social Service Expenditure**	**Health Expenditure**	**HE as % of SE**
1990/91	4311.9	660.6	15.32
1991/92	6039.3	918.1	15.20
1992/93	8514.8	1061.0	12.50
1993/94	8456.9	1065.6	12.60
1994/95	10666.2	1495.6	19.51
1995/96	12987.8	1714.5	13.20
1996/97	15190.4	2506.6	16.50
1997/98	17316.8	3125.1	18.02
1998/99	17642.3	2814.6	16.00
1999/00	20734.1	3451.5	19.56
2000/01	23754.9	3519.7	16.65
2001/02	24880.6	3856.6	15.50
2002/03	25937.8	3652.0	14.8
2003/04	27943.7	3968.6	14.20
2004/05	31149.5	4597.5	14.7
2005/06	35534.4	5722.5	16.1
2006/07	45026.9	7440.7	16.52
2007/08	55356.8	9844.3	17.83
2008/09	47437.9	12731.4	26.83
2009/10	62394.7	15913.8	25.5

Sources: Economic Survey; Various Issues

Table 4.6 shows the share of health expenditure on social expenditure. In the FY 1990/91, the share of health expenditure on social expenditure was 15.32 percent, when health and social expenditure was Rs. 660.6 and 4311.9 million respectively. In the further years, both social and health expenditure have been increasing in absolute amounts. But the ratio has more or less similar. Social expenditure has increased quite more than the health expenditure. The share of the health expenditure reached at 19.56 in FY 1999/00. In that year, the social expenditure and health expenditure was Rs. 20734.1 and 3451.5 million respectively. Then the following years, the share started to decline slowly but the absolute amount has seen increasing in further years. The share was only 25.5 percent in FY 2009/10. In which these amount were Rs. 62394.7 and Rs. 15913.8 million on social service and services respectively.

The table shows the share of health expenditure on social expenditure excluding some years shows the government is keeping its equal attention every year towards public health care but the share is still lower. It refers that the government is not providing highly attention to the people's health problems.

Figure 4.6



4.7 Growth of Health Expenditure

This chapter shows the growth rate of total expenditure, social expenditure and health expenditure. It shows that the expenditure in absolute amount on each sector has been increasing every year. The growth rate of total expenditure seems steady but the growth rate of social expenditure and health expenditure seems more fluctuation.

Table 4.7
Annual Growth of Health Expenditure

FY	% Change in Total Expenditure	% Change in Social Expenditure	% Change in Health Expenditure
1990/91	19.7	-8.1	-4.3
1991/92	12.2	40.1	39.0
1992/93	17.0	41.0	15.6
1993/94	8.7	-0.7	0.4
1994/95	15.5	26.1	40.4
1995/96	20.0	21.8	14.6
1996/97	9.0	17.0	46.2
1997/98	10.6	14.0	24.7
1998/99	6.2	1.9	-9.9
1999/00	11.2	17.5	22.6
2000/01	20.5	14.6	2.0
2001/02	0.3	4.7	9.6
2002/03	4.9	4.2	-5.3
2003/04	6.5	7.7	8.7
2004/05	14.7	11.5	18.0
2005/06	8.1	14.1	23.9
2006/07	20.5	26.7	27.7
2007/08	20.8	22.9	33.3
2008/09	32.4	28.3	29.7
2009/010	24.7	21.8	19.3

Source: A handbook of Government Finance Statistics (Nepal RastaBank)

Table 4.7 shows that the growth on total public expenditure seems to be increasing positively every year but the growth on health and social expenditure shows positive and negative. As a whole, the moment seems positively increased. In 1990, the growth on health expenditure was 39 percent where as the total public expenditure was increased by less than 13 percent. Most of the years, the growth of health expenditure has been more than that. It means, the growth on health expenditure is more than total public expenditure. In the years 1998/99 and 2002/03 the growth rate on health expenditure was negative.

It indicates more fluctuation on growth of health expenditure. In the average, the growth rate of public expenditure remained rather more than 18 percent whereas

the growth rate of total expenditure is ground 13 percent. In figure 4.7 the growth health expenditure seems slightly fluctuating than total public expenditure.

4.8 Plan-wise Public Health Expenditure

Table 4.8 presents the allocation of development expenditure by different plan period. The development expenditure in different plan periods has been increasing in which expenditure on social and increasing. In which expenditure on social and health services are in increasing trend. In aggregate, one third of total public expenditure has allocated in health sector.

Table no. 4.8

Plan-wise Public Health Expenditure (Rs. in million)

Different Plan Pervious	**Total Budget**
First five years plan (1956-1961) Social service Health	300.0 25.0 (7.56)
Second three years plan (1962-1965) Social services Health	600.0 102.7 (17.12)
Third five years plan (1965-1975) Social services Health	2500.0 414.5 (16.6) 130.0
Fourth five years plan (1970-1975) Social service Health	3540.0 381.5 (10.8) 15102 (4.3)
Fifth five years plan (1975-1980) Social service Health	11404.0 2007.4 (17.6) 455 (3.99)
Sixth five years plan (1980-1985) Social service Health	21750 5320 (24.45) 455 (3.99)
Seventh five years plan (1985-90) Social service Health	29000.0 7336.7 (25.30) 1344.0 (4.6)
Eighth five years plan (1992-97 Social service Health	111824.4 37037.9 (33.1) 4721.7 (12.7)
Ninth five years plan (1997-2002) Social service Health	158190.0 56947.0 (36.0) 9995.0 (6.3)
Tenth five year plan (2002-2007) Social service Health	411848.0 90380.0 (38.6) 14000.0 (6.0)
Eleventh three years plan (2007-10) Social service Health	280301 110348 (41.51) 30114 (10.74)

Source: Economy Survey, Various Years.

In the table 4.8 the first five years plan, the total development expenditure was Rs. 300 million in which the health expenditure was Rs. 25.0 million . This is the 7.56 percent of total development expenditure. The trend of expenditure on each sector seems to be in increasing trend. In tenth five years plan period, the total development expenditure was Rs. 411848.0 million. Around 38.6 percent of total development expenditure had allocated in social services where as the health expenditure was only 6 percent of total development expenditure. As a whole (According the table), the trend of expenditure allocating in social as well as health service seems smoothly decreasing. After eleventh three year interim plan, there was increased by 4.74 percent.

Table 4.9

4.9 Extension of Health Services

Descriptions	1992/93	1995/96	1998/99	2000/01	2003/04	2006/07	2008/09	2009/10
1. Extensive of service	1833	3722	4406	4418	4401	4396	4392	4393
a. Hospital	114	82	83	83	83	87	94	102
b. Health centers	18	17	13	10	10	6	5	0
c. Health Posts	816	775	723	700	700	676	676	1176
d. Ayurvedic	165	172	260	275	287	293	293	291
e. Sub-health Post	700	2597	3187	3170	3141	3129	3114	2617
f. Primary health centers	20	79	140	180	180	205	202	207
2. Hospital beds	4848	3604	4955	5250	5250	6944	6944	6944
3. Skilled manpower	32798	30520	78371	81351	89311	91840	92010	92181
a. Doctors	1497	872	923	1259	1259	1457	1627	1798
b. Nurses	2999	4606	3925	4655	10099	11637	11637	11637
c. Kaviraj	240	249	201	211	387	394	394	394
d. Vaiday	144	197	195	210	354	360	360	360
e. Health assistants	3461	5092	5295	5295	7491	7491	7491	7491
f. Health workers	20442	2400	3190	3190	3190	3190	3190	3190
g. Village level health workers	4015	4015	4015	3985	3985	3985	3985	3985
h. Others	-	13089	60627	62546	62546	63326	63326	63326

Source: Economics Survey: Various Issues: MoF/ GON≠ Including 193 doctors return from study on scholarship,
+ GoN employed only[+] Others: Trained Studies, Women health workers

Table 4.9 shows that the extension of health service has seen enlarging during the nineteen years periods. There were only 4418 health services in 1992 that reached to 4433 in the year 2000, which was the largest amount. But in the late years, it reduced slowly and reached 4393 in fiscal year 2010. Among these various health services, hospital is in decreasing trend. It was 114 in 1993 that was highest, but it reduced and became only 82 in 1994. Recent, the number of hospital has been increasing by the private efforts into city areas. The table4.9 also gives us the health centers and health posts have been reduced in the one hand but on the other hand, the Ayurvedic centers and sub-health posts have been increased. The number of bed in hospital has also been increased that was 4848 in 1992/93 and becomes 6944 in 2009/10. It seems around 1.5 times increase during the 19 years period. Even though it is insufficient according to the people, many times it can be heard and seen that the patients couldn't get bed in hospital for the treatment. They are compelled to treat by lying on the floor.

The skilled manpower also increased six times by 1992/93 to 2009/10. The man power was 32798 in FY 1992/93, now it became 92181 (in 2009/10). It is satisfactorily increased with comparison to the other service. But the number of doctors (MBBS, MD) could not increase more. The other like nurses, health assistants and health workers are increasing in number but they have no proper knowledge about the disease and treatment.

If proper attention is given to prepare skilled doctors there will not be any improvement on health sector. So, it can be said that the government has not given any attention to the infrastructure development and not appointed skilled human resources on health sector. All the services are increased than the previous year but not sufficient amount. Even these days, there are more people dying by the very normal diseases in the rural and mountain areas due to the lack of treatment facilities and human health resourced.

CHAPTER-FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

Public expenditure refers to the expense which the government ensures to meet its own maintenance as well as society where the state expense is essential to maintain the administration, laws and order. The state also spends for overall economic development. The main goal of the government is to provide maximum social services to the people and economic stabilization. To meet this goal, the government is trying to develop their economic sustainable. The objective of the government has not been same in developed and developing countries.

Government expenditure programs are the main viable sources of expending the production base of the economy. The slow process of structural changes, law refers to the capital accumulation and non-significant change in employment pattern indicates that Nepalese economy has not been still able towards sustained growth.

This study is primarily confined to the analysis of trend and pattern of public expenditure on health sector during the period 1990/91. It has attempted to examine the health sector in economic approach such as how much the expenditure has been allocated in health sectors. What is the share of health expenditure on total, how is the contribution of GDP or health sector working.

This chapter is reviewed the trend and pattern of public expenditure on health. In addition, the reviewed is concerned with the total public expenditure, social expenditure and share of health expenditure on total expenditure. The public expenditure on health sector is minimal through the expenditure on health increases more than ten times during the considering period.

The total expenditure and health expenditure has increased by more than ten times during the study period. But the public expenditure on health is nominal. The allocation of expenditure in health sector is very low. Equity in health sector remains as an important problem in Nepal. Not only the poor health status but also the health service is poor by quality and distribution.

Data indicates that there has been increasing trend in public expenditure in Nepal. Both regular and development expenditure on health sector was declining trend in development and increasing trend in regular budget on health. The development expenditure had increased rapidly until 1999. It was more than regular expenditure. But in the contrary the development expenditure started to reduce and

become lower than regular expenditure. The declining trend continued reached 7.5 percept of the total development expenditure in 2009. The ministry of health reported that the decline the development budget in health was due to Maoist insurgency. On the other hand, trend of development health expenditure also due to the low funded by donor's fund on the health are similar. And on increasing trend on regular budget was recorded due to the salary revision. Therefore, it is concluded that the amount is not sufficient to the development activities on health.

Regarding the health institutions and resources, Nepal doesn't have enough hospitals as well as doctors. Only 102 government hospitals for more than 2.85 million people are not sufficient. Most of the hospitals are concentrated in urban areas, which is out of reach for the regular poor people. And most of the buildings which are under construction are in urban areas in case of doctor it is not only a problem to produce the doctor but also the services problem which unequal distribution of health researches and lack of maintaining as required. The number of health assistants, nurse and health workers is increasing quite more during the study period. But it is not sufficient according to population growth. If a country is unable to develop productive manpower with well education and well health, it can't develop overall sectors. So it can be said that Nepal is undeveloped (developing) country because most of people in Nepal are poor due the lack of skilled human resource. It may be due to the lack of sufficient people expenditure and its allocation in human resource development especially on health and the other obstacle to get improvement in this sector may be the lacking of plan, policies and programs and it implementation.

Lack of the sufficient financial resource is the main constraints for the economic development in Nepal. The total expenditure has been incrassating every year due to the expansion of government activities. The country is always facing financial problem. There is a serious problem of resources gap, which is increasing trend.

5.2 Finding

i. The health expenditure is growing year by year with average annual growth rate of 4.5 percent during the study period of 1990/91 to 2009/10.
ii. Integrated health program expenditure holds a large share under total development and administrative health expenditure with total regular.

iii. The trend in regular and development health expenditure shows that the share development was increasing till 2000 A.D. But than it started to decrease slightly.

iv. Data indicate that the government, may want to make empowered the local governance focused and decentralization.

v. Data of various plan period shows that the expenses of health sector are large in absolute amount but the share of total expenditure in health sector is fluctuating.

vi. The growth rate of total expenditure and social expenditure has been positively increasing. In which the growth rate of health expenditure seems fluctuating.

vii. Extension of the health service seems at increasing trend. Hospital, health post and health center are reduced. On the other hand Doctors, Nurses, Vaida's, Ayurvedic Centers, Sub-health post and other increased.

viii. The data of health indicator shows that the health status of Nepalese people is satisfactorily improving then the previous year.

5.3 Conclusion

This study has concluded from the economic perspective, Nepal has poor economic status because of low precipitate income, poverty, less economic growth rate, budget deficit, dependency on foreign aid and import oriented trade. And from the political perspective, it is facing the political instability and insurgency due to the unstable government, corruption and strict law. Nepal has been attempting to improve health status of the people. It is improving the conditions of health centers as much as possible. But these are mismanaging, which are inequitably and insufficiently. The resources are concerned more in urban areas. The rural areas and primary health services are under low concern.

More than 80 percent people live in rural and mountainous area and more than 30 percent portion of health expenditure has been allocated in secondary health services in urban areas. The investment in health plays an important role to improve HRD. But, Nepal is very poor in HDI. It means Nepal has poor HRD in comparison to developed countries and even in SAARC region because of the lack of investment in human resource, education, health etc.

Similarly, the public expenditure is continuously increasing. In Nepal but the growth rate of revenue is lower than that of government expenditure during the study period. The overriding trend on the public expenditure reflects alarming situation with regard to fiscal discipline and the overall development programmed of the country. The rapid growth of regular expenditure after 1990 can be attributed to the increasing expenses on defense. The important aspects on the substantial amount is allocated for the salaries and wage categories which have left a little amount for other categories like social services expenditure, economic services expenditure and mainly for the organization and management. In effect, allocations have been highly inadequate. The overall pattern, thus, corresponds to the fact that public expenditure is, mainly diverted to the consumption type only instead of capital expenditure.

5.4 Recommendations

In any useful budgetary policy, public expenditure has an essential role for the overall development of a nation. In Nepal public expenditure is assumed important because of the responsibly which the government has been assumed through various measures. The government has to ensure and equitable distribution of income and decentralization of economic power. On the basis of the findings of the study, some general suggestions can be recommended as follows:-

i. Government should adopt the appropriate policy to convert the unproductive expenditure into productive sector. This can be done by diverting the regular expenditure into development expenditure.
ii. As the large number of population depend an agriculture sector, the government should give adequate attention towards this sector. Therefore, a large amount of expenditure should be diverted to this sector.
iii. The government should choose income generating sector and the amount as much as possible.
iv. The rapid growth in regular expenditure over the last few years can be attributed to the increase in defense expenditure. Therefore, peace and political stability is necessary condition for economic development.
v. Social sector development is needed to upgrade the quality of life.
vi. For rapid economic growth sub-section of social sectors such as basic education, health, safe drinking water should be given high priority because of their significant role in human life.

vii. Public expenditure should be best allocated for the development of transpiration, communication and social services in order to reduce geographical fragmentation and increase the profitability of private investment as well as by expending the size of the market, skill and efficiency of labor.

viii. The government should increase development budget on health sector as regular budget.

ix. The government should provide equal distribution of health resources and health services to improve in health sector.

x. According to the time period, the health policy should be updated.

xi. There should be co-ordination among the NGOs, INGOs, social organizations, health centers and educational institutions.

xii. The utilization of expenditure on health as well as other sectors should be transparent.

ANNEXES:

Annex : 1 Public Expenditure **(Rs. in million)**

FY	Total Expenditure (TE)	Regular Expenditure (RE)	Development Expenditure (DE)	Total Health Expenditure (THE)	Regular Health Expenditure (RHE)	Development Health Expenditure (DHE)
1990/91	23553.6	75749.1	15979.5	660.6	293.9	366.8
1991/92	26418.2	9905.4	16512.8	918.1	410.9	507.2
1992/93	30897.7	11484.1	19413.6	1061.0	460.8	600.2
1993/94	33597.4	12409.2	21188.2	1065.6	505.1	360.5
1994/95	39060.0	19265.1	19794.9	1495.6	637.1	858.5
1995/96	46542.4	21561.9	24980.5	1714.5	799.0	915.5
1996/97	50723.7	24181.1	26542.6	2506.6	885.4	1621.2
1997/98	56118.3	27174.4	28943.9	3125.1	1049.0	2076.1
1998/99	59579.0	31047.7	28531.3	2814.6	1137.4	1677.2
1999/00	66272.5	34523.3	31749.2	3451.5	1324.8	2126.7
2000/01	79835.1	42769.2	37065.9	3519.7	2606.6	913.1
2001/02	80072.2	48590.0	31482.2	3856.6	2957.3	899.3
2002/03	84006.1	54973.0	29033.0	3652.0	3492.7	159.3
2003/04	89442.6	55552.1	23095.6	3938.6	3826.4	142.2
2004/05	102560.5	61686.4	27340.7	4597.5	4148.3	449.2
2005/06	110889.2	67017.8	2960.66	5722.5	4774.4	948.1
2006/07	133604.6	77122.4	39729.9	7440.7	6255.1	1185.6
2007/08	161349.9	91446.9	53516.1	9844.3	7409.5	2434.8
2008/09	219661.9	127738.9	73088.9	12731.4	10103.5	2627.8
2009/10	259689.1	151019.1	90237.7	15913.8	12836.6	3077.2

Annex: 2 Extension of Health Services.

Annex : 2.1 **(in numbers)**

Descriptions	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99
1. Extensive of service	1098	1312	1833	2441	3097	3722	4340	4377	4406
a. Hospital	111	113	114	114	82	82	82	82	83
b. Health centers	18	18	18	18	17	17	17	17	13
c. Posts	816	816	816	801	775	775	754	736	723
d. Ayurvedic	153	165	165	168	167	172	200	230	260
e. Sub-health best	-	200	700	1300	19997	2597	3187	3192	3187
f.Primary health centers	-	-	20	40	59	79	100	120	140
2. Hospital beds	4570	4798	4848	4848	3604	3604	3904	4189	4955
3. Skilled manpower	30195	32815	32798	33441	27960	30520	73572	77107	78371
a. Doctors	1196	1497	1497	917	952	872	894	894	923
b. Nurses	2986	2986	2999	2980	4606	4606	4706	3588	3925
c. Kaviraj	240	270	240	193	249	249	290	390	201
d. Vaiday	130	144	144	168	197	197	219	219	195
e. Health assistants	1186	3461	3461	1168	4492	5092	5152	5192	5295
f. Health workers	20442	20442	20442	24000	2400	2400	3187	3190	3190
g. Village level health workers	4015	4015	4015	4015	4015	4015	4015	4015	4015
h. Others	-		-	-	11049	13089	55109	59719	60627

Annex: 2.2

2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10 *
4418	4429	4408	4401	4390	4396	4396	4396	4392	4393
83	83	83	83	87	87	87	94	102	102
10	10	10	10	6	6	6	5	5	0
700	700	700	700	699	699	676	699	676	1176
275	286	287	287	287	293	293	293	293	291
3170	3170	3148	3141	3131	3131	3129	3104	3114	2617
180	180	180	180	180	180	205	201	202	207 #
5250	5250	5250	5250	6796	6796	6944	6944	6944	6944
81351	18351	86162	89311	90847	90849	91744	91840	92010	92181
1259	1259	1259	1259	1257	1259	1361#	1457 #	1627#	1798
4655	4655	9146	10099	11637	11637	11637	11637	11637	11637
211	211	387	387	387	387	394	394	394	394
210	210	354	354	354	354	360	360	360	360
5295	5295	5295	7491	7491	7491	7491	7490	7491	7491
3190	3190	3190	3190	3190	3190	3190	3190	3190	3190
3985	3985	3985	3985	3985	3985	3985	3985	3985	3985
62546	62546	62546	62546	62546	62546	63326	63326	63326	63326

Source: Economics Survey : Various Issues : MoF/ GON.

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