6.
PLANS, POLICIES AND THEIR IMPLICATIONS

In the early days of health planning in this country a number of plans were made. Subsequent to this, there was a tendency for part of the plans to be suddenly and periodically changed by ministers and secretaries. With change in individuals, the priorities were sometimes so drastically altered that it became difficult to work. It was in that setting that the need was felt to have a Long Term Health Plan or even just a Plan, which could not just be arbitrarily changed.

Long Term Health Plan (1975-1990)

Twenty-five years after the ushering in of democracy in Nepal it was felt that the infrastructure for proper delivery of health care was in place. It was thought to be the opportune moment to think in terms of a Long Term Health Plan. An initial draft was made by a group of three doctors at the Ministry of Health.

With the blessings of the then Minister of Health, an eight-member committee with five doctors and three baidyas was formed to formulate an overall health plan for the whole country. The five doctors involved were:

Dr. Lakshmi N. Prasad
Dr. Narendra B. Rana
Dr. Manindra R. Baral
Dr. Sundar Mani A. Dixit
Dr. Nagendra Dhoj Joshi

This team travelled to various parts of the country with the objective of making a twenty-five year plan. Following initial discussions at the Ministry

some other doctors were added to the committee. The question of whether the posts at the government hospitals should be "non-practising" or "practising" was discussed.

After further deliberations at the *Janch Bujh Kendra* of those days, this was modified and ultimately resulted in to the Long Term Health Plan 1975-90 (1). This included therefore the Fifth, Sixth and Seventh Plan periods with the idea that what was achieved in one plan period would be dovetailed into another. The inference at that time was that the future health policies, strategies and activities were to be according to this. The main emphasis in this LTHP was the provision of basic health services to a large majority of the people. This was an honest attempt by the authorities to get things moving in the health field.

This document recorded the state of the health services existing, and the long-term aspects. Primary health care, hospital services, family planning and management aspects were also looked at. The annexure gave the criteria of service and manpower allocations to various grades of health institutions.

As time went on however, it soon became apparent that things were not going on as per the plan. The general complaint was that when people asked for activities listed, the excuse was lack of budgetary resources and that it would be done in due course. What was not in the plan could not be considered. The end result as per the gossip going around was that only facilities for the doctors working in the ministry was carried out and everything else was held in abeyance.

It was the mid-term review of the first of the three plan periods i.e. 1975-1980, which had been done over the period from March 1978 to June 1979 by a special team with the help of New ERA for the collection of data. To make the survey accurate the authors:

"undertook a sample survey of a variety of health institutions and of population with differing access to health services. In all, thirty-one of the seventy-five districts were included in this survey, providing representation of all four development regions as well as both hill and Terai areas. Over 150 separate health facilities were visited, and interviews were conducted in nearly 3,700 households in eighty panchayats."

It is interesting to quote from Chapter 7 of this document (2), which goes on to state:

"Although health services are provided with the intention of meeting the needs and health requirements of the people, there is not always unanimity

about what those needs are, or about what priority a given individual or community would place on a particular action to improve health. Because health planners and health technicians often have rather different ideas about the importance of various health activities than do non-technical persons, the perspectives of health service providers and the rest of the community are often different."

Even before 1990 came, the general complaint was that whenever one went to the Health Ministry with a proposal, the first reaction as to its feasibility was whether it was in the Plan or not. If it was not in the plan, there was no possibility of getting it done. If it was in the plan, the authorities would consider it, but in all probability it would not be done because of lack of funds etc. As a result of all this, ad hoc decisions on the basis of political expediency were the order of the day. At times when offers simply came out of the blue e.g. that of a teaching hospital by the Japanese, then there were grounds for such action. Just as the Teaching Hospital came into existence in the eighties without really having been fully planned earlier so also the BP Koirala Institute of Health Sciences (BPKIHS) also came out of the blue in the post *andolan* period of the nineties.

All said and done this mid-term review report was ready by June 1979, but as it was thought to be fairly critical of the state of health and its affairs and so was not distributed. The observations were categorised into two groups **viz.** those regarding policy and those related to management. Some of these, which were critical, are given below:

On Policy Issues

- District Hospital role in preventive care delivery, training and supervision largely not being discharged.
- Leprosy and tuberculosis follow-up programmes are largely not being implemented.
- Government health services still have low geographic accessibility, extremely limited outreach facility, and as a consequence low use.
- VHWs visit more households than PBWs but both much less than MFWs. The PHW-VHW difference is greatest in Terai. More VHWs than other field staff feel the number of houses to be visited is serious constraint to effectiveness.
- District Health Committees seldom have representation from projects or are even known to project staff other than ICHP.

- Supply shortages in all projects except Malaria.
- Most post level units do not have their own water supply. At best only half the post units have latrines with Ayurvedic clinics being the least well served.
- For over half the staff at district and health post units no housing is provided. To a small extent this is compensated for by some free accommodation provided by the community.
- A fixed programme of refresher training is not offered by any project. The need for further training among field worker is most felt by PBWs.

On Management Issues

- Community awareness and use of family planning and maternal and child health services, and facilities is low. Understanding is low even among the aware population in areas where FP and MCH services and facilities are available.
- Many workers are unclear about role in preventive tasks prescribed by central organisation.
- Most Health Committees at both district and health post were inactive. Few people in HP areas knew of the existence of Health Committees.
- Few community leaders had been involved with the selection of local health worker; those who had been involved were mainly in the VHW selection.
- Critical shortages in disease prevention vaccines in all units, which may severely inhibit preventive programmes, particularly in hospitals.
- The majority of all units never receive operating funds either development or regular on time. The situation improves with each quarter of the fiscal year.
- There is a shortage of written guidelines for supervision in all projects but primarily in ICHP.

Country Health Resources & Priorities (CHRP)

This exercise may be said to have been done to review what had been achieved in the Seventh Five Year Plan period and at the same time to help the National Planning Commission to lay down guidelines for the Eighth Plan 1990-95.

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The first phase consisted of a 5-day preparatory workshop, which looked at various issues on hand. This was followed by a second phase of 14 days where four groups of between 5 to 10 members each looked at the under mentioned four areas:

a. National Health Policy

b. Development of Health Services and Institutions

c. Minimizing Risk Factors

d. Prevention and Control of Diseases

A fifth working group worked for a further 8 days and made a CHRP working document which the organising committee then improved and sent as the second draft to various HMG officials plus various agencies for comments and suggestions. The final version of the document was brought out in January 1990 but was never distributed thereafter (3). During the one-year period of the Interim Government it was not referred to. The National Planning Commission went on a so-called "one year Plan holiday" which in fact turned out to be two. Thus the schedule of the Eighth Plan period came to be 1992-1997.

The World Bank, too, did a survey and came out with suggestions for a reorganisation (4).

Situation analysis for the re-structuring of the health services was done over a six month period during end of 1990 and early 1991 (5). Taking the commitment of Basic Minimum Needs Programme of HMG, it brought into focus the fact that previous studies had shown that the existing health system was not, "both quantitatively and qualitatively geared up to achieve the BMN goals". Following the period of study, certain macro recommendations were made for the re-structuring of health services. These were:

a. Strengthening outreach services i.e. health posts and below

b. Strengthening district health system

c. Development of appropriate, effective and efficient Regional and National (central) health organisations

d. Development of strategic national perspective plan

e. Manpower planning and development

Following elections of 1991 the Nepali Congress formed the government and the PM took the portfolio of the Health Ministry. It was at

this juncture that a delegation of the Nepal Medical Association met him and requested a White Paper on Health. This was agreed to and a committee was formed under the Secretary of Health to think about the matter and proceed accordingly.

Before any firm decisions were taken, a medical doctor became the new Minister of Health. HMGN in Sept 1991 formed a committee and subsequently a number of other subcommittees to draw up a plan of action with appropriate strategies to provide health services up to the village level as per the guidelines of the contemplated National Health Policy 1991. The new group looked at various aspects of health and their reports were submitted by the deadline of Nov. 1991. In hindsight, it may have been a strategy to keep people occupied, and to create a state of "make believe" that something is happening. The first reaction is that this report is now shelved and unlikely to see the light of day.

National Health Policy - 1991

The National Health Policy of 1991 focuses on two broad areas for singling out and may be categorised as follows:

Preventive Health Services

Family Planning (FP), Safe Motherhood, Expanded Programme for Immunisation (EPI), Control of Diarrhoeal Diseases (CDD), Acute Respiratory Infections (ARI), Malaria.

Promotive Health Services

Health Education, Nutrition and Environmental Health.

Strengthening of the District Health Systems

Special efforts were made to prepare plans and strategies for the strengthening of the health service delivery at the district levels (6).

But all said and done one has to look for a delivery of health care, which one can afford. A Global Research Project conducted by SCF(UK) looked at the sustainability of the health sector in Nepal during the course of 1991/92 (7). Some of the comments in its executive summary are:

- At approximately $ 1.30 per capita, the expenditure on health by the Ministry of Health is very low, even for a developing country,

although the share of government expenditure on health (about 4% in recent years) is about average for less developed countries.

- The period between 1951-74 was characterised by the entry into Nepal of INGOs for direct health service delivery and the establishment of vertical disease control programmes by major donors.
- The period between 1975-90 was characterised by greater attention to planning for the health sector for meeting national and global goals.
- Nevertheless, the health sector infrastructure and numbers of staff continued to expand rapidly, most due to donor initiatives and funding, while the capacity to manage these new resources tended to lag behind.

It was in this context too that a special consultation was done towards the end of 1993 to look into ways and means of strengthening the district health systems. Task forces were created with a view to tackle the problems. It was felt that some of the district hospitals could be made into models to show it's functioning to be mutually supportive with the district health systems. To ensure that HRH personnel function effectively to deal with the health problems of the society, this particular report makes a plea for training and research to be located in the settings and systems in which the health workers are most needed. Quoting from a Round Table discussion article entitled "Educating Tomorrow's Doctors" in World Health Forum, it goes on to say:

"The consensus is becoming firm in both developed and developing countries that academic health centres should associate themselves with defined populations, where they focus teaching and research related to the health of the population and the effectiveness of the health care system."

The recommendation is that the universities should be encouraged to collaborate with the government in the development of district health systems for the purposes of education and research. Such thinking is very pertinent in view of the fact that a number of teaching institutions have been established over the last decade in different parts of Nepal.

In this same vein it is worthwhile remembering that just prior to starting of the MBBS course at the Institute of Medicine a number of district health surveys were done at Tanahu, Bara, Dhankuta and Nuwakot. A later survey was at Surkhet. Repeat survey done at Dhankuta. Such research identified the existing situation, the health service demands and the needs. During the course of the eighties foreign medical graduates did a number of health

studies with accompanying Nepalese medical students and sometimes faculty in other areas of Nepal. A regular feature of the community oriented MBBS programme of the IoM is that each batch of medical students have spent time in the community and done a report of that study. A recent report by Tiwari (8), which drew on some of these studies stated that "there is generally poor response by the majority of the people to the available health services particularly in the rural areas." This report of April 1994 stated that the primary health services in the country were inadequate and that the existing health institutions are not functioning properly due to the lack of trained manpower, medicines and equipment.

The year 2052 BS (mid-April '95 to mid-April '96) may be taken as the policy-making year for during this one year a number of policy documents were made public. These were:

National Policy for AIDS & STD Control - 2052 BS
National Ayurvedic Health Policy - 2052 BS
Safe Motherhood Policy of HMG/N

Logistic Management Division

The division was started in the Department of Health Services in 1993. This attempt to systematise health care logistics was started then and is continuing to this day. An efficient logistic management of health care commodities (essential medicine, vaccines, contraceptives, medical equipments / instruments, HMIS / LMIS forms etc) involves technical, managerial and administrative expertise, which has to be maintained at all, times.

Nepal Multiple Indicator Surveillance (NMIS)

The NMIS was designed as an ongoing monitoring scheme to produce information useful for planning at national, district, and community and household levels. Started with a multisectoral baseline survey in early 1995 the NMIS process comprised of repeated cycles of data collection, analysis, interpretation and communication of results with and objective of stimulating action (9). Each cycle focuses on a priority set of issues as given below:

Cycle 1. Information about malnutrition and feeding practices among young children. Indicated need for more information

Cycle 2. Primary Education (in Spring/Summer 1995)

Cycle 3. Diarrhoea, Water and Sanitation (in first half of 1996)

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Cycle 4. Early Childhood Feeding, Nutrition and Development (in second half 1996)
Cycle 5. Care during Pregnancy and Delivery

Second Long-term Health Plan (1997-2017)

The specific purpose of the Second Long Term Health Plan (SLTHP) is to provide a guiding framework to:

- Build successive periodic and annual health plans that would lead to improvement in the health status of the population.
- Develop appropriate strategies, programmes and action plan that: reflect the national health needs and priorities; are affordable and consistent with available resources.
- Establish co-ordination among public, private sectors (including NGOs) and donor partners (10).

Based on the demographic and disease profile a "Essential Health Care Services (EHCS)" of highly cost effective public health measures and essential clinical services for traditional and other systems of medicine is proposed. The EHCS is to address the essential health needs of the population at the district level and below during the course of the next twenty years.

To effectively implement the EHCS the health sector must:

1. redirect resources from high-cost low-impact interventions to those that could substantially reduce morbidity, mortality and disability without increasing expenditures;
2. address the issues which limit the effective utilization of scarce human and financial resources; and
3. adopt alternative financing mechanisms, which seek to mobilize non-governmental funds to support health care and increase the public-private mix in terms of financing and provision of services.

Within this context, the Second Long Term Health Plan defines the EHCS and identifies the key issues and policy options necessary for:

1. improving the efficiency and effectiveness of the health care system;
2. improving inter- and intra-sectoral coordination and providing the necessary conditions and support for effective decentralisation;

3. overcoming management and organizational constraints for effective public health sector service delivery;
4. ensuring that appropriate numbers, types and distribution of technically competent and socially responsible health personnel are available to provide quality health care to all the people of Nepal, particularly those living in rural areas;
5. ensuring that the health care system provides care that is effective in producing positive health outcomes as defined by health care professionals and in which the community is satisfied that their needs are being met;
6. providing the requisite data, analysis and interpretation necessary for informed decision-making and
7. addressing the changing trends of communicable and non-communicable diseases and emerging health issues.

Strategic analysis of the health sector was done in the presence of External Development Partners (EDP), NGOs and the private sector in Sept / Oct. 1999. The purpose was to map out future action with the objective of operationalisation of the strategies for the improvement of the health services (11).

While the concept and stress on working through NGOs is a good idea, the crucial first step is to separate the wheat from the chaff. In the long range, the SLTHP may turn out to be a document of good intentions, liberal rhetoric but short in action !

a. NATIONAL HEALTH POLICY NEPAL (1)

The Nepali Congress Government committed itself to creating a socioeconomic environment to allow all Nepalese citizen to lead a healthy life in conformity with the saying "Health is Life." Highest priority was being given to upgrading the health standard of the ninety-three percent of the Nepali people who live in rural areas using a Primary Health care approach. Particular attention is being paid to availability of family planning and MCH services, preventive health services, and easily accessible referral. In pursuit of the goal of improved health, the Government wanted to establish one sub-health post in each village development committee and 205

primary health care centres throughout Nepal.

The health system in Nepal has suffered from a number of problems in the past, including a lack of village orientation, weakness in implementation of plans, weakness in monitoring and evaluation, centralization of resources, and unfilled posts. The new health policy of the Nepalese government hoped to resolve these problems, and will strive, towards the targets of reducing infant mortality from 107 per thousand to 50 per thousand, reducing mortality of children under five from 197 per thousand to 70 per thousand, reducing total fertility from 5.8 to 4, reducing maternal mortality from 8.5 per thousand to 4 per thousand, and increasing life expectancy from 53 to 65 years.

The basic government plan for attacking the health problems of the Nepalese people was to have the following components:

1. Preventive health service to concentrate on family planning and MCH, including safe motherhood; expanded immunization; diarrhoea and acute respiratory infection control; and prevention and control of communicable and non-communicable diseases.
2. Promotive health services including health education and information for increased awareness of health matters; promotion of breast-feeding, use of iron, iodine and Vitamin A supplementation; and personal and environmental hygiene.
3. Curative health services to be expanded to provide sub-health posts, health posts and primary health care centres in the rural areas and district, regional and central hospitals for referral services.
4. Basic primary health care services to be based on the sub-health posts and 205 primary health care centres.
5. Community participation in health care to involve women volunteers, TBAs, and local leaders at every level.
6. Organization and management improvements to be made, including decentralized management, improved supervision, improved management information and improved logistics and supply arrangements.
7. Improved manpower development and management policies for HRH to be implemented, including increased cooperation between service and training, and improved policies posting, transfer and promotion.

8. Private, non-government and inter-sectoral coordination with the government system to be encouraged.
9. The ayurvedic and other traditional systems to be developed in a gradual manner to assist in the improvement of health in those areas where they are appropriate.
10. The quality and availability of drugs at the village level to be increased and effective funding mechanisms will be developed.
11. Every effort to be made to mobilize all government and external resources possible in a coordinated manner.
12. Health systems research to improve all aspects of service delivery and effectiveness attainment be encouraged.
13. The regionalization and decentralization process to be strengthened, district level health organizations to be given a more prominent role and micro-planning procedures to be adopted at the village level with special effort to reach the least privileged groups.
14. Nepal Red Cross Society to be authorised to conduct all programmes related to blood transfusion services, the practice of buying, selling and depositing of blood to be prohibited.

b. NATIONAL DRUG POLICY - 1995.

This drug policy has been promulgated in accordance with the objective of the National Health Policy 1991, to fulfil the commitment of HMGN to provide "health for all" and to improve and manage by establishing co-ordination among governmental, NGOs and private organizations involved in the activities related to drug production, import, export, storage, supply, sales, distribution, quality assessment, regulatory control, rational use and information flow.

Besides the preamble other sections are:

- Main policy
- Objectives
- Policy Strategies including:
  - Drug Management
  - Quality Assurance & Regulatory Control Measures
  - Rational Drug Use & its Information
  - Manpower Development
  - National Drug Industry

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- Traditional Medicines
- Research and Development
- Technical Co-operation
- Monitoring and Evaluation

c. NATIONAL POLICY FOR CONTROL OF AIDS & STDs - 2052 BS

This policy has been promulgated with the objective of controlling the problems related to AIDS and STDs. This is being done as noted below:

- Policy
- National Executive & District Co-ordination Committee
- Co-ordination with NGOs
- Integrated Programme
- Blood Examination
- Reporting on AIDS and STD patients
- Maintenance of confidentiality
- Non-discrimination
- Stress on Safe Sex behaviour education
- Sterilization of equipment

Middle level executive committee
District level AIDS co-ordination committee

d. NATIONAL AYURVEDIC HEALTH POLICY - 2052 BS

Passed by HMGN on 14th Falgun, 2052 BS / February, 1996, it is divided into the under mentioned sections:

- Justification
- Objectives
- Organisation of Ayurvedic health services
- Mobilization of Inter Institutional and Community Participation
- Cultivation of herbs, production of medicines and profession
- Ayurvedic education and manpower development
- Ayurvedic manpower management
- Research in Ayurved
- Provision for resource mobilisation

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- Nepal Ayurvedic Council

Duties of District Ayurvedic Health Centre

Responsibility of Ayurvedic Aushadhalaya

e. SAFE MOTHERHOOD POLICY

Under the umbrella of the Safe Motherhood programme, which is a component of PHC, the stress in the coming years will be on improving maternity care services, including family planning, at all levels of the Health Care Delivery System, even the community. This policy document has been arranged as:

Policy Directive
Policy Objectives
- General
- Specific
- Strategies

Maternity Care
- Definition
- Component

Family Level
Community Level
Sub Health Post (SHP) Level
Health Post (HP) Level
Primary Health Care (PHC) Centre Level

District Level
Zonal / Regional Level
Centre Level

Referral System
Institutional Arrangements

Targets

OTHER EFFORTS:

Health Sector Reform

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Aware that health care facilities are not uniformly distributed in the country, HMGN is trying to make it more equitable. After much deliberation, MoH came to the conclusion that it should focus and deal with those health problems, which are disproportionately, and maximally contributing to the highest level of mortality and burden of diseases.

This is the rationale of the health care reform that is underway with the involvement of policy makers, NGOs, INGOs, private sectors and community in workshops, meetings etc, and a document was prepared in 2002. This was subsequently endorsed by the Council of Ministers in 2003. Key issues to be addressed by this strategy include (13):

- better value for the money that the public spends from its own resources
- strategy for better access of essential health care services (EHCS) to the poor and vulnerable. This comprises of safe motherhood & family planning, child health, control of communicable diseases and OPD services
- running of existing public services by HMGN in a more efficient manner
- access to facilities of essential health care services provided by HMGN
- better monitoring of health sector performance.

This reform will be over a 15 years period, which extends to the end of the Second Long Term Health Plan. There will however be an attempt to have realistic outputs at the end of the first five years.

The emphasis is on outputs and health outcomes. For this it is envisaged that there will be better Sector Management, which includes planning, programming, budgeting, and financing and performance management within the Ministry of Health.

It must be noted that the Health Sector Reform and is implementation is in the light of the National Health Policy 1991 and Second Long Term Health Plan (14).

The Millennium Development Goals (MDG)

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These goals were adopted by the United Nations in 2000 with the objective of initiating concerted action for global Health. In Sept. 2000 representatives from 189 countries, including 147 heads of state met at the Millennium Summit in New York to adopt the United Nations Millennium Declaration. Commitment has been made in seven areas: peace, security and disarmament; development & poverty eradication; protecting our common environment; human rights, democracy & good governance; protecting the vulnerable, meeting the special needs of Africa and strengthening the UN (15).

There is also a Road Map, which has established the goals and targets to be reached by 2015 in each of the seven areas. The goals in the area of development and poverty eradication are referred to Millennium Development Goals (MDG). This means that governments world wide are obliged to do more to reduce poverty and hunger, tackle ill health, gender equality, lack of education, lack of access to clean water and environmental degradation.

Three of the eight goals are directly health related; all of the others have important indirect effects on health without commitment from all the developed and developing countries the goals will not be met globally.

Vision 20/20.

As from Nov. 1999 Nepal committed itself to Vision 20/20: The Right to Sight. This is an international campaign to create awareness and mobilise additional resources for preventing and treating blindness. This global initiative is to tackle avoidable (preventable and curable) blindness by the ear 2020. Whereas previously the thrust had been from hospital to community, it is now moving towards households and individuals. (15). Hopefully this 'Sight for All by 2000' will achieve a lot for the Nepali people.

Bed Ratios for Different Nations

At the end of the Seventh Five Year Plan period there were 12 districts without any hospitals and thus no facilities for admission. The total number of hospitals, Governmental and non-governmental, including private ones, at the end of 1990 was 123 with a total bed capacity of 4,717 beds (17). This in terms of a population of 19 million works out to just 2.4 beds for every 10,000 population.

Table 5.2 Hospital Beds per 1000 population for Different Nations

Country	Year	Hospital Beds (per 10,000 population)
Bangladesh	1985	2.9
Bhutan	1984	6.1
Burma	1983-84	8.8
DPR Korea	1982	130.0
India	1984)	6.9
Indonesia	1982	8.4
Maldives	1982	6.1
Mongolia	1981	107.6
NEPAL	**1988**	**2.4**
Sri Lanka	1983	24.0
Thailand	1982	15.4

Source: Bulletin of Regional Health Information, WHO SEARO.1986.

Three Ministries Comparison.

The present trend is for the budgetary provision to be increased for the two social sectors – health and education. Because of ongoing conflict within the country, Nepal's expenditure on defence has been going up. The figures pertaining to the ministries, both in Nepal and in the region is given below.

Country	Health -% of Budget.	Education - % of Budget.	Defence - % of Budget.
Bangladesh	5	11	10
Bhutan	11	17	0
India	2	2	15
Maldives	9	18	10
Myanmar	3	8	29
Nepal	5	18	8
Pakistan	1	1	18
Sri Lanka	6	10	18
Thailand	8	17	6

Source: State of the Worlds Children 2005 (18).

Human Development Index (HDI)

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Most newspapers make a great show of the fact Nepal moves up or down the HDI. Whilst this is a form of assessment of what is happening in the country, it does not warrant the amount of hullabaloo that is being generated every year. Noting the fact that Nepal had been making "good progress" over 25 years (1975-2000), the UNDP ranked Nepal 129 out of 162 countries in 2001.

In 2002 Nepal moved to 142 out of 173 countries with HDI value of 0.490. It must be pointed out however that 11 new countries were created during the course of this year and as their position in the ranking was higher than that of Nepal, one finds our ranking has slipped. This year, Nepal position in the Human Development Index is at present at 140 amongst the countries of the world with a HDI value of 0.504.. This is two points up from what it was in 2002. This HD Report, which has been brought out annually by UNDP, is based on various indications pertaining to the country (19).

Comparison in SEARO

The overall level of public expenditure on health remained at 1% though it varies among the different countries of South Asia. The public expenditure in health in terms of percentage of GDP shows that in 1998, Maldives spent the highest amount at 5.1% whereas India and Pakistan spent the lowest amount on health viz. 0.8% and 0.9% respectively (20).

Table 6. 1 Expenditures on health in South East Asian Countries as % of GPD

	1990	1998
India	0.9	0.8
Pakistan	1.1	0.9
Bangladesh	0.7	1.7
Nepal	0.8	1.3
Maldives	4.9	5.1
Bhutan	1.7	3.2
Sri Lanka	1.5	1.4
South Asia	1.0	1.0

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