Government of Nepal
Ministry of Health and Food Safety
Singhadurbar, Kathmandu

Nepal's Basic Health Services Package: Clear Priorities, Rising Financing Needs

KEY MESSAGES

1. Of 224 candidate clinical care pathways (204 interventions), 131 (114 interventions) are recommended for the revised Basic Health Services Package (BHSP). Another 82 can follow as resources permit, and 11 are deferred.
2. The recommended package would cost NPR 204.4 billion over five years in nominal terms, about 95% of the projected BHS budget envelope. From FY 2087/88, however, annual costs exceed the envelope, with an indicative gap of NPR 13.0 billion in FY 2088/89.
3. Nearly half (47%) of the cost of all candidate pathways at target coverage is for additional services: new content in existing services and interventions not yet part of BHS practice. Extending existing services to more people accounts for 19%.
4. Delivering the revised BHSP requires commitment from federal, provincial and local governments, predictable financing, and a clear division of roles: the BHSP financed from government budgets and free for all, and health insurance focused on care beyond basic services.

Article 35 of Nepal's Constitution guarantees every citizen the right to free basic health services, and the Basic Health Services Package (BHSP) puts this right into practice. Yet the current package was defined without explicit prioritization of individual interventions or a full assessment of their costs.

This brief draws on the first systematic, evidence-informed priority-setting exercise for the BHSP. It sets out which interventions should come first, what they would cost and how the package could expand in phases, based on health benefits, equity, feasibility and other policy considerations.

The challenge now is to turn these priorities into a formally revised package backed by predictable financing. Decisions on the scope and pace of expansion will determine whether the constitutional commitment can be sustained.

What Comes First: Priority Clinical Services, Health Promotion and AAM

The exercise assessed 300 candidate interventions: 204 clinical, 36 Health Promotion and 60 Ayurveda and Alternative Medicine (AAM). For costing and prioritization, the 204 clinical interventions were specified as 224 care pathways. Of these, 131 form Group 1, the recommended priority package; 82 form Group 2, to be added as resources become available; and 11 are deferred (Group 3).

More than cost-effectiveness. Cost-effectiveness estimates were available for some clinical interventions. They were weighed alongside disease severity, equity, policy relevance and social impact. Pathways without such estimates were assessed on their budget impact and the same criteria, through structured deliberation.

Health Promotion and AAM. All 36 Health Promotion and 60 AAM interventions were retained after separate assessments. These rested on different evidence and policy considerations, so each category is retained on its own merits rather than on a common measure of effectiveness.

Status. The three groups are technical recommendations on the scope and sequencing of the revised BHSP. They do not change existing legal entitlements until formally adopted.

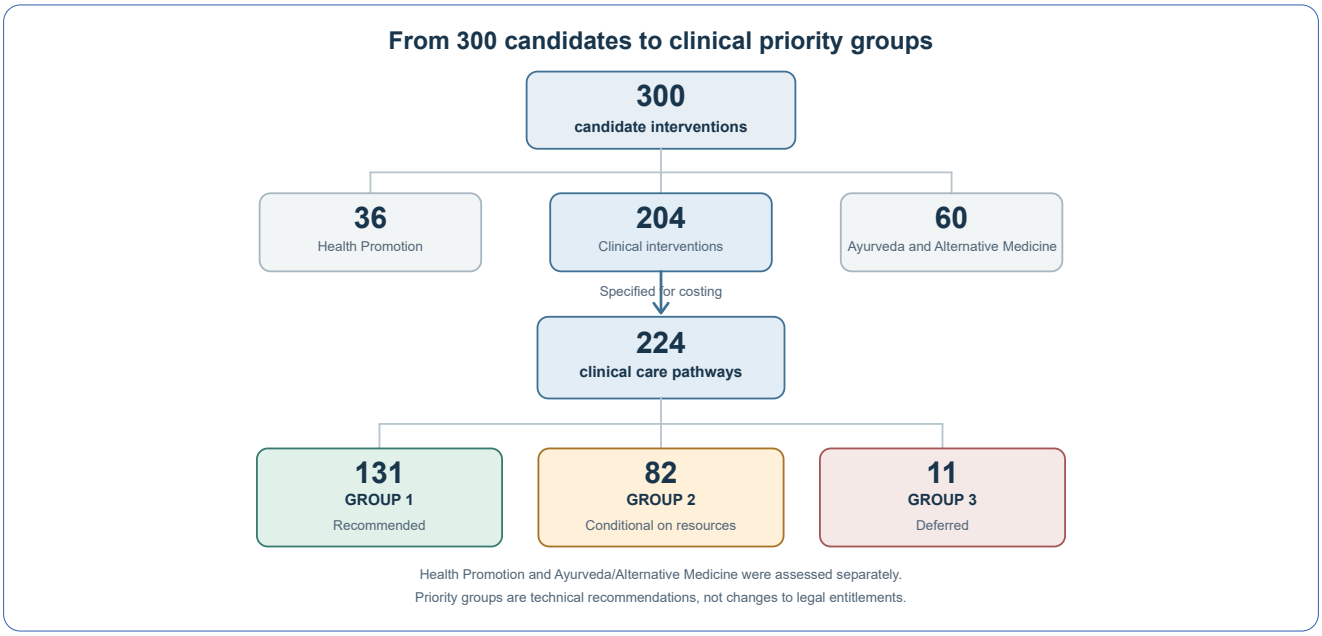


Figure 1. From candidate interventions to BHSP clinical priority groups.

Note: Some clinical interventions comprise more than one pathway. Health Promotion and AAM interventions were assessed separately. The groups are technical recommendations, not changes to legal entitlements.

Costs Fit the Five-Year Budget Projection, but Not Every Year

Group 1 would cost NPR 44.2 billion a year at target coverage (2025 prices). As coverage scales up over FY 2084/85 to 2088/89, it would need NPR 204.4 billion in nominal terms, about 95% of the projected BHS envelope of NPR 214.8 billion.

The annual picture is tighter. Because coverage rises each year, costs start well below the envelope but exceed it from FY 2087/88. In FY 2088/89, Group 1 would need NPR 59.2 billion in nominal terms against a projected NPR 46.2 billion, an indicative gap of NPR 13.0 billion.

Reading the comparison. The envelope is a projection, not a confirmed allocation, and it is built from budget lines, while the pathway costs are built up from the inputs each service uses. The costs do not cover the full cost of

implementation and exclude Health Promotion and AAM, which are budgeted against their own existing allocations rather than costed. The comparison is therefore indicative: it neither confirms affordability nor measures the additional public funding needed.

Implication. Sustaining Group 1 at target coverage requires the BHS envelope to grow faster than currently projected.

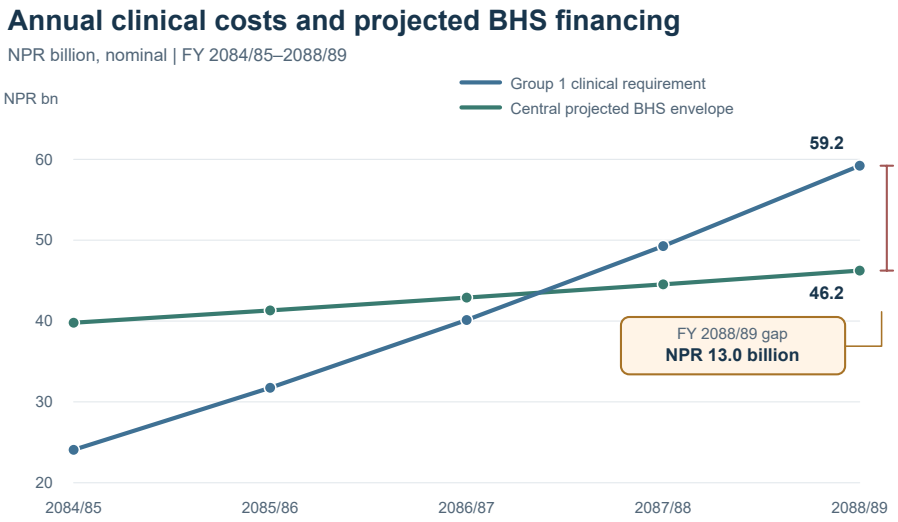


Figure 2. Group 1 clinical costs exceed the projected BHS budget envelope from FY 2087/88.

Note: Nominal estimates for FY 2084/85–2088/89. The envelope is a central projection, not an approved allocation; pathway costs and budget categories are not fully comparable. Health Promotion and AAM are not included in the clinical costs. They are budgeted against their own existing allocations: the Ayurveda allocation within the BHS envelope (NPR 1.9 billion over five years, nominal) and the allocation for health promotion and preventive services (NPR 50.8 billion, nominal), which overlaps with the BHS envelope and is not additive.

Reaching More People and Adding Services Carry Different Costs

The package can grow in two ways: by reaching people who lack access to existing services, and by adding new content to existing services or new interventions to the package. Both need public financing, but they differ in cost and in what they do for coverage and equity.

If all 224 candidate pathways reached target coverage, the annual cost would be NPR 65.8 billion (2025 prices). Of this, 34% maintains current coverage, 19% extends existing services to more people and 47% adds services not yet part of BHS practice.

Where to start. Reaching underserved people with existing services is a direct route to greater equity, without the full set of new inputs. New content can also bring health and equity gains but widens the scope of publicly financed care. The assessment therefore supports emphasizing coverage expansion in the early years, with additional services introduced gradually.

Scope. These shares refer to all 224 candidate pathways, not to the cost composition of Group 1. The 47% also overstates new spending: many services counted as additional already reach some people outside current BHS practice, but their full cost was counted, pending a detailed mapping during the formal BHSP revision.

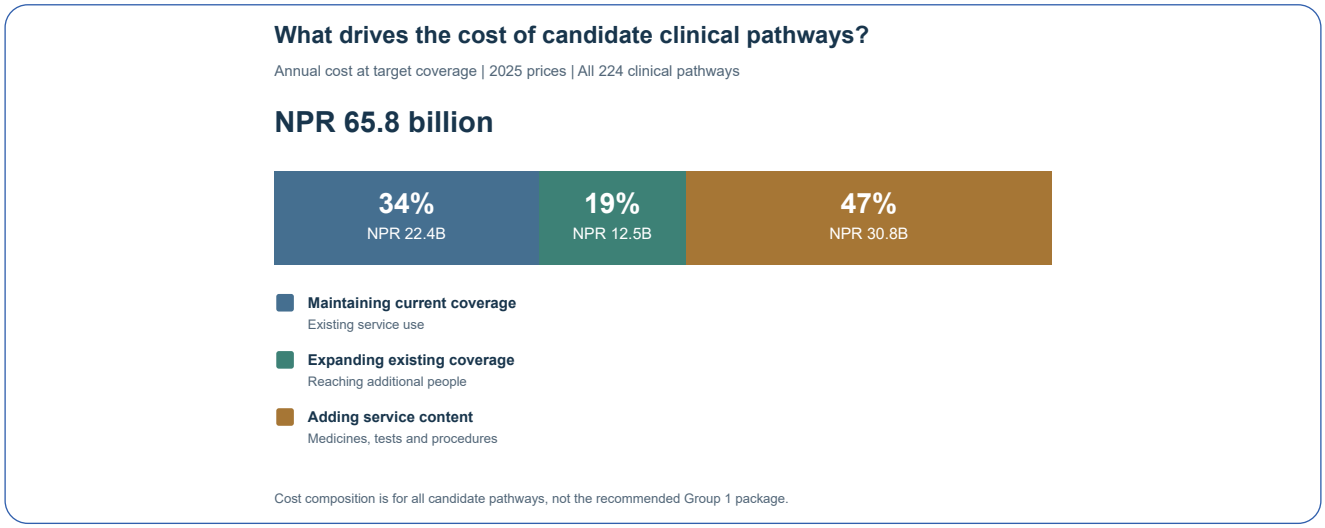


Figure 3. Additional service content accounts for nearly half of the estimated cost of all candidate clinical pathways.

Note: Annual cost at target coverage, 2025 prices, for all 224 candidate pathways. Additional services comprise new medicines, tests and procedures within services already provided and interventions not yet part of current BHS practice, many of which already reach some people through other programmes. Figures are rounded.

From Priorities to Policy: Three Actions

1. Formally adopt the priorities through revision of the BHSP.

The recommendations give a technical basis for the revised package. The MoHFS intends to consult across the three tiers of government and complete the statutory approval process. Implementation could then be phased: Group 1 first, extending existing services to people not yet reached before adding new content, and Group 2 as fiscal space grows.

2. Secure predictable financing for the revised BHSP.

The MoHFS aims to secure a protected minimum allocation for basic health services, linked to the Medium-Term Expenditure Framework, with the cost of Group 1 along its scale-up path as the benchmark. It also intends to seek minimum floors for Health Promotion and Ayurveda services, so that interventions that were not costed are not crowded out when budgets tighten. Working with the Ministry of Finance, the MoHFS will work towards aligning conditional grants with the revised package, so that local governments receive resources that match their service responsibilities.

3. Define clear roles for the BHSP and health insurance.

BHSP services are to remain financed from government budgets and free at the point of use for everyone, with health insurance concentrating on referral and specialized care beyond basic services. The MoHFS intends to map services now provided through free programmes and review the insurance benefit package once the revised BHSP is in place, to reduce duplication and fragmented spending.

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UNIVERSITY OF BERGEN
NEPAL HEALTH ECONOMICS ASSOCIATION NHEA 1998
Norway

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Source: Basic Health Services in Nepal: Priority Setting and Essential Health Interventions (2026).

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Beyond Cost-Effectiveness: How Nepal Set Priorities for Basic Health Services

KEY MESSAGES

1. Six criteria, endorsed by the MoHFS, guided priority setting: health maximization, disease severity, equity, policy relevance, social impact and feasibility.
2. All 224 clinical care pathways (204 interventions) had unit cost and budget impact estimates, and 92 (81 interventions) also had cost-effectiveness ratios. Where health gains could not be modelled, the other criteria and structured deliberation guided the decisions.
3. The priority groups set a recommended sequence for financing and scaling up services. They do not judge lower-ranked services to lack value, and they do not by themselves change legal entitlements.
4. The recommendations will be updated as local evidence on costs, coverage and effectiveness improves.

Revising the Basic Health Services Package (BHSP) required more than finding the interventions that give the greatest health gain for the resources available. The priority-setting exercise combined economic analysis with explicit criteria and structured deliberation, because the evidence available differed widely across interventions.

This brief explains the criteria, the evidence and the decision process behind the priority groups, and how the results should be read.

1. Six Criteria for Priority Setting

Six criteria guided the exercise: health maximization, disease severity, equity, policy relevance, social impact and feasibility. They were developed through a four-phase consultative process and endorsed by the MoHFS.

How each criterion was applied depended on the evidence. For clinical pathways with modelled health gains, health maximization and disease severity were assessed quantitatively; elsewhere, the qualitative criteria and deliberation carried more weight. For Health Promotion and Ayurveda and Alternative Medicine (AAM), where health gains could not be quantified, two additional criteria, preventive value and positive externalities, took the place of health maximization and disease severity.

The criteria thus served as a common framework for decisions, not a single scoring formula.

Figure 1. Six Criteria for Priority Setting

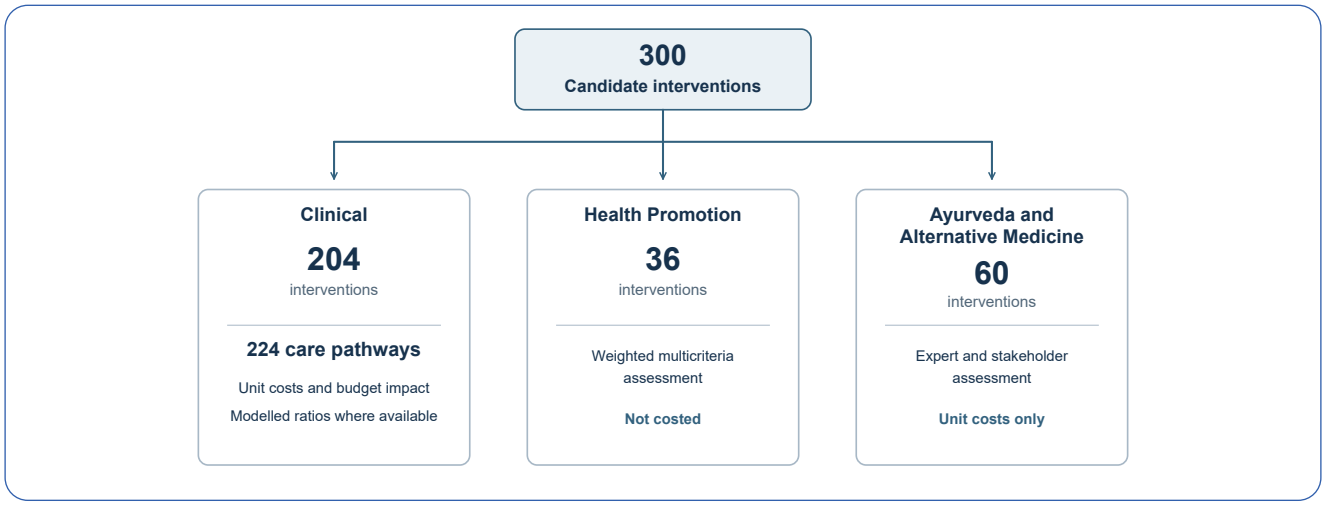


2. The Reach of Economic Evidence

The 204 clinical interventions were costed as 224 care pathways, because some interventions cover more than one condition or method. Every pathway has a unit cost and a budget impact estimate, so its resource needs could be assessed even where health gains could not be modelled.

Unit costs and budget impact. Unit costs value the staff time, medicines and supplies needed to deliver each service. Budget impact adds the population in need and the target coverage.

Figure 2. Different Evidence, Different Assessment Routes



Note: The three categories followed different assessment routes, suited to the evidence available for each.

Cost-effectiveness. To estimate health gains, Nepal's costs were combined with FairChoices, a modelling tool that draws on demographic, epidemiological and effectiveness evidence. Ratios, expressed as cost per healthy life year gained, were available for 92 pathways (81 interventions). Of these, 71 pathways were full matches and 21 partial matches, in which the Nepal pathway delivers only part of the modelled care, such as screening and referral, so the ratio is optimistic (Table 1).

For the remaining 132 pathways (123 interventions), priorities rested on budget impact, the other criteria and deliberation. Economic evidence was one input to decisions, not the sole determinant.

Table 1. Availability of Economic Evidence for Clinical Pathways

Evidence available	Clinical pathways	Interventions
Modelled cost-effectiveness ratio	92	81
FairChoices counterpart, without modelled health gains	16	16
No FairChoices counterpart	116	107
Total	**224**	**204**

Note: All 224 pathways had unit cost and budget impact estimates. Breast cancer screening and referral, linked to a FairChoices intervention without modelled health gains, was assessed with Stream D because of its large budget impact, so the counts differ slightly from the assessment streams.

3. Different Routes to Assessment

The evidence available set the assessment route for each intervention.

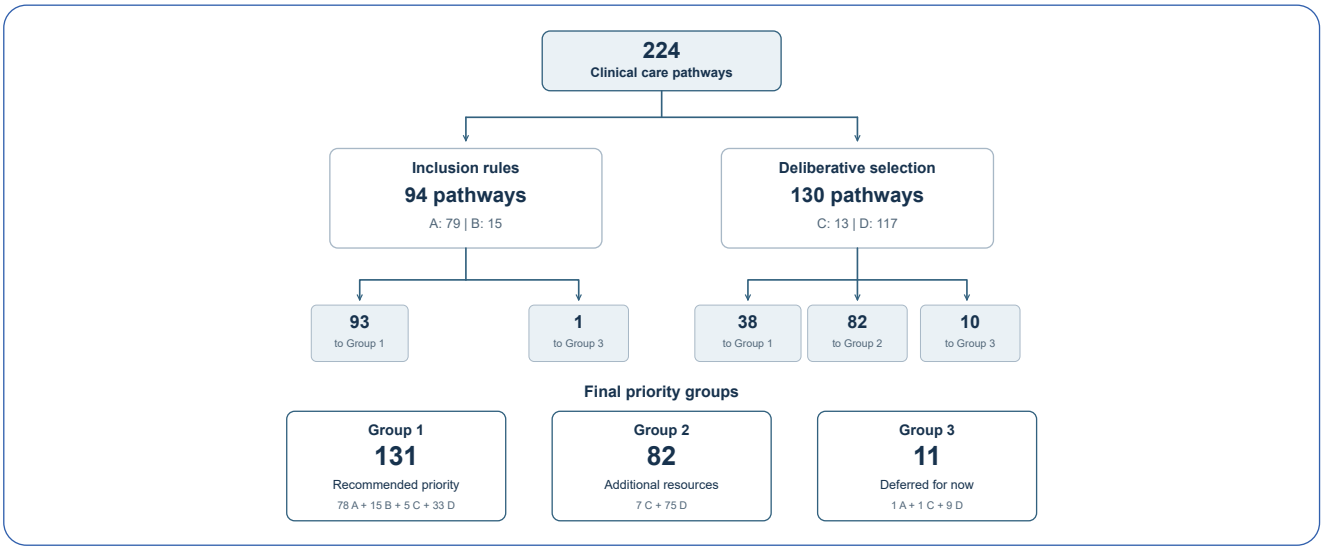
Clinical pathways were grouped into four streams according to their economic evidence (Figure 3). The final assessment used Nepal-specific costs and a threshold of 0.5 times GDP per capita per healthy life year gained.

Health Promotion. The 36 interventions were assessed through consultations and a weighted multicriteria assessment covering preventive value, effectiveness and value for money, equity and wider benefits, policy relevance and feasibility, and fiscal implications. They were not costed in this round.

AAM. The 60 interventions were assessed mainly through expert and stakeholder consultations, supported by unit cost estimates rather than full budget impact estimates. Evidence on their effectiveness, coverage and population in need was not available in this round.

Each category was therefore retained on its own merits rather than on a common measure of effectiveness.

Figure 3. From Assessment Streams to Final Priorities



Note: A: modelled ratio below 0.5 times GDP per capita per healthy life year gained, included. B: linked to FairChoices interventions without modelled health gains, mainly family planning, included as programme commitments. C: modelled ratio at or above the threshold. D: no FairChoices counterpart, plus breast cancer screening and referral. Streams C and D (130 pathways) were placed in priority groups through consensus, on budget impact and the qualitative criteria, with disease severity also considered for Stream C. The management of wounds and suturing (Stream A) appears in Group 3 because it is covered within primary trauma care.

4. From Assessment to Final Priorities

Economic analysis gave a starting point; deliberation shaped the final priorities. Provincial consultations identified constraints on service delivery, and federal deliberations ranked interventions by cost-effectiveness and weighed those close to the cutoff on equity, policy relevance, social impact and feasibility.

Updated estimates. The early deliberations used default FairChoices costs and a reference point of one times GDP per capita. The final assessment used Nepal-specific costs and the stricter threshold of 0.5 times GDP per capita. Because ratios and rankings changed, the earlier judgements informed the final selection rather than being carried over directly.

Streams C and D. National stakeholders agreed by consensus on groups for these 130 pathways. Thirty-eight were placed in Group 1, including five with ratios at or above the threshold, retained as programme commitments or as essential on the qualitative criteria. Other decisions set conditions, such as phased scale-up, a specific delivery platform, or screening and referral in place of treatment.

Final package. After national validation and endorsement, Group 1 comprised 131 pathways (114 interventions), Group 2 comprised 82 pathways (79 interventions) to be added as resources become available, and Group 3 comprised 11 deferred pathways (11 interventions). All 36 Health Promotion and 60 AAM interventions were retained in the recommended package, alongside the clinical groups.

5. Interpreting the Recommendations

What the groups mean. The groups set a recommended sequence for financing and scaling up services. Every pathway was placed in a group, and lower groups are not judged to lack value. The sequence does not establish or amend legal entitlements under the constitutional guarantee; formal package decisions follow separately.

Cost-effectiveness results. Ratios cover only part of the clinical package, and partial matches give optimistic ratios. The threshold of 0.5 times GDP per capita is a benchmark for selection, set closer to estimates of what the same resources would achieve elsewhere in the health system, rather than a measured value for Nepal.

Cost estimates. Costs and budget impact depend on assumptions about service delivery, population in need and target coverage. Unit costs exclude equipment and referral costs, include overheads only as a flat mark-up, and use national averages that may hide differences across facilities and areas. On their own, the priorities do not establish affordability.

Next round. The recommendations will be revisited as local data on costs, coverage, effectiveness and delivery improve, starting with the pathways that have no modelled health gains.

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Government of Nepal
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From Priorities to Services: Implementing Nepal's Revised Basic Health Services Package

KEY MESSAGES

Technical priorities do not guarantee delivery. Formal adoption, credible financing and clear institutional responsibilities are needed to turn recommended services into deliverable commitments.

Annual financing pressures remain. Over five years, Group 1 costs fit within the projected budget envelope, but annual costs exceed it in the final two years. The estimates also exclude equipment and referral costs.

Service readiness varies by pathway. Of the 131 recommended clinical pathways (114 interventions), 116 rely on existing delivery platforms, eight need readiness investment or phased introduction, and seven depend on screening, stabilization and referral. Facility readiness has yet to be verified.

Monitoring must lead to decisions. The MoHFS intends to assign clear responsibility for operational correction, technical reassessment and formal package revision, so that service gaps, once identified, are acted on.

Nepal's evidence-informed priority-setting exercise has established a basis for revising the Basic Health Services Package (BHSP). Identifying priority services does not, by itself, revise legal entitlements, secure financing or ensure delivery.

Turning these priorities into accessible services requires formal adoption of the revised package, financing aligned with delivery requirements, delivery arrangements that respond to differences in local capacity, clear institutional responsibilities, and monitoring that guides corrective action. Guided by equity, this brief sets out the decisions and actions the MoHFS intends to take, with provincial and local governments, to move from technical priorities to service delivery.

Formalize and Finance the Package

Formal adoption. The priority-setting results provide the technical basis for revising the BHSP. The Ministry of Health and Food Safety (MoHFS) has initiated the formal revision process, which is to be completed through an amendment to the Public Health Service Regulation. Until the revised package is adopted, the recommendations can guide implementation planning, but they do not change existing free-service entitlements or authorize patient charges.

Financing. The MoHFS aims to advance financing alongside formal revision. Over FY 2084/85 to 2088/89, Group 1 would cost NPR 204.4 billion in nominal terms, within the projected BHS envelope of NPR 214.8 billion. Annual costs, however, exceed the envelope from FY 2087/88, with an indicative gap of NPR 13.0 billion in nominal terms in FY 2088/89. Because the envelope is a projection and the costs exclude equipment, referral and geographic differences in delivery costs, this is not a full implementation funding gap. Financing plans will therefore address annual requirements rather than rely on the five-year comparison.

Aligning financing with delivery. The MoHFS intends to work with the Ministry of Finance and with provincial and local governments to link service obligations to annual budgets, funding channels and actual delivery requirements: predictable allocations to local governments, provision for geographic differences in delivery costs, and targeted support where local capacity is weaker, so that implementation constraints do not deepen inequalities in access. Health Promotion and Ayurveda and Alternative Medicine (AAM) services are budgeted against their own allocations, and the MoHFS intends to seek minimum floors to protect them.

Together, not in sequence. Formal adoption without credible financing risks unfulfilled service commitments, while financing without an agreed legal scope leaves responsibilities uncertain. The MoHFS therefore aims to take both forward together.

Match Services to Readiness

Inclusion in the revised BHSP does not mean every service can be delivered immediately at its designated facility. Of the 131 Group 1 pathways, 116 rely on existing platforms with routine readiness needs, eight require readiness investment or phased introduction, and seven depend on effective screening, stabilization and referral (Table 1). These are pathway-level requirements, not verified readiness of individual facilities.

Table 1. Delivery requirements for the 131 Group 1 clinical pathways

What delivery depends on	Pathways	Cost at target (NPR billion a year)	Examples	What is needed
Existing platforms, with routine readiness	116	35.6	Immunization, family planning, maternal and newborn care, common infections, tuberculosis, programme commitments	Medicines, supplies and staff in line with the Minimum Service Standards
Readiness investment or phased introduction	8	5.5	Tiered chronic care for diabetes, cardiovascular disease and COPD; basic physiotherapy; burn care; dementia and PTSD; primary palliative care	Treatment protocols, trained staff, diagnostics and medicines at each tier; phased rollout
Screening, stabilization and referral	7	3.1	Primary trauma care; screening for cervical, oral and colorectal cancer; emergency care of stroke and ischaemic heart disease; child and adolescent mental health	Referral links and transport that reach care in time; capacity at referral hospitals
Total	**131**	**44.2**		

Note: Cost at 2025 prices. The classifications describe pathway-level requirements, not verified readiness of individual facilities. COPD: chronic obstructive pulmonary disease; PTSD: post-traumatic stress disorder.

Assessing readiness. The Department of Health Services (DoHS), with provincial health directorates, is to assess facilities against the Minimum Service Standards, covering staffing, medicines, diagnostics, equipment and referral capacity, to establish actual readiness and guide the response: targeted investment or phased introduction where capacity is lacking, and timely access to receiving facilities for services that depend on referral. Responsibilities for closing gaps are to be clearly assigned across the DoHS, provincial health directorates and local governments. In remote and underserved areas, phasing is to be accompanied by corrective support and referral arrangements, not prolonged exclusion from services.

Updating guidance. The DoHS is to update standard treatment protocols, the National List of Essential Medicines and referral guidelines to reflect the revised package and the role of each level of care. Referral is to build on existing guidelines, linking primary facilities with higher-level services, so that people whose local facility cannot provide every intervention can still reach it.

Make Monitoring Actionable

Clear responsibilities. Monitoring is useful only if its findings lead to action. The MoHFS proposes a technical team within the DoHS, working with a new Health Economics and Analytics Team in the MoHFS, to assess implementation evidence, with a decision authority such as the Steering Committee deciding on changes to the package. Both teams would require formal mandates and defined links with provincial and local governments.

Building on existing systems. Monitoring is to use the Basic Health Services Monitoring System (BHSMS), routine health information systems and facility assessments rather than create parallel reporting. Indicators are to be aligned with the revised interventions and delivery platforms, with defined numerators, eligible-population denominators, reporting periods and data sources. Baseline and target coverage estimates will remain provisional where further validation is needed.

Measuring what matters. Monitoring is to distinguish service availability and use from effective coverage and quality, since changes in use do not by themselves show the effect of the revised package. Differences across geographic areas and population groups are to be examined to identify inequalities in access.

Matching responses to problems. Medicine shortages, staffing gaps and weak referrals are to be addressed through operational correction by local governments and facilities, supported by provincial health directorates and DoHS divisions. Changes in costs, coverage or effectiveness would prompt technical reassessment by the proposed federal teams. Adding, modifying or removing services will follow the statutory revision process (Figure 1). Linking these responses to routine planning and review would allow the BHSP to adapt to changing needs while keeping existing commitments accountable.

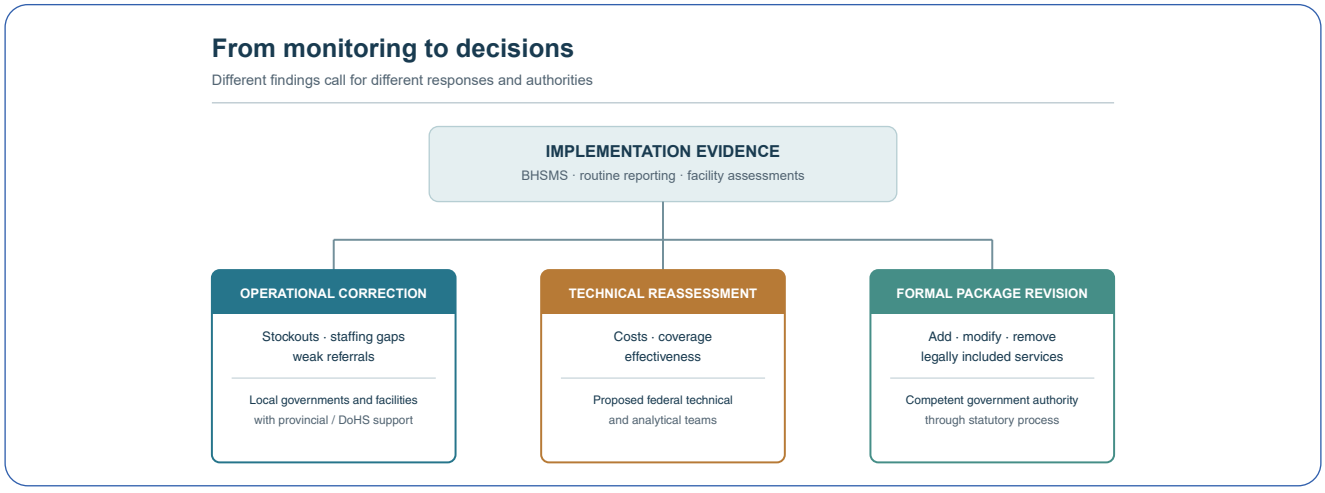


Figure 1. Three distinct responses to implementation evidence, not sequential stages.

The technical teams are proposed arrangements; statutory changes require competent government authority.

Priority Actions

The immediate priority is to turn the revised BHSP into authorized, financed and deliverable service commitments. The MoHFS plans to take forward the actions below, which set out indicative responsibilities, conditions and expected outputs. They are numbered for reference, not sequence: several can proceed in parallel, while others depend on formal adoption.

Priority action	Indicative lead and support	Depends on	Expected output
1. Formally adopt the revised BHSP through amendment of the Public Health Service Regulation.	Lead: MoHFS (Curative Service Division and PPRD). Support: Relevant ministries; provincial and local governments consulted.	Statutory consultation, legal review and financial concurrence completed.	Revised regulation approved and published in the Nepal Gazette.
2. Align financing with service commitments through annual budgets and conditional grants.	Lead: MoHFS (PPRD), jointly with the Ministry of Finance. Support: Provincial and local governments.	Group 1 costing available; intervention-linked budget classifications agreed.	Package-linked budget provisions and revised conditional grant guidelines.
3. Assess facility readiness and address priority gaps, with differentiated support for underserved areas.	Lead: DoHS and provincial health directorates. Support: Local governments responsible for BHS facilities.	Minimum Service Standards assessment tools and facility infrastructure data available.	Facility readiness findings and prioritized corrective plans.
4. Update service delivery guidance, including treatment protocols, essential medicines and referral arrangements.	Lead: DoHS (Curative Service Division and relevant programme divisions). Support: Provincial health directorates and facilities.	Technical drafting may begin earlier; final issuance follows formal adoption (Action 1).	Updated treatment protocols, essential medicines list and referral guidance issued.
5. Establish arrangements for continuous priority setting, with defined mandates and links across government levels.	Proposed lead: MoHFS (PPRD). Proposed support: DoHS and provincial health authorities.	Government decision authorizing the functions and providing staffing and resources.	Mandated and staffed technical and analytical functions, with a defined package-review process.
6. Align monitoring with the revised package and use findings to inform decisions.	Indicative monitoring lead: DoHS (Curative Service Division). Support: Existing HMIS functions, provincial health directorates and local governments. Technical reassessment and formal revision rest with separately designated authorities.	Agreed package interventions and delivery platforms; existing BHSMS and routine reporting systems.	Revised BHSMS indicators and documented operational responses. Technical reassessment recommendations and statutory revision proposals referred to the competent authorities as warranted.

Source: Adapted from the roadmap in Basic Health Services in Nepal: Priority Setting and Essential Health Interventions (2026). Leads, dependencies and outputs are indicative and are to be confirmed during implementation planning. PPRD: Policy, Planning and Research Division; HMIS: Health Management Information System.

Across these actions, equity remains a guiding principle: differences in local capacity are to prompt differentiated support rather than become persistent differences in access to basic health services.

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