Addressing Barriers to the Growth of Traditional Health Services Export of Nepal

[A country study for the study "South Asian export potential in traditional health services: A case study of Bhutan and Nepal", conducted for South Asia Network of Economic Research Institutes (SANEI)]

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1. Introduction

Health is important for economic growth and development. Accordingly, the Government of Nepal (GON) has been increasing its expenditure on health services: during the period 1990–2004, health spending increased by 14.3 percent compared to the 10.6 percent and 11.8 percent rise in total government expenditure and nominal gross domestic product (GDP), respectively. In the past, there was much intervention by GON in trade in health services. However, this trend is changing with the recognition that international trade in health services can potentially increase the contribution of the health sector to the national economy (Maskay 2004).

The objectives of this study are to:

- Examine the role of traditional health system in Nepal
- Assess the export potential in traditional health services, particularly Ayurveda, via a case study methodology, questionnaire survey, in-depth interview and focus group discussion
- Suggest policy and institutional measures to address the barriers to export of traditional health services

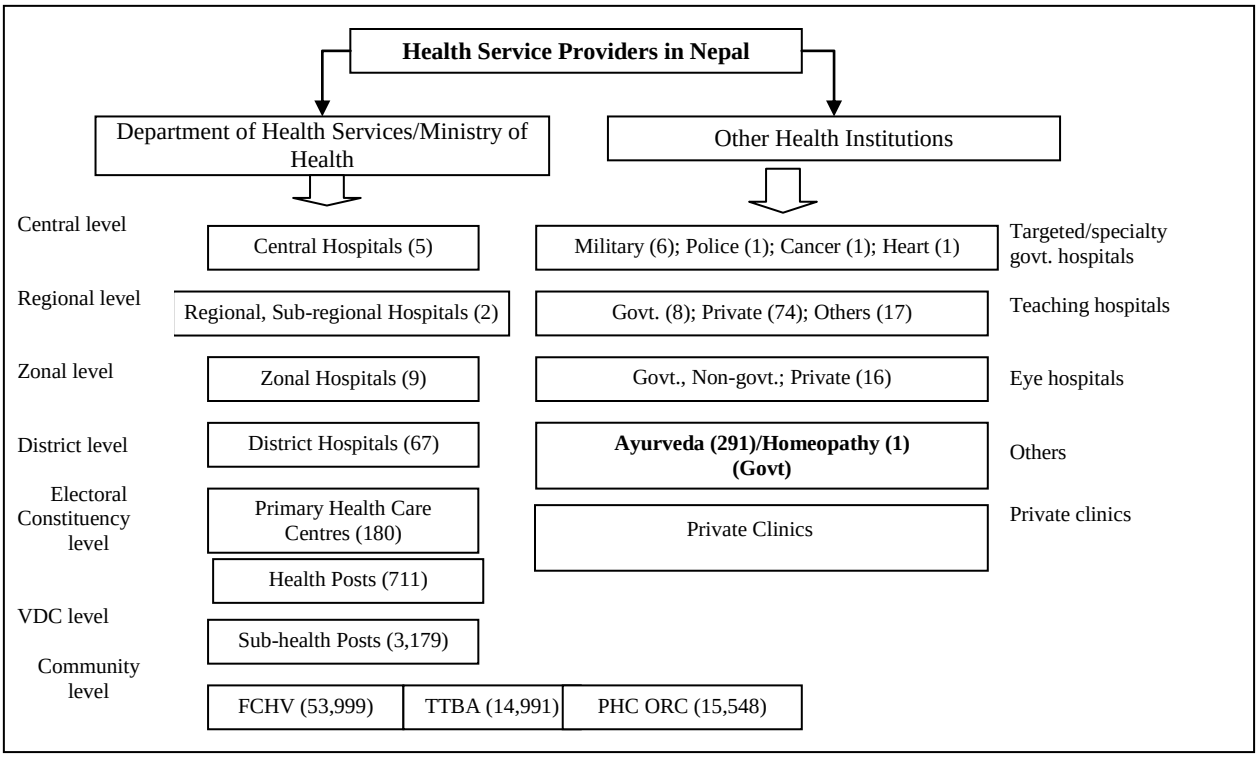
2. National health care system

2.1 Structure

Primary and secondary health services in Nepal are largely provided by the public sector. Specialized services are open to both the public and private sectors. The public sector health service delivery mechanism is organized in a hierarchal structure—from the sub-health post (SHP) level to the central level.[1] The structure is presented in Chart 1 for both the public and private sectors.

Chart 1: Network of health institutions and community health workers in Nepal

1 The SHP is a first contact point with referral as necessary to higher levels of health services. The referral chain, as a policy objective, is to ensure that the majority of population are able to receive public health and minor treatment in places accessible to them and at a price they can afford.



Source: http://www.moh.gov.np/Home/FACT.ASP; SAWTEE (2008).

Public sector health institutions provide 59 percent of total beds. The private sector, comprising "for profit" institutions, non-governmental and mission organizations provide the remaining 41 percent (MoH 2003). However, the private sector institutions are concentrated in urban areas.

2.2 Overall health policy

Nepal's health policy is primarily guided by the National Health Policy, 1991. The policy was adopted to bring about improvement in the health conditions of the people of Nepal with emphasis on preventive health services; promotive health services; curative health services; basic primary health services with one health post each in all 205 electoral constituencies to be converted into primary health care centre; ayurvedic and other traditional health services; community participation; human resources for health development; resource mobilization; decentralization; regionalization; drug supply; and health research (MOH 1993).

The salient features of the policy are:

- It considers primary healthcare as is a human right.
- It aims to provide an equitable and acceptable quality of health services for all citizens.
- It provides for free healthcare to all citizens through health posts and sub-health posts.
- It envisions free healthcare through hospitals with up to 25-bed capacity to the poor, the elderly, most vulnerable groups, and underprivileged and marginalized groups, among others.
- It accords priority to primary healthcare, but does not give much importance to trade in health services. It implicitly recognizes tertiary health services as trade in health services.

- It calls for public-private partnership for providing health services.

The recognition of primary healthcare as a human right by the health policy has been further bolstered by the right to health being enshrined as a fundamental right in the Interim Constitution of Nepal 2007.

Other policy documents governing health services in Nepal are the Second Long-Term Health Plan (SLTHP, 1997–2017), the Eighth (1992-1997), Ninth (1997-2002) and Tenth (2002-2007) Five-Year Development Plans, the ongoing Three-Year Interim Plan (TYIP) (2007-2010), the Health Sector Strategy: An Agenda for Reform, 2003 and the Nepal Health Sector Program–Implementation Plan (NHSP-IP), 2004. All policies and programmes focus on primary healthcare for citizens.

The main objective of the TYIP is to ensure citizens' fundamental right to improved health services through access to quality health services without any discrimination. The constituent elements of the objective are a) to provide quality health service; b) to ensure easy access to health services to all citizens; and c) to ensure an enabling environment for utilizing available health services (NPC 2007). The TYIP recognizes the potential for trade in health services and incorporates strategies like promoting the establishment and expansion of telemedicine, and developing and expanding Ayurvedic and other alternative health service systems. Providing computers and internet access for facilitating telemedicine, collecting information regarding herbs and intellectual property, and enhancing research activities are the important programmes envisioned in the plan which are relevant in terms of export of health services. The TYIP has identified the importance of health services trade and aims to produce benefits from international trade in services. However, no concrete strategies have been delineated for mode-specific supply of the services.

3. Traditional health care systems

Although the use of modern medicine has been increasing over the years in Nepal, more than 75 percent of the population in the country are estimated to use traditional medicine.[2] Ayurveda, Amchi, Homeopathy (including Yunani) and Naturopathy are the important traditional health systems in practice in Nepal. Among them, Ayurveda is the oldest and most popular traditional health care system in Nepal (Koirala n.d.). The government not only recognizes Ayurveda and Homeopathy (including Yunani) health service systems but also provides such services, with Ayurveda service providers having the greatest network and reach.

Traditional medicine in Nepal has a strong cultural and religious background; indigenous and local communities have been using traditional and indigenous knowledge for centuries under local laws, customs and traditions (Koirala and Khaniya 2008). Literature shows there more than 400,000 such knowledge holders (ibid.).

Though the study focuses on Ayurveda, a brief description of the status of Homeopathy, Naturopathy and Amchi is presented before discussing Ayurveda in detail in the next section.

[2] http://www.ayurnepal.com/articles/rajendra_status_ayurveda_nepal.htm

Homeopathy
The government has recognized this health system as part of the national health system. A 56-year-old state-run Pashupati Homeopathic Hospital, the only such hospital in the country, is located in Kathmandu with three Indian-educated Ayurveda graduates and eight junior-level technicians from allopathic background with a refresher training in Homeopathy (Koirala, n.d.). It provides free-of-cost in-patient and OPD services to the people in general. There is no separate regulatory body to regulate and monitor this system of medicine and to register its practitioners, unlike the cases of modern medicine and Ayurveda (details are in the section on Ayurveda). The Yunani system of medicine is also incorporated in this hospital. Nearly 150 Homeopathy technicians are practising in Kathmandu, registered with the Health Professional Council. There is one private institution providing formal Homeopathy education.

Naturopathy
This is not an official system of medicine, but is widely practised at the community level. Training in Naturopathy is provided by the private sector. There are private hospitals, training centers, clinics, and dispensaries in the country.

Amchi
Amchi (or Sowa Rigpa) is a Tibetan medicine practised in the Himalayan region of the country. This is not an official system of medicine. There are two types of practitioners in this system: the institutionally trained and traditional healers. There is no official record of this system of medicine. However, media reports suggest that this system has a remarkable role in the northern parts of the country, especially the far-western region, in the treatment of various kinds of ailments using locally available medicinal plants. Amchi practitioners have long been demanding official recognition and the formation of a separate regulatory body. There is a body, the Himalayan Amchi Association, working for the preservation and development of Amchi, and networking with and mutually supporting Amchi throughout the greater Himalayan and Central Asian region.

4. Ayurveda

Ayurveda by definition means the science of life. It is the oldest known continuously practised medical system in the world. Ayurvedic theory has influenced the development of many other medical systems, including Chinese, Arabic, Greek, Tibetan and modern medicine. The origin of Ayurveda can be traced back to the Vedic times, around 5,000-10,000 years ago. The medical knowledge in Atharvaveda, one of the four Vedas, is said to have gradually developed into Ayurveda. The knowledge of Ayurveda was passed down orally for generations before being recorded as part of the Vedas, the oldest books known on earth. Ayurveda is based on the ‘tridosha theory of disease’. The three doshas or humors are vata (wind), pitta (gall) and kapha (mucus). According to Ayurveda, a disturbance in the equilibrium of these humors causes disease.

Nepal has a special place in the history of Ayurveda as it is widely believed that the original knowledge of Ayurveda was obtained in the Himalayan foothills of Nepal. Not only is the country is home to nearly 40,000 hand-written classical Ayurvedic manuscripts, its rich

biodiversity associated with its topographical diversity makes Nepal home to some 1,700 medical plants used in Ayurvedic treatment.

4.1 Supply situation

Ayurveda practitioners in Nepal can be divided into two categories (Koirala, n.d.). First, Ayurveda based-traditional healers, who have been practising it as a family profession for generations. Second, academic Ayurveda practitioners trained from educational institutions, training centers, colleges and universities. The former are mostly concentrated in the informal sector whereas the latter operate in the formal sector.

The estimated number of traditional healers in Nepal is 400,000 (Koirala, n.d.). A large proportion of the population still depends upon these practitioners. Only about two dozen traditional healers are registered practitioners. Although they are not counted in the official system of health care as health practitioners, traditional healers' role in providing health services to the people is highly important. Some traditional healers are the 23rd generation of practitioners in their family. Ayurvedic knowledge and techniques are handed down from generation to generation in a family and also through the master-disciple tradition. A study (Koirala and Khaniya 2008) found some 150 traditional healers in Kathmandu valley, Biratnagar (east Nepal), Pokhara (west Nepal), Banke and Bardiya (mid-west Nepal treating a wide range of diseases such as jaundice, stomachache, gastric, gano-gola, bone fracture, sprain, mal union of bones, abdominal pain, and arthritis, cut wound, cholelithiasis, sexual weakness, epilepsy, gynaecological problems, common cold, and even cancer. The study recorded 18 traditional healers in Kathmandu valley alone and also found that traditional healers in the valley continuing their practice from generation to generation as a family profession are able to treat a majority of common diseases, and prepare a variety of Ayurvedic drugs themselves, while other traditional healers can treat only certain particular diseases like jaundice, stomachache, gastric and gano-gola, and eight do not have adequate knowledge of or do not take interest in other health disorders.

As per data available from Nepal Medical Council, formally trained Ayurveda practitioners number around 1,300, including 239 Ayurveda Doctors (graduates/post-graduates), 754 Ayurveda Health Assistants (with certificate-level or equivalent education), and 308 Ayurveda Health Workers (with training of at least 15 months).

At the formal level, the state is the major provider of Ayurveda services. There is one Ayurvedic Hospital with 118 beds (including 18 cabins) in Kathmandu (established with four beds around 1918), another Ayurvedic Hospital in Dang district in west Nepal with 30 beds, 61 District Ayurveda Health Centers, 14 Zonal Ayurveda Dispensaries, and 214 local Ayurveda Dispensaries across the country.3 All these Ayurveda facilities are providing services free of cost or at nominal charge. The departments in the Ayurveda Hospital in Kathmandu include Internal Medicine (Kayachikitsa), Surgery (Shalya), ENT (Shalakya), Pediatrics (Baal Roga), Gynecology (Stri Roga) and Obstetrics, Acupuncture, Moxibustion, and Panchakarma. The hospital has its own pharmacy to manufacture medicine. It is very popular for the treatment of

[3] Nepal is administratively divided into five development regions, 14 zones and 75 districts.

Jaundice. Its pathology lab has facilities for testing urine, stool and blood with x-ray, USG and ECG. It also provides facilities of Swaden (therapeutic sweating) and Snehana (massaging the skin with different oils). The hospital is also functioning as a teaching hospital for Bachelor's in Ayurveda Medicine and Surgery (BAMS) students.

Table 1: State-owned Ayurveda health service institutions

	Central Ayurveda Hospital (Kathmandu)	Mid-Western Regional Ayurveda Hospital (Dang)	Zonal Ayurveda Dispensaries	District Ayurveda Health Centres	Local Ayurveda Dispensaries
No.	1	1	14	61	214

Source: Department of Ayurveda, Ministry of Health

Most of the patients at the state-run Ayurveda Hospital in Kathmandu are Nepali nationals. The inflow of foreign patients is negligible, though the exact numbers are not available.4 The few foreigner visitors are patients with jaundice and chronic diseases.

There is no reliable data on the number of private sector providers of traditional health services, including Ayurvedic. As mentioned above, there are at least 18 traditional healers in Kathmandu valley alone. Piyushabarshi Aushadhalaya is one of the oldest Ayurvedic clinics in Kathmandu, run by a family for the last 700 years. It attracts people with chronic diseases such as hepatitis, breast cancer, prostate cancer, tumor and cysts, and metastatic conditions. Discussion with experts, practitioners and the head of the Department of Ayurveda (where Ayurveda clinics are required to register) indicates that Ayurveda clinics are mushrooming in the country, especially in Kathmandu, but most are not duly registered with the government. Most of the clinics offer only short consultation services, including prescription of Ayurvedic medicines. Usually, a private Ayurveda pharmacy doubles as an Ayurveda clinic. There are about half a dozen (exact number is not known) Ayurveda service centres offering Ayurveda in Kathmandu. Experts say that such service centres are not available outside Kathmandu valley. One such service centre is Ayurveda Health Home, a private organization in Kathmandu run under Nepal-German management, providing a variety of Ayurveda services and also exporting the same to foreign consumers through Mode 2.

Besides, there are more than five dozen non-governmental organizations (NGOs) and international non-governmental organizations (INGOs) working in the areas of conservation of medicinal and aromatic plants (Koirala and Khaniya 2008). Yoga/pranayam classes are also run across the country, mainly informally.

There are nine Ayurveda campuses/colleges/institutes running Bachelor's and Certificate Level classes in Nepal. The state-run Ayurveda Campus, under the Institute of Medicine of Tribhuvan

[4] Based on discussion with the Director of the hospital.

University, is located in Kathmandu and runs Bachelor's in Ayurveda Medicine and Surgery (BAMS). It dates back to 1928 and hence predates formal teaching of modern medicine in the country. It admits 15 students every year for its 5.5-year course with three "professionals" of 18 months each, together with a one-year internship. A recently established private institute in Janakpur district (southeast Nepal) affiliated to Nepal Sanskrit University also offers BAMS. Seven private institutes/campuses/colleges, affiliated to Council for Technical Education and Vocational Training (CTEVT) and Nepal Sanskrit University, offer certificate-level courses, which produce para-medics, that is, Ayurveda Health Workers and Ayurveda Health Assistants. Many people obtain BAMS, Master's and Doctorate degrees in Ayurveda from India, though an estimate of their numbers is not available. Data on private sector Ayurveda training institutes is also not available. One known formal sector provider of Ayurveda training is Ayurveda Health Home. In addition, a National Ayurveda Research and Training Centre is being established with the assistance of the Chinese government.

There is one government-owned Ayruveda medicine-producing unit, the over 350-year-old Singha Durbar Baidhyakhana Vikas Samiti. It is operating below capacity and faces quality constraints (Koirala n.d.). There are 31 private, domestic-owned Ayurveda pharmaceutical companies and 28 foreign-owned Ayurveda pharmaceutical companies.

4.2 Institutional structure

The Ministry of Health (MoH) has a focal unit called Ayurveda and Alternative medicine Branch which is responsible for developing plans, policies, rules and regulations regarding all kinds of traditional medicine in the country and coordinate with other organizations/institutions/bodies related to traditional medicine under the ministry. The following organizations/institutions/bodies are working currently under the ministry.

- Department of Ayurveda: It oversees the following Ayurveda hospitals, dispensaries and health centres.
    - Ayurveda Hospitals: 2
    - Zonal Ayurveda Dispensaries: 14
    - District Ayurveda Health Centers: 61
    - Local Ayurveda Dispensaries: 214

- Council of Ayurvedic Medicine: It is responsible for the registration and regulation of Ayurveda professionals, traditional healers and academic institutions. The following three categories of professional are registered.
    - Ayurveda Physicians (Graduates) are registered as full-fledged members of the council.
    - Ayurveda Para-medics are registered under a sub-committee of the council.
    - Traditional Ayurveda practitioners are enrolled and licensed for their practice. Those with at least three generations' experience in Ayurveda practice and who are at least 50 years old are eligible for enrolling.

4.3 Budget

The national budgetary allocation for traditional medicine is low. The government allocates budget for Ayurveda and homeopathy, with Ayurveda accounting for close to 98 percent of the allocation for traditional medicine. For Fiscal Year (FY) 2008/09, NRs. 355.6 million was allocated for Ayurveda, which came to 2.4 percent of the total health spending through the Ministry of Health (NRs. 14.94 billion). While the total allocation for health for FY 2008/09 represented an increase of 54 percent over the revised estimate for the previous year, the allocation for Ayurveda increased by just 37 percent.

4.4 Constraints

In a survey conducted among 70 Ayurveda doctors5, the main factors impeding the provision of quality Ayurveda services were identified as: lack of resources and budget in government-owned health institutions; lack of medicines and equipment; lack of programme as per the need of the communities; malpractices at the local level; lack of training/ workshops / seminars for doctors; lack of Pathology and Radiology Services at District Ayurveda Health Centres; lack of awareness among people of available Ayurveda services; and lack of team spirit among health workers and doctors.

Likewise, Koirala and Khaniya (2008) identify the absence of documentation of traditional Ayurvedic manuscripts and knowledge and the piracy of such materials and knowledge as a serious problem facing Nepali Ayurveda.

5. Policy on traditional medicine

The National Health Policy, 1991 identifies the development of Ayurveda system along with other traditional medicine systems as one the strategies of achieving its objectives. It also emphasizes research in the area of traditional systems of medicine to enhance their quality and support their development.

The ongoing Three-Year Interim Plan (2007-2010) envisions that at the end of the plan period, "Ayurvedic and alternate health services made available in effective measure" (NPC 2007). The relevant strategy is to develop and extend Ayurvedic and other alternate health service systems. The plan envisions the policy of providing health services, including Ayurvedic and other alternate health services, to the people as per their own choice in health institutions at the district level and below. Human resources are to be mobilized in a coordinated way for national programmes under the plan. The plan places priority on Ayurvedic research, among others, at the initiative of the Health Research Council.

The plan has a separate section "Ayurveda and Alternate Medical System" under its Regular Programme. It aims to, among other things, make Ayurvedic and alternate medical services units more effective; construct 30-bed regional Ayurvedic hospitals in the western and far-western regions in the three years and take initiatives to establish 30 Ayurvedic dispensaries every year; take effective measures to enable the Singh Durbar Vaidyakhana (Aurvedic medicine centre)

[5] http://www.ayurnepal.com/articles/rajendra_status_ayurveda_nepal.htm

Development Committee to manufacture quality, safe and effective Ayurvedic drugs in adequate quantity; develop Ayurvedic health human resources; devise and implement a programme for technical efficiency promotion, training, structural strengthening and development of Ayurveda campuses, and establishment of an Ayurvedic Study Institution, and human resource production for the National Ayurveda Research and Training Centre; bring Homeopathy, Yunani and natural medicine systems under the Health Ministry's jurisdiction for their planned operation; and conduct special programmes for collecting data about medicinal herbs and intellectual property rights, concerning knowledge, skill and technology of traditional health and treatment professionals.

The Ayurveda Health Policy (AHP), 1995 has the principal objectives of improving the health conditions of the people at large and making them self-reliant in health services by utilizing local medicinal herbs and medical entities. It seeks to develop Ayurveda treatment as a special treatment method in the country in a phase-wise manner. It recognizes Ayurveda as "national method of therapy/treatment". For the development of the Ayurvedic science and procurement of efficient manpower, the policy has emphasized the need for the establishment of specific institutions. Some of the key features of the AHP are as follows.6

- ***Expansion of public provision of services:*** Upgrading the capacity of the two state-run Ayurveda Hospitals. Regional Ayurveda Hospitals to be built in each development region. Establish an Ayurveda Dispensary for every five Village Development Committees.
- ***Provision for inter-institutional and people's participation:*** Health workers, wizards, women volunteers, birth attendants, workers of social organizations, who are providing medical services by way of herbs in a traditional manner in rural areas will be provided with trainings of growth, promotion, collection, protection and use of herbs, and people's participation will be mobilized in the Ayurvedic treatment service.
- ***Encourage herb farming, production and enterprise:*** Quality herb business will be encouraged by developing model herbs farms in the Himalayan region, Hill and Tarai (southern plains) regions and providing the people with knowledge of the use of the herbs in domestic treatment and their preparation, protection and promotion. Co-ordination will be made with governmental and non-governmental associations related with herbs, so as to maintain a standard of quality in domestic trade and exports by identifying genuine herbals. Governmental and non-governmental Ayurvedic medicine manufacturing companies that are already established or are to be established in the country will be encouraged to manufacture qualitative medicines on the basis of 'Good Manufacturing Practice' and imports will be reduced and export promoted.
- ***Ensure Ayurvedic education and manpower development*:** Taking into consideration of paramount role of qualified, efficient and duty-bond manpower in a technical field like health treatment, a National Ayurvedic Institute, equipped with necessary equipment as well as a research centre, will be established under Tribhuvan University, for enhancing and carrying on further development in the effective production of Ayurvedic human resources capable of carrying out functions related to the field of Ayurveda, including

[6] Based on the English version of the policy translated by Dr. Shyam Mani Adhikari, Ministry of Health, available at: www.ayurvepal.com.

ensuring the standard of quality of its various dimensions (education, health, and preparation of medicines). Similarly, the programme of producing Bachelor's-level manpower in Ayurveda will be conducted so that physical infrastructure will be developed in harmony with the objective to provide Master's-level and PhD-level Ayurvedic education in the future.

- ***Management of Ayurvedic manpower*:** Various organizational structures under the Ayurveda Group will be made responsive and service-oriented for the consolidation of the management aspect of Ayurvedic manpower. Ayurvedic doctors and Ayurvedic health workers will be provided with the same allowances and special facilities as doctors or health workers of other systems.
- ***Ayurvedic research*:** An Ayurvedic Research Institute will be established furnished with the required equipment, for research of international standard in matters related with the use of Ayurvedic medicines and entities and the Ayurvedic treatment.
- ***Provision of resource mobilization*:** Assistance of native and foreign donor agencies will be made available so as to provide financial support to various programmes of Ayurveda, including in the export of herbs and prepared medicines. Such assistance will also be sought in the implementation of the programmes.
- ***Nepal Ayurvedic Medicine Council*:** Establishment of Nepal Ayurveda Medical Council at the national level for setting the necessary standards of Ayurvedic education and services, registration of Ayurvedic doctors, and making arrangements for monitoring and evaluation**.**

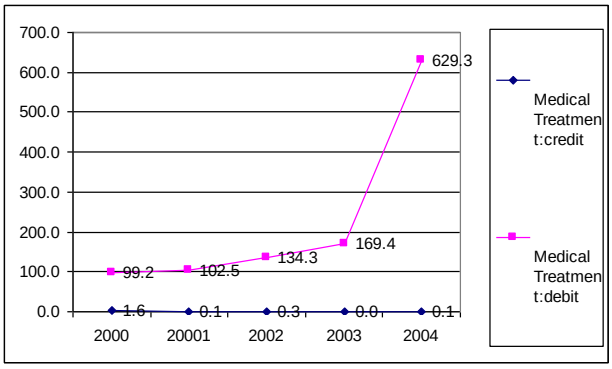
6. Nepal's international trade in health services

6.1 Status and trend

Although the health sector in Nepal has been significantly liberalized, trade in health services is yet to become a matter of policy focus. Trade in health services makes up a small proportion of total trade in services[7]; it was only 0.8 percent in 2004. Data recorded by the Nepal Rastra Bank (NRB), the central bank, show minimal credit flows, which were more than offset by massive debit flows, resulting in a net deficit in trade in health services (Figure 1). This indicates that Nepal is a net importer of health services under Modes 1 and 2.

Figure 1: Trend of health trade through Modes 1 and 2 (NRs. million)

7 Tourism is the dominant sector contributing one third of the total trade in services and half of the total foreign direct investment flow into the services sector in Nepal.



Source: NRB (2005).

However, health services have been expanding in terms of foreign direct investment (FDI) flows, attracting 28.2 percent of the total FDI flowing into the services sector in 2004 (NRB 2005). Requests for approval for FDI (Mode 3) in this sector are also on the rise. No data is available for trade in health services under Mode 4.

More pertinent to this study, no macro-level data is available for export trade in traditional health services in general and Ayurveda in particular, although discussion with experts and Ayurveda doctors reveals that some private facilities inside the country are providing Ayurveda services to foreigners.

6.2 Nepal's WTO commitments in health sector

Horizontal commitments: Under the General Agreement on Trade in Services (GATS) under the World Trade Organization (WTO)8, Nepal has made horizontal commitments to keep the first three modes of service supply generally unrestricted except for some conditions. In terms of market access, Nepal has committed to remove all restrictions in Mode 2 except providing only US$2,000 to Nepalese citizens while going abroad. In Mode 3, Nepal has committed that the supply of services by an existing foreign supplier will not be made more restrictive than they existed at the time of Nepal's accession to the WTO. However, Nepal's commitment in Mode 4 is restrictive except in the categories of services sales persons, persons responsible for setting up a commercial presence, and intra-corporate transferees, that too for a limited time and not exceeding 15 percent of local employees.

With respect to national treatment, there are no restrictions in Mode 3 except that foreign investments and reinvestments are required to obtain the approval of the Department of Industry, and that only wholly owned Nepalese enterprises will be entitled to incentives and subsidies, if any, in the sector. The maximum foreign equity is also limited in most services, and firms wanting to sell their services have to be incorporated in Nepal.

Besides these commitments, Nepal also restricts selling and buying of real estate by foreigners.

8 Nepal became a WTO member on 23 April 2004.

Specific commitments[9]: Health services consist of two major sub-sectors: hospital services (Central Product Classification (CPC) 9311)10, and other human health services (CPC 9319 other than 93191)11. Sector-specific commitments have been made only for hospital services. There are no major specific limitations in this sub-sector except in market access in Mode 3 where foreign services providers must be incorporated in Nepal with a maximum foreign equity capital of 51 percent. In addition, medical experts can work with the permission of Nepal Medical Council for a maximum of one year.

Table 2: Nepal's sector-specific commitments in health services under the GATS

Sub-sector	Limitation in market access	Limitations on national treatment
A. Hospital services (CPC 9311) and direct ownership and management by contract of such facilities on a 'for fee' basis.	1) None 2) None 3) None, except only through incorporation in Nepal and with a maximum foreign equity capital of 51 percent. 4) Unbound, except as indicated in the horizontal section. Medical experts can work with the permission of Nepal Medical Council for a maximum of one year.	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section.

Source: WTO (2004)

GATS and traditional health services: There are calls for making the classification of services more comprehensive under the GATS and efforts in that direction may result in traditional health services being included in the classification, offering new opportunities as well as challenges.

7. Empirical study

7.1 Case study

Following the overall methodology of the study, the Ayurveda Health Home (AHH)—a leading private sector Ayurveda health service provider (under Nepal-German joint management) staffed

9 Under GATS, health services can also potentially include business service commitments in medical and dental services (9312) and veterinary services (932).

10 Hospital services: Surgical, medical, gynaecological and obstetrical, rehabilitation, psychiatric and other hospital services delivered under the direction of medical doctors chiefly to inpatients, aimed at curing, restoring, and/or maintaining the health of such patients.

11 Other human health services: ambulance services; residential health facilities services other than hospital services. Services in the field of: morphological or chemical pathology, bacteriology, virology, immunology etc., and services not elsewhere classified, such as blood collection services.

with ace practitioners that also exports its services—was selected as an institution for the Nepal country case study. By surveying the consumers as well as interviewing the service provider12 at AHH, one can gauge the potential for Ayurveda services exports and barriers to the same as well as assess the possibility of the replication of this success story.

7.1.1 General information

Ayurveda Health Home (AHH) was established in 1995 as a Nepal-German joint venture. Located in Dhapashi on the outskirts of Kathmandu city, it has been providing services to Nepali nationals as well as foreign nationals since its inception. Its staff size is 36, including two doctors, one chief therapist and 22 therapists. The chief therapist and therapists are trained by AHH. A one-year theoretical training is followed by two years of paid on-the-job training. The trainees have to sit for three levels of exams and their promotion is based on their performance in the exams. AHH has institute a system of pay being linked to performance. A productivity record is maintained. Staff are paid for overtime work. The organization is operating at 85 percent capacity utilization. AHH has six residential beds and eight treatment beds. However, AHH is not a hospital. It does not admit patients with communicable infectious diseases or who need emergency or continual medical attention or who cannot manage themselves. AHH has an outreach centre at Putalisadak, Kathmandu that provides short consultation services, mainly catering for domestic consumers. AHH also provides Ayurveda training.

7.1.2 Consumer flow

AHH has treated 6,981 patients in the last five years. Though inflow of consumers has been on a declining trend over the last three years, it is still higher than what it was in 2003/04 (Figure 2). The share of locals (Nepalis living in Nepal) among AHH averaged 26.38 percent in the five-year period from 2003/04 to 2007/08. The rest (73.62 percent) were foreigners—64.57 percent were tourists and 9.04 percent expatriates who had been in Nepal for more than six months (Table 3). The expatriate category registered the highest growth rate in the period, an annual compound growth rate of 17.4 percent, followed by the local category (12.7 percent) and the tourist category (8 percent).

Figure 2: Trend of consumer flow by residence

12 Dr. Rishi Ram Koirala, Medical Director, AHH, Ayurveda practitioner and expert, was interviewed.

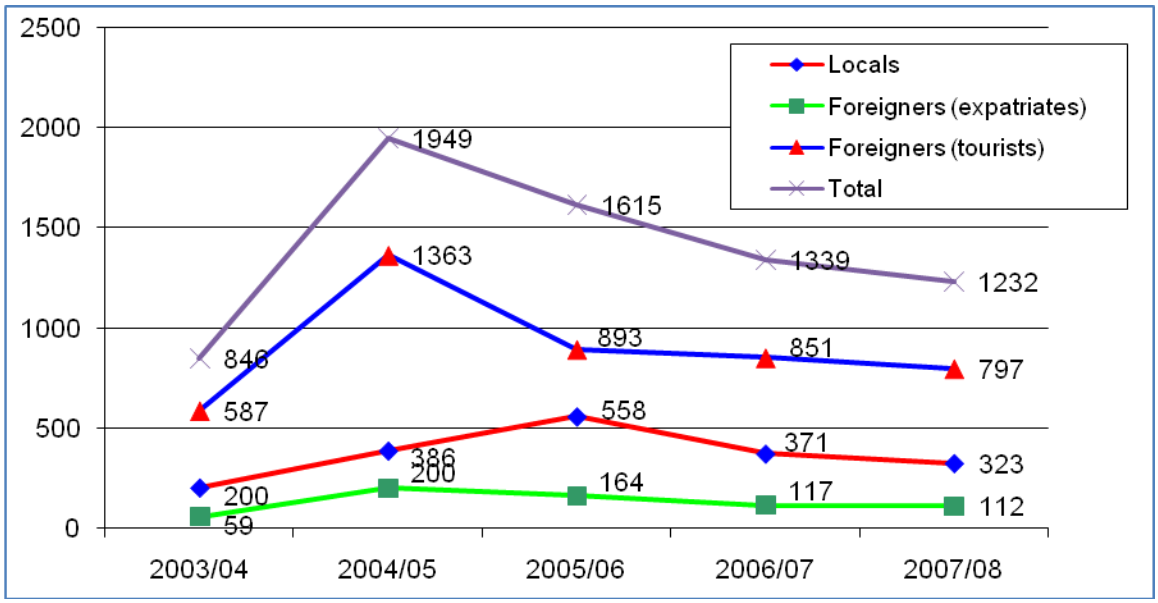


Table 3: Share of consumers by category

Fiscal Year	Locals	Foreigners (expatriates)	Foreigners (tourists)
2003/04	23.64	6.97	69.39
2004/05	19.81	10.26	69.93
2005/06	34.55	10.15	55.29
2006/07	27.71	8.74	63.55
2007/08	26.22	9.09	64.69
Average	**26.38**	**9.04**	**64.57**

Female consumers consistently outnumber male consumers (Figure 3). In 2007/08, female consumers (adults) accounted for nearly 65 percent of total consumers while males (adults) accounted for over 34 percent. The share of children was less than 1 percent. Females outnumber males in all categories of consumers by residence, but the margin is highest in the expatriate category (78:22), followed by the tourist category (69:31). Among locals, females outnumber men by a narrow margin, 52:48 (Figure 4).

Figure 3: Consumer flow by gender

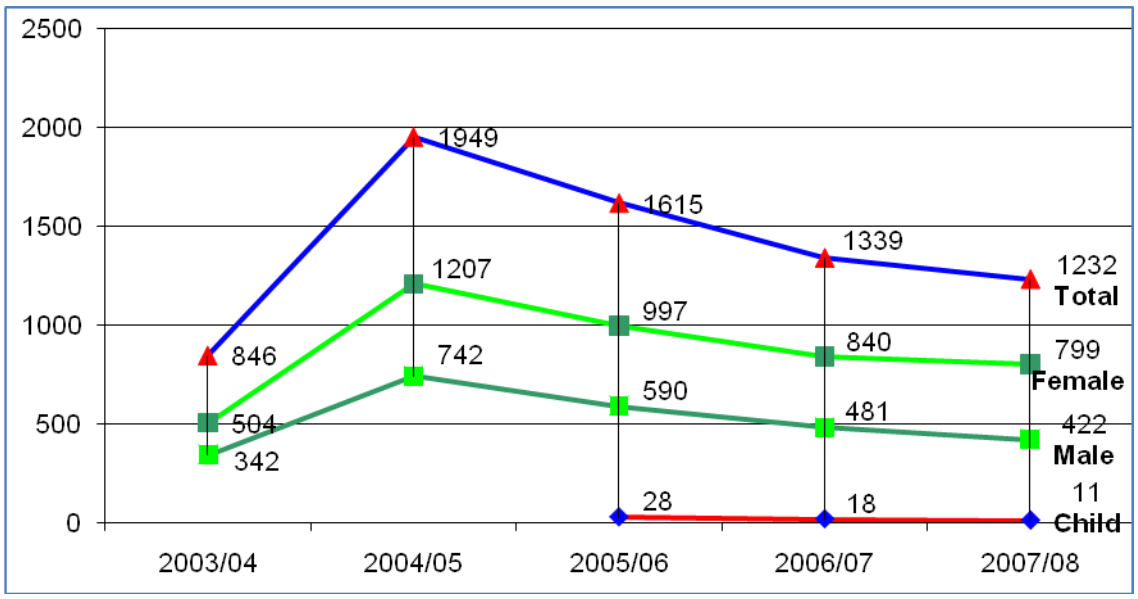
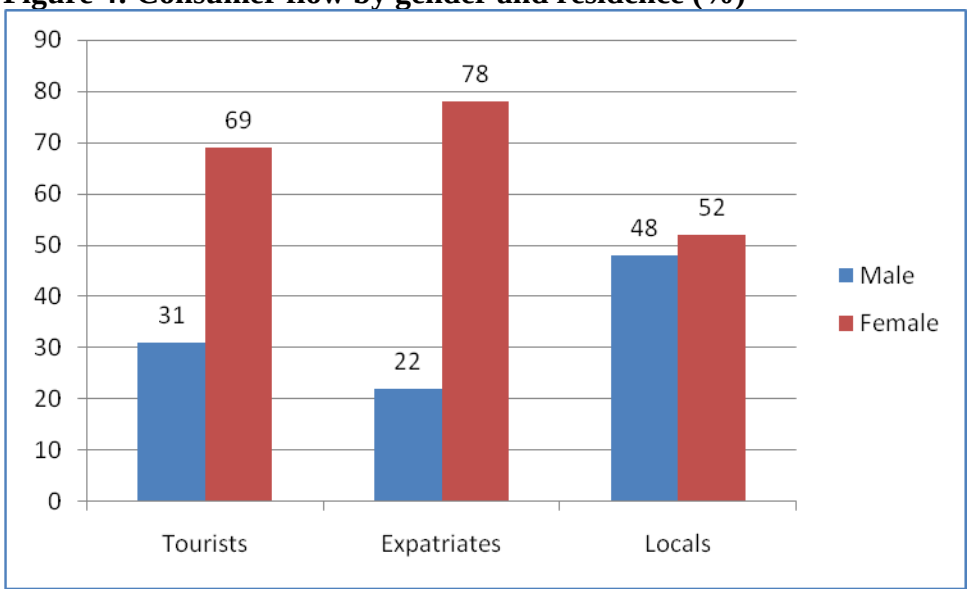


Figure 4: Consumer flow by gender and residence (%)



In the five-year period 2003/04-2007/08, AHH received consumers from 91 different countries (see Annex 1 for the list of countries). The major foreign markets are western European countries, United States (US) and Japan. The 18 major countries shown in Table 4 accounted for 57 percent to 67 percent of total consumers, and 81 percent to 90 percent of foreign consumers during the period.

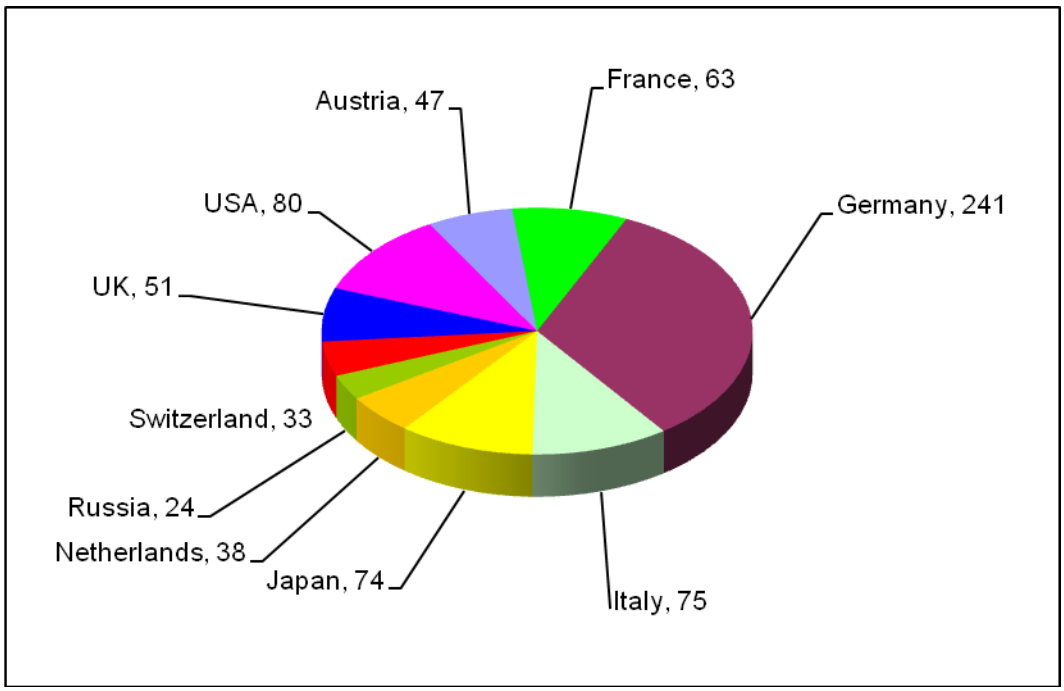
Table 4: Consumer flow by major countries

Country	2003/04	2004/05	2005/06	2006/07	2007/08	As % of foreign consumers

						in 2007/08
Australia	21	47	23	17	14	1.54
Austria	33	185	97	101	47	5.17
Belgium	13	33	15	15	10	1.10
Canada	7	16	21	21	14	1.54
Denmark	11	27	20	7	6	0.66
France	37	82	48	62	63	6.93
Germany	127	303	225	244	241	26.51
India	28	51	20	18	18	1.98
Italy	35	101	60	47	75	8.25
Japan	41	86	55	52	74	8.14
Malaysia	14	31	22	7	5	0.55
Netherland	37	69	42	45	38	4.18
Russia	11	11	21	23	24	2.64
Spain	6	22	33	20	13	1.43
Switzerland	28	53	36	53	33	6.63
Turkey	1	8	24	5	1	0.11
UK	45	93	78	45	51	5.61
USA	32	94	84	90	80	8.80
% of total consumers	**62.29**	**67.32**	**57.21**	**65.12**	**65.50**	
% of foreign consumers	**81.58**	**83.94**	**87.42**	**90.08**	**88.78**	

Consumers from 72 countries visited AHH in 2007/08. The top 10 countries in 2007/08 were Germany (26.51 percent of foreign consumers), the US (8.8 percent), Italy (8.25 percent), Japan (8.14 percent), France (6.93 percent, the United Kingdom (5.61 percent), Austria (5.17 percent), the Netherlands (4.18 percent), Switzerland (3.63 percent) and Russia (2.64 percent). More than 20 consumers came from each of these countries (Figure 5); there were less than 20 consumers each from the remaining 62 countries in 2007/08). India took the 11th position with just under 2 percent share.

Figure 5: No. of consumers from top 10 foreign markets in 2007/08



In 2007/08, AHH got visitors from eight new countries. Some 25 percent (303) of the total visitors to AHH in that year were repeat visitors making follow-up visits to the institution (Table 5). The percentage of repeat visitors was the highest among expatriates (41 percent), followed by locals (36.5 percent) and tourists (17.4 percent).

Table 5: New and repeat visitors to AHH in 2007/08

New visitors	**Tourists**	**Expatriates**	**Locals**	**Total**
Male	206	15	107	**328**
Female	452	51	98	**601**
Total	**658**	**66**	**205**	**929**

Repeat visitors	**Tourists**	**Expatriates**	**Locals**	**Total**
Male	45	10	48	**103**
Female	94	36	70	**200**
Total	**139**	**46**	**118**	**303**
Repeat visitors as % of total within category	**17.4**	**41**	**36.5**	**24.5**

7.1.3 Services

AHH's services are basically outpatient services. Located in a quiet and peaceful environment, it also serves as a guesthouse with six residential beds for its patients, but they are not meant for inpatient services in the conventional sense and are basically for sheer accommodation purposes. Patients staying at AHH are subject to a vegetarian diet drawing on Ayurveda. It provides a range of classical Ayurveda therapy services and guidance based on original Ayurvedic scriptures. It provides treatment services for stress-caused imbalances; muscle, joint and ligament and vertebral disorders caused by traumas, degenerations, or autoimmune reactions; respiratory system disorders; gastrointestinal disorders; liver disorders; skin diseases; metabolic disorders; gynecological disorders; neurological and immunological problems; and problems in the urogenital system. It also provides Pancha Karma treatment—which is highly popular among global consumers of Ayurveda services.

Therapy duration at AHH ranges from one day to 40 days. For therapies involving more than one day, patients stay at AHH or visit it every day; the latter is more common. A one-week therapy package attracts the maximum number of foreign consumers. However, the average services time consumed by foreigners is around two weeks. A therapy package, say lasting two weeks, comprises different therapies. There are targeted programmes for foreigners. Pre-designed programmes, ranging from 30 minutes to four weeks of duration, are offered in the form of therapy packages. Pancha Karma service, comprising four programmes, is specially designed for foreign consumers.

AHH's treatment services cover the following disorders/diseases:

1. Stress-caused imbalances

- Sleeplessness
- Migraine and other different headaches
- Different types of depression
- Post-traumatic stress disorders like panic attacks and emotional traumas
- Burned out syndromes
- Chronic fatigue syndromes

2. Muscles, joints and ligaments and vertebral disorders caused by traumas, degenerations, or autoimmune reactions

- Arthritis, ankylosing disorders, rheumatic joint problems, specially chronic pain, deformities, functional disorders
- Spinal or vertebral disorders, Lumber or cervical spondylitis, gouty arthritis, frozen shoulders, knees problems, tennis elbow and others
- Muscles stiffness and tearing, dystrophy and atrophy of muscles

3. Respiratory system disorders

- Post-high altitude respiratory sickness, recurrent cold, sinusitis, throat problems, etc.
- Chronic cough, chronic bronchitis, bronchial asthma

4. Gastrointestinal disorders

- Digestion and absorption difficulties, hyperacidity, and chronic gastritis
- Irritable bowel syndromes, colitis and ulcerative colitis etc.
- Chronic constipation, piles and anal fissures
- Fistula in ano (by specific Kshara Sutra procedure)

5. Liver disorders

- Chronic liver function disorders

6. Skin Diseases

- Acne, facial hyperpigmentation
- Atopic Dermatitis, Neurodermatitis
- Psoriasis

7. Metabolic disorders

- Lipid metabolic problems, e.g. High cholesterols, High triglycerides, Atherosclerosis
- Diabetes
- Overweight and underweight
- High Uric acid levels

8. Gynaecological disorders

- Dysmenorrhoea, secondary amenorrhoea, and pre-menstrual stress,
- Pre-menopausal and post-menopausal syndrome

9. Neurological and immunological problems

- Hemiperesis
- Parkinson's syndrome
- Multiple Sclerosis,
- Scleroedermas

10. Urogenital system-related problems

- Chronic urinary tract infection
- Benign prostatic enlargement, chronic prostate infection
- Dysperunia or dryness of genital tract

7.1.4 Pricing

AHH charges three sets of prices for its services in general. Foreign tourists are charged one set of prices, which are the quoted prices. Expatriates (those who have been in Nepal for more than six months) are given 20 percent discount. Nepali consumers get 40 percent discount on the majority of the services and up to 80 percent on some services. There is also a provision for 5-10 percent discount for foreign tourists on service packages, depending upon the duration of the treatment they opt for.

Quoted prices vary according to programmes and their duration. If a one-hour head and foot programme costs NRs. 2,060, a seven-day Ayurveda luxury programme costs NRs. 60,450. The most expensive programme is the 28-day Panca Karma programme, which costs NRs. 166,250. The price of consultation and counseling services ranges from NRs. 700 to NRs. 6,000. The price of individual therapies ranges from NRs. 750 to NRs. 2,650. Table 6 shows the prices of various therapy services and Table 7 shows room rates and other charges at AHH's guest house.

Table 6: Prices of services at AHH

Services	Price
1 Hour Programme:	
- Head & Foot Programme	NRs. 2060
- Spinal Programme	NRs. 2250
3 Hrs. Ayurveda Programme	NRs. 4180
1 Day Ayurveda Programme	NRs. 8080
3 Days Programmes:	
- Ayurveda Deluxe Programme	NRs. 34280
- Ayurveda Programme	NRs. 21930
5 Days Programmes:	
- Ayurveda Deluxe Programme	NRs. 47150
- Ayurveda Recreation Programme	NRs. 31590
7 Days Programmes:	
- Ayurveda Luxury Programme	NRs. 60450
- Ayurveda Wellness Programme	NRs. 46990
Intensive Cakra Therapy Package for 8 days	NRs. 74150
14 Days Ayurveda Cleansing & Rejuvenation Programme	NRs. 85710
Panca-Karma Programmes:	
- 7 Days Allied Panca-Karma	NRs. 50700
- 10 Days Allied Panca-Karma	NRs. 80200
- 14 Days Seasonal Panca-Karma	NRs. 114360
- 28 Days Panca-Karma	NRs. 166250
Consulation & Counselling:	
➢ Short Consultation	NRs. 700
➢ Consultation & Life Style Management	NRs. 3000
➢ Regular Consultation & Counseling	NRs. 6000
➢ Sattavavjaya (Mastery over Mind)	NRs. 3000
Individual Therapies:	
1- Whole Body Relaxation Abhyanga	NRs. 1430
2- Synchronized Cleansing Abhyanga	NRs. 1850
3- Wholebody Cleansing Abhyanga	NRs. 1600
4- Ubatan Abhyanga	NRs. 1880
5- Master Kayaabhyanga	NRs. 2600
6- Relaxation Spinal Abhyanga	NRs. 750
7- Relaxation Foot Abhyanga	NRs. 750
8- Relaxation Head Abhyanga	NRs. 750
9- Relaxation Facial Abhyanga	NRs. 750
10- Facial Beauty Package	NRs. 1250
11- Whole Body Steam	NRs. 1200
12- Pinda Sveda	NRs. 2650
13- Siro Dhara	NRs. 1550
14- Siro Basti	NRs. 1900
15- Cakra Basti	NRs. 1350
16- Picu 15 min.	NRs. 1350

17- Picu 30 min.	NRs. 1500
18- Yoga/Meditation/Pranayama	NRs. 950

Prices are subject to government tax. Prices are effective up to 31 December 2009.

Table 7: Room rates and other charges at AHH's Guest House: "Happy Home"

Rooms	**Single**	**Double**
Nights	(NRs./ per night)	(NRs./ per night)
1-5	1800	2800
6-12	1700	2700
13-23	1600	2600
>23	1550	2550
Breakfast	**Lunch**	**Dinner**
NRs. 350	NRs. 450	NRs. 450

Prices are subject to government tax. Prices are effective up to 31 December 2009.

7.1.4 Service provider's perspective[13]

Why foreign consumers visit AHH?

Foreign consumers (expatriates and tourists) visit AHH mainly because of their faith in the Ayurveda system and the quality of services provided by the organization. Another source of attraction for foreign consumers is that AHH offers specialized services (e.g., Pancha Karma) and pre-designed therapeutic programmes. Until about five years ago, most of the tourists that visited AHH were tourists visiting Nepal for some other purposes. However, AHH now receives foreign consumers who are visiting Nepal with health treatment as a primary purpose.

Business prospects for 2009

The economic downturn will not affect AHH's business volume in 2009 as the flow of patients is likely to remain robust. However, profits stand to fall due to an increase in operational cost due to high inflation.

Problems/barriers

- **Language:** With consumers from 93 countries having visited AHH, language is a barrier to communicating effectively with consumers from non-English-speaking countries.
- **Human resource:** BAMS is the highest level of Ayurveda education formally taught in Nepal. However, Nepal's BAMS is not recognized in India. As a result, BAMS products from Nepal cannot pursue advanced Ayurveda courses (e.g., Master's) in India. Furthermore, BAMS students do not have practical experience, thereby constraining their potential to provide professional services. Lack of specialization is also a constraint. [The

[13] Based on interview with Dr. Rishi Ram Koirala, Medical Director, Ayurveda Health Home.

Chinese government is building a National Ayurveda Training and Research Institute at a total cost of NRs. 620 million. A major objective of establishing the institute is national documentation of Ayurveda resources. But there is an acute scarcity of human resources to operate the institute.]

- **Policy implementation:** The right policy framework for developing traditional medicine is there. However, implementation is very weak. There is leadership vacuum at the policymaking level [In 1993, the Japanese government had pledged NRs. 850 million to the development of Ayurveda in Nepal. The area of the pledged support encompassed Ayurveda hospital, Ayurveda pharmaceutical company and Ayurveda academic institution. However, the pledge did not materialize due to absence of effective leadership at the policymaking level.

Export potential

- The increasing trend of foreigners visiting Nepal with the major purpose of health treatment at AHH is an indication of the potential for exporting Ayurveda health services through Mode 2.

- Under Mode 2, there is also potential for providing Ayurveda education to foreigners. Dr. Koirala, for one, gives training to foreign doctors in both general and specialized areas, as well as researchers.

- There is potential for supplying Ayurveda-related manpower to developed countries (Mode 4), which are gradually becoming receptive to the traditional medicine of the east. Provided that the Ayurveda course in Nepal is fully recognized, specialization is ensured and practical experience is provided to students, some 50-60 Ayurveda practitioners can be easily be exported to developed countries straightaway.

7.1.5 Survey of health consumers

A total of 43 consumers—32 of them Nepali nationals and 11 foreign nationals—were surveyed. The Nepali consumers were surveyed at AHH and its outreach centre, Maharshi, while foreign consumers were surveyed at AHH. The survey results are analysed separately for Nepali and foreign consumers.

Nepali consumers

Sampling and typology of respondents

A total of 32 of Nepali nationals visiting Ayurveda Health Home and its outreach clinic, Maharshi, in Kathmandu for treatment were surveyed in March 2009. The sample was selected on a random/convenience basis. Of the 32 respondents, 25 (78 percent) were permanent residents of Kathmandu valley. Of the remaining seven (22 percent), one was a Nepali national residing in the United States (US), one was a Nepali national working in the United Arab Emirates (UAE)

but with permanent residency in Kathmandu, one had come to Kathmandu exclusively for health treatment from Syangja district in west Nepal, and the remaining four were temporary residents of Kathmandu valley. Both the respondents from the US and the UAE were in Kathmandu with the primary purpose of health treatment and the secondary purpose of visiting their family and friends.

An overwhelming majority of respondents were men (78 percent as opposed to 22 percent women). The age of the respondents ranged from 19 years to 61 years, with about 64 percent of the respondents in their mid-20s to early 40s. Nearly two thirds of the respondents had Bachelor's level education or above, about 19 percent had higher secondary level education, a little below 10 percent secondary level education and just above 6 percent were just literate. As regards profession, some 62.5 percent of the respondents were engaged in the service sector, about 22 percent in business, 9.4 percent were students, one respondent was engaged in industry, and another respondent was a farm labourer.

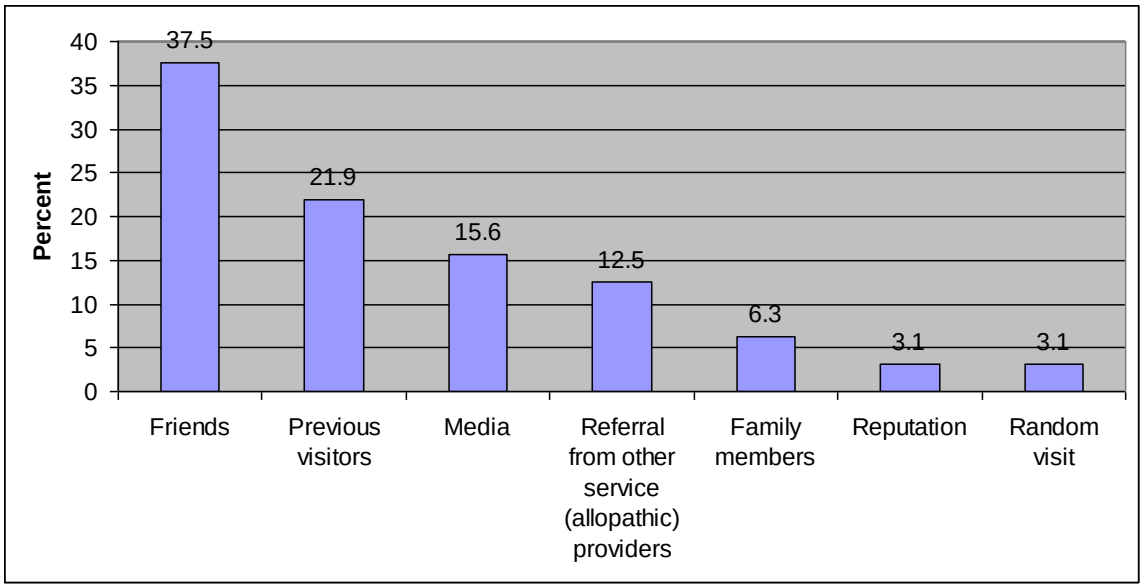
The monthly income of the respondents ranged from NRs. 1,500 to NRs. 176,000. However, about two thirds of them earned between NRs. 1,500 and NRs. 15,000. About 32 percent were in the NRs. 6,000-10,000 range, 19.4 percent in the NRs. 11,000-15,000 range, and 13 percent each in the NRs. 16,000-20,000 and NRs. 1,000-5,000 ranges.

Close to 60 percent of the respondents were accompanied by at least one person, while the rest were unaccompanied.

Channels of information

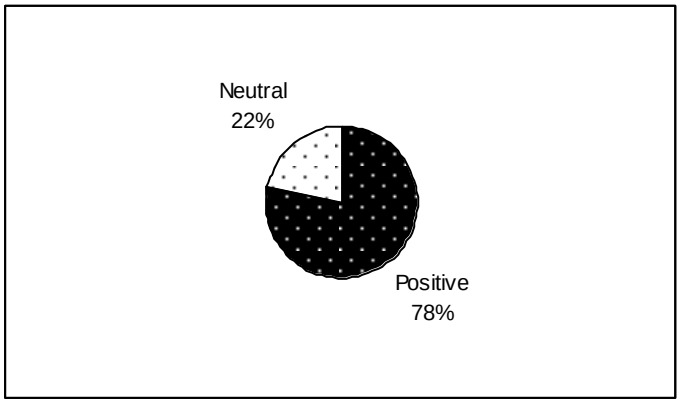
Friends were the main source of information about the traditional health service provider for 37.5 percent of the respondents; previous visitors for about 20 percent of the respondents; other service (allopathic) providers for 12.5 percent of the respondents; and media for another 15.6 percent (Figure 6). Other sources of information were family members and the reputation of the service provider itself, while one respondent was on a random visit.

Figure 6: Channels of information



For 78 percent of the respondents, the information thus received had a positive influence on them to decide to choose opt for traditional health service provider vis-à-vis other health systems. For the remaining 22 percent, the information had a neutral effect on their decision (Figure 7).

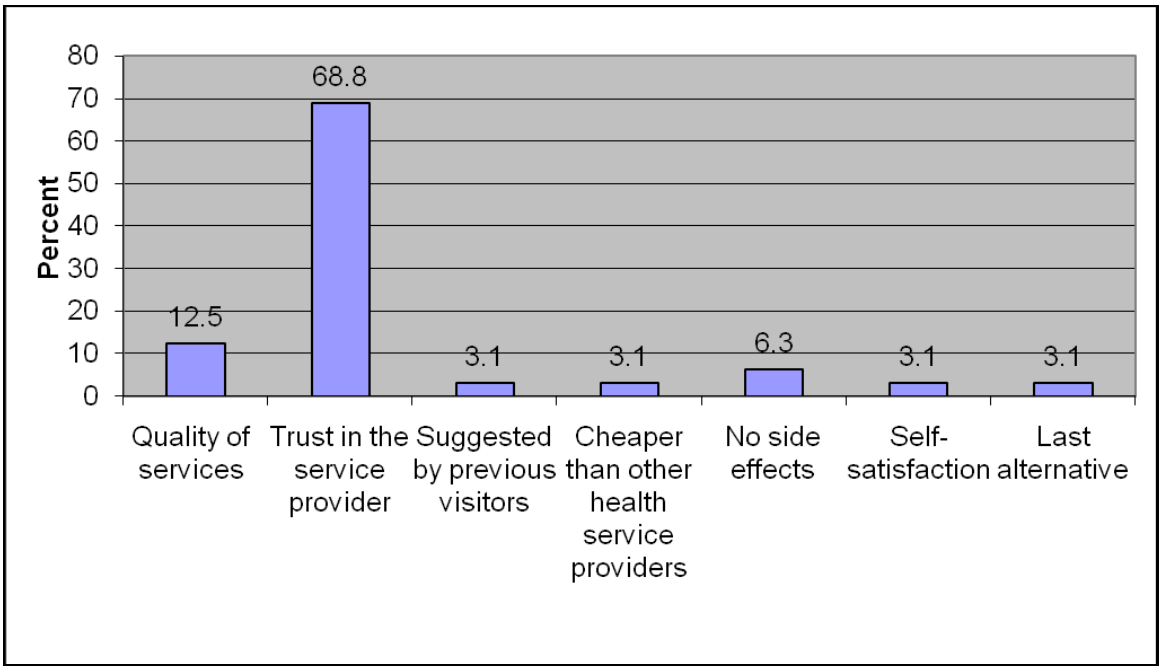
Figure 7: Effects of information on decision to choose traditional health service



Reasons for visiting the service provider

For well over two thirds of the respondents, trust in the service provider was the main reason for visiting the clinic. The other main reasons cited were quality of services (12.5 percent) and no side effects (6.3 percent) (Figure 8). For one respondent, treatment at the clinic was the last hope of getting cured.

Figure 8: Main reason for visiting the service provider



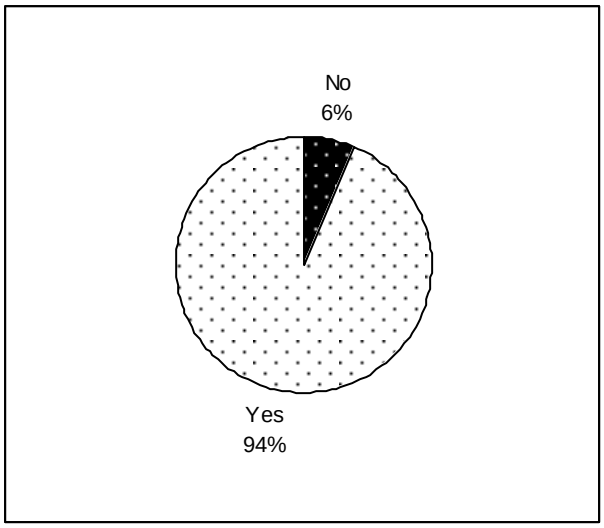
Respondents were asked to cite multiple reasons, if applicable, and rank them. The second important reason for visiting the clinic was quality of services for 74 percent of the respondents who cited more than one reason, followed by trust in the service provider (17.4 percent). Among the respondents who cited three reasons, 55.6 percent identified recommendation by previous visitors as the third reason for visiting the clinic.

It should be noted that only four respondents said that a reason (first, second, third and fourth important, respectively) for visiting the clinic was it is cheaper than other health service providers.

Expectations, quality of services and satisfaction

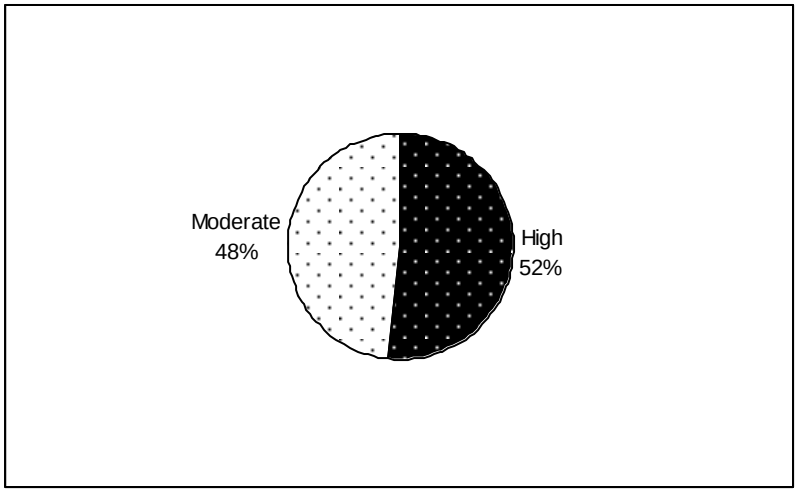
Of the 32 respondents, 30 said their expectations were met by the service provider while 2 said their expectations were not met by the service provider (Figure 9).

Figure 9: Were consumers' expectations met?



The majority of the respondents (50 percent) rate the quality of the services received as high while some 47 percent rate it as moderate (Figure 10). (One respondent did not respond). This indicates that the consumers are satisfied with the quality of services at the clinic.

Figure 10: Quality of services received



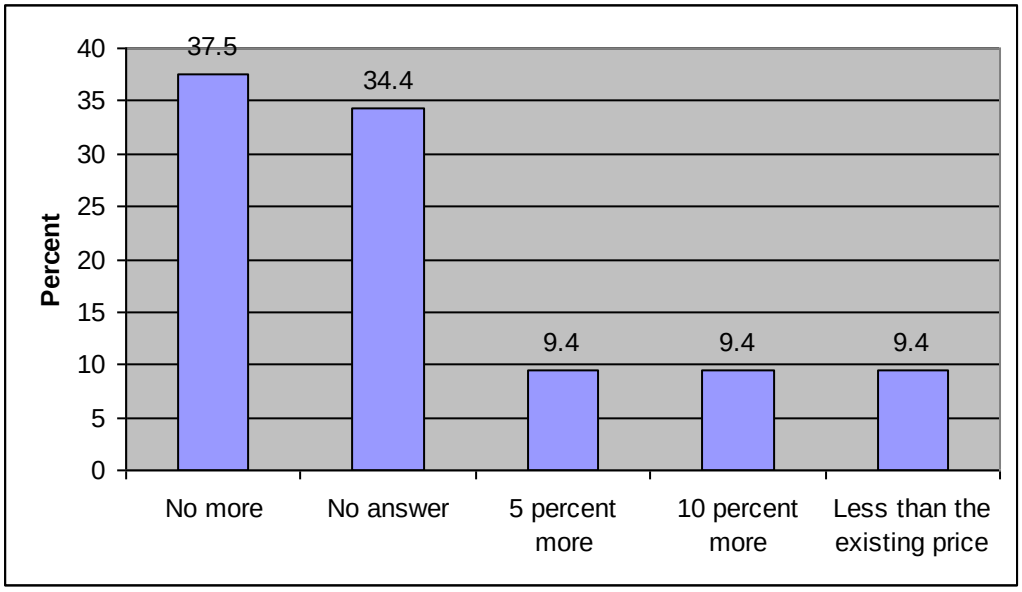
Likewise, all the respondents said they wanted to come to the same service provider for treatment again if need be and they would also recommend others to visit the place.

Willingness to pay

Willingness to pay indicates what a consumer is willing to pay for the service rather than go without that service. In our survey, the maximum proportion of respondents (37.5 percent) were not willing to pay any more than what they were already paying for the service, while 9.4 percent said that the service was very expensive and the cost should be reduced (Figure 11). Only 9.4 percent each were willing to pay 5 percent and 10 percent more, respectively. There were no responses from a sizeable proportion of the respondents (34.4 percent). This, together with the

responses regarding the reasons for visiting the service provider, indicates that the service is perceived as costly by consumers.

Figure 11: Willingness to pay



Problems

The bulk of the respondents (84.4 percent) said they did not face any problems while receiving services at the clinic. For the 15.6 percent who faced problems while receiving services, the problems identified were the crowd of consumers at the clinic and lengthy queues leading to long waiting time, and the lengthy recovery process.

Likewise, 90.6 percent of the respondents said they did not face any problems outside the service provider in connection with receiving the service, while 9.4 percent of the respondents cited traffic jams in the major thoroughfares of Kathmandu valley as a problem while coming to the clinic to receive services.

Recommendations

Respondents were asked to give suggestions for improving the services for Nepali patients. The majority of the respondents suggested improving accessibility for patients through branch expansion. A sizeable proportion of respondents (46.2 percent) identified the need for publicizing the service and the benefits of Ayurveda so that more patients can avail themselves of the traditional health service. About 19 percent said the clinic should be turned into a hospital (as so far there is not a single private Ayurveda hospital in Nepal). Other suggestions were provision of government support to Ayurveda health system, reduction of cost of Ayurveda medicines, opening up more Ayurveda research centers, production of qualified Ayurveda doctors, integration of Ayurveda with modern medicine, assuring consumers that there are not side effects and further enhancing service quality.

Foreign consumers

Sampling and typology of respondents

A total of 11 foreigners visiting Ayurveda Health Home were surveyed in April 2009. The sample was selected on a random/convenience basis. Of the 11 respondents, two each were from Austria, the US, the UK and Switzerland, and one each from Turkey, France and Kazakhstan. All were tourists.

The majority of respondents were female (64 percent as opposed to 36 percent women). The age of the respondents ranged from 29 years to 66 years, with the median age of 49.5 years. Of the 10 respondents who stated their education level, the median years of education was 15 years. As regards profession, some 45.5 percent of the respondents (5) were engaged in the service sector, two respondents were therapists/health workers, and one each was engaged in business, a student, a housewife, and retired (doing voluntary work).

The average duration of stay of the nine respondents who replied to the query 21.56 days. Some 78 percent of them were staying for 21 days or more.

About 64 percent of respondents were accompanied by one person, 18 percent by two persons and the rest were unaccompanied.

Purpose of visit

The primary purpose of visit to Nepal for 9 respondents (81.8 percent) was health treatment. For one respondent religion was the primary purpose while for another, it was visiting friends and sightseeing. Among those respondents who also had a secondary purpose of visiting Nepal, 37.5 percent cited visiting friends and/or sightseeing, 25 percent each cited health and religion, and 12.5 percent cited business. One respondent had been visiting Nepal for "many years". This indicates that the majority of visitors to AHH come to Nepal with health treatment as the main purpose.

Channels of information

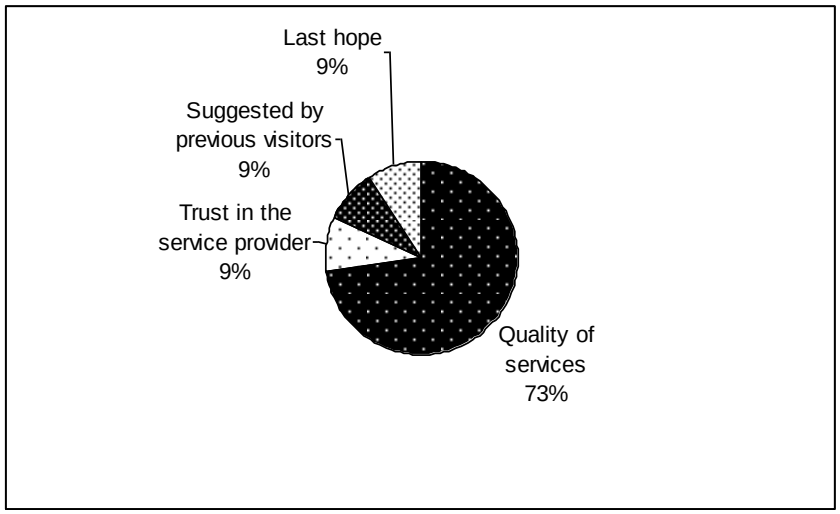
For 36.4 percent of the respondents, the media was the major source of information about AHH service. For 27.3 percent, previous visitors were the major source of information. Reputation of AHH was the major source of information for 18.2 percent, and family members and friends for 9 percent each. Respondents were also asked to cite multiple channels if applicable. Taking into account all the responses, previous visitors were a source of information for 54 percent of the respondents, and reputation for 36 percent. This indicates that word of mouth is an important source of information for foreign consumers.

All the respondents said the information they got positively influence their decision to opt for traditional health service vis-à-vis other health systems.

Reasons for visiting the service provider

For 73 percent of the respondents, quality of the service was the main reason that drew them to AHH. Trust in the service provider and recommendation by previous visitors were cited as the main reason by 9 percent each. One respondent's reply was "they say they can treat", implying that treatment at AHH was his/her last hope of getting cured (Figure 12).

Figure 12: Major reasons for visiting service provider



Respondents were also asked to cite more than one reason if applicable and to rank them. Trust in the service provider was cited by 75 percent of the respondents (who gave two reasons) as the second important reason, followed by quality of services (25 percent). Among the five respondents who cited three reasons, two each cited recommendation by previous visitors and low cost of receiving services overall, and one cited quality of services.

This indicates that quality of services and trust in the service provider are the most important factors behind foreigners visiting AHH. It is to be noted that no respondent cited low cost of service at AHH as a reason for visiting the service provider.

Cost

Only 8 of the 11 respondents gave data on their cost of receiving services. Data on cost breakdowns (cost of service, cost of travel to Nepal, transport cost within Nepal, food expenses within Nepal and other cost) were not available uniformly for all eight of them. However, all eight gave estimates of cost of health service (Table 8). The mean and median costs of service were US$1410.94 and US$1500 respectively. Cost of service ranged from US$600 to US$1937.5.

Table 8: Cost of service

		Cost of service (US$)

Mean		1410.938
Median		1500
Std. Deviation		483.0353
Minimum		600
Maximum		1937.5
Observations	**Valid**	8
	Missing	3

Expectations, quality of services and satisfaction

All the respondents said their expectations were met by the service provider (Figure 13). Similarly, all the respondents ranked the quality of service as high (Figure 14).

Likewise, all the respondents said they wanted to come to the same service provider for treatment again if need be and they would also recommend others to visit the place.

Figure 13: Were consumers' expectations met?

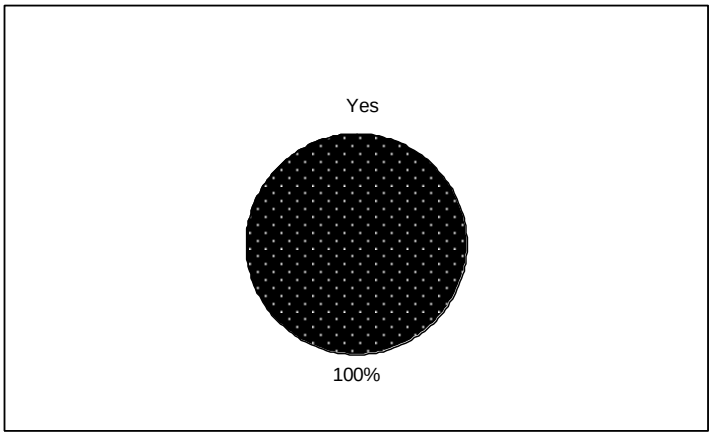
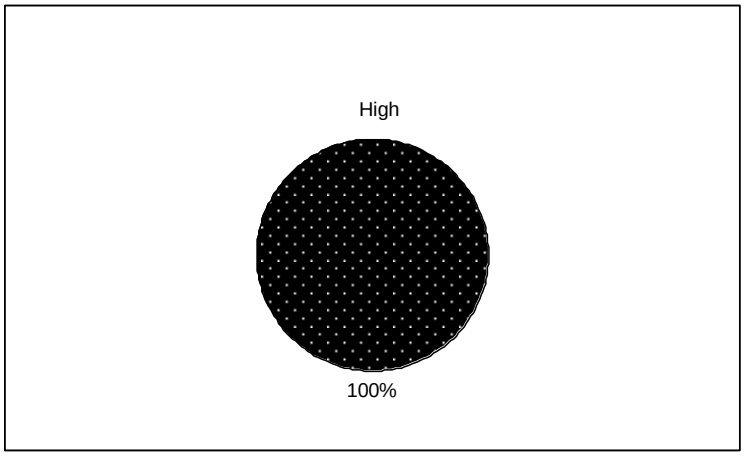


Figure 14: Quality of service



Willingness to pay

Only five of the 11 respondents responded to the question of willingness to pay. Three (60 percent) were willing to pay 10 percent more, one (20 percent) was willing to pay 5 percent more and another one was not sure.

Problems

All the respondents had come to Nepal by air. Only six respondents replied to the query about problem while traveling to Nepal. Four said they faced no problem, one cited cost of travel and one cited theft at the international airport in Kathmandu.

All respondents said they did not face any problem at the service provider.

As regards problem outside the service provider, six of the eight respondents said they did not face any problem while two cited heavy traffic in Kathmandu, pollution and power cuts as problems.

7.2 In-depth interview

In-depth interviews were taken with one service provider (AHH), one policy maker14 and one health economist15. The results of the interview with the service provider have been presented in the case study section above. The following is a summary of the findings from the two other interviews.

Status

The Government of Nepal (GON) has a policy framework in place that recognizes people's right to choose from among various health/medical systems. The National Health Policy, 1991 and the current Three-Year Interim Plan (TYIP) have provisions for developing and mainstreaming traditional health systems, including Ayurveda. However, despite the provisions and the fact that an overwhelming majority of the population has faith in and utilize the traditional health system16, traditional medicine has not received its due share in government budgetary allocation. The network of public Ayurveda facilities is not as widespread and dense as allopathic service facilities. The Tenth Five-Year Plan (2002-2007), which preceded the TYIP, had envisioned a policy of integrating modern and traditional health services into a single system so that both kinds of services are available at a single health facility. This provision, if implemented, would offer two benefits—first, a reduction in the cost of service delivery, mainly

14 Gyanendra Kumar Shrestha, Coordinator, National Planning Commission, Government of Nepal.
15 Bishnu Prasad Sharma, General Secretary, Nepal Health Economics Research Council, Kathmandu.
16 Nepalis are attracted to traditional medicine including Ayurveda as there are no side-effects of such treatment and they have faith in the system that is part of their own culture and heritage. Moreover, the popularization of pranayam/yoga by Ram Dev, the Indian pranayam guru, is also attracting city dwellers towards various forms of traditional medicine.

through reduced overhead expenses, and second, convenience for consumers and improvement in their access to health services.

Export potential

Consumption of traditional health services in Nepal by foreigners is grossly underreported. There are plenty of anecdotal evidences of foreign nationals suffering from terminal illness (e.g., cancer) and who could not be cured by allopathic medicine in their countries getting much relief or cured by traditional medicine in Nepal.

Furthermore, given that people of developed countries are increasing attracted towards what they call alternative and complementary medicine, there is potential to export traditional health services through Mode 2. While it may not be feasible at the moment to attract foreigners exclusively for medication, tourists visiting Nepal for various purposes can be drawn to various forms of traditional health services. At this stage, it would not be realistic to attempt to attract developed-country nationals towards traditional health services in Nepal as a main source of treatment, though there is potential to develop such services as a secondary level of treatment, provided the quality of services is of international standard.

Nepal has a potential to export Ayurvedic services through Mode 2 by cashing in on its climatic diversity and pleasant climate of places like Kathmandu. Natural beauty is a potential source of comparative advantage for exporting traditional health services through Mode 2. Natural healing could be an attraction for tourists visiting Nepal and hence could be made a component of vacation packages. Ayurveda services could be offered at resorts/healing centres on the picturesque outskirts of Kathmandu valley.

Barriers

Absence of recognition by health insurance companies in developed countries of traditional medicine practised in Nepal is a major deterrent to inducing foreigners to seek medication in traditional health service facilities in the country for any illness.

Lack of awareness among foreigners about the effectiveness and special features of traditional medicine practised in Nepal (e.g., absence of side effects) is another barrier to exporting such services substantially. Lack of publicity is the major cause behind such lack of awareness.

Maintaining international standards in the quality of human resources and service quality is of vital importance.

Traditional medicine has developed as a supplementary medicine only. It remains to be systematized, institutionalized and made transparent. The attitude of modern medicine towards traditional medicine in Nepal is to a large extent that of mistrust.

The two state-run Ayurveda Hospitals do not provide individual care and comfort for patients—which is a must if foreign patients are to be drawn in.

Suggestions

- Improve and maintain quality of human resources and services
- Launch an effective publicity campaign highlighting the effectiveness and special features of traditional medicine of Nepal targeted at foreigners
- Increase budget for traditional medicine
- Enhance R&D in traditional medicine
- Implement the plan to integrate traditional and modern health systems so as to expedite the effective mainstreaming and formalization of traditional medicine in the country.
- Traditional medicine (e.g., natural healing therapies) should be incorporated in tourist packages and such packages should be publicized far and wide. Lessons can be drawn from India's success in publicizing its traditional medicine globally.
- Nepal's climatic conditions should be capitalized on for promoting health tourism with focus on traditional medicine.
- Ways to integrate traditional medicine with modern medicine should be explored. At least, disease-wise cross-referral, if not full-fledged integration altogether, may be feasible in the short to medium run. Traditional medicine should be institutionalized and systematized, and transparency should be ensured in its practice.
- Private sector should be encouraged to provide quality traditional health services targeting tourists.

7.3 Focus group discussion

A focus group discussion (FGD) was held on 13 May 2009 at SAWTEE office in Kathmandu. There were eight participants, including Ayurveda practitioners, academicians, public and private service providers, government officials, policy makers and experts. The FGD centred on two issues: Nepal's export potential in Ayurveda services and the constraints to realizing that potential.

Export potential

Demand for traditional medicine (called complementary and alternative medicine in the West) has been growing strongly over the last 15 years, especially in developed countries. Though various traditional medicine services, including Ayurveda services, are available in rich countries, consuming those services at the countries of origin has a special appeal. As the land of Ayurveda, Nepal is a natural attraction for foreign consumers of alternative medicine. Encouragingly, there is resurgence of faith in traditional medicine among Nepalis living in urban areas after decades of domination of traditional health systems by modern medicine.

Nepal's altitudinal and climatic diversity that provides a natural habitat for medicinal plants, its rich Ayurvedic history and heritage rooted in its multi-ethnic and multi-cultural population, and the fact that the country has a huge tourism potential point towards potentiality in Ayurveda health tourism. Resorts offering Ayurveda health services in tourist circuits as in Sri Lanka could be an effective vehicle for health tourism. Such services can also be provided through old-age homes, in which Nepali has a comparative advantage due to pleasant climate and low of cost of living compared to developed countries. In fact, Americans and Japanese have shown interest to open such homes in Nepal.

Health tourism can also serve as a vehicle for exporting Ayurveda-based pharmaceuticals.

Another potential area is provision of Ayurveda-related training courses for foreigners.

Constraints/solutions

Natural resources and knowledge have neither been effectively preserved nor utilized. Despite a ban, some medicinal plants are being smuggled out of the country through the open Nepal-India border. Three is a growing practice of Indian traders buying certain medicinal plants (e.g. chirayatu) in advance from Nepali hill villages. Ancient texts of Ayurvedic knowledge are unaccounted for or have been pirated by foreigners. Also, there is no authority to verify claims regarding uses of medicinal plants.

Comprehensive identification, mapping and documentation of medicinal plants and traditional medicinal knowledge at the district level are required. Lesson can be learnt from Sri Lanka, where traditional medicine is promoted, including as an attraction for tourists.

There is not much research on Ayurveda. In-depth research and documentation are needed to inform foreigners about the special services Nepal has to offer in Ayurveda. It is important to identify diseases and ailments for which Ayurveda is more effective than modern medicine. Those Ayurveda services will have to be promoted. This will also help better integrate Ayurveda into the national health system.

Human resource is a constraint, both quantitatively and qualitatively. Nepal's BAMS course is not recognized abroad; this is holding BAMS graduates from pursuing higher Ayurveda education in India. Efforts should be made at the national level, making use of diplomatic channels, to have Nepali BAMS course recognized by Indian universities.

There is lack of inter-ministry coordination. There is little coordination between the Deparment of Ayurveda (DoA) under the Health Ministry and the Department of Plant Resources under the Ministry of Forests and Soil Conservation.

Maintaining quality standards expected by foreigners is a challenge. There are extremely few service centres offering international quality Ayurveda services.

The government-run Ayurveda Hospital at Nardevi, Kathmandu has a low occupancy rate (50 percent). Foreign patients are negligible in number although it has the potential to attract foreign consumers. Quality standard remains a barrier.

Ayurveda medicines not available in all districts in adequate quantities; pharmaceutical production is limited; 85 percent of Ayurveda pharmaceuticals are imported. There is a lot of room to broaden and deepen the use of Ayurveda medicine at the domestic level. Doing so will foster domestic consumption of Ayurveda services, creating a base for exports through Mode 2.

There is uncertainty about eligibility for reimbursement of expenses on Ayurveda medication by foreigners. Eligibility varies across insurance companies and services. However, 33 percent of the patients at AHH get reimbursed.

Allopathic medicine lobby dominates Ayurveda lobby in policy, plan and programme formulation and implementation. The Interim Plan has provisions for the development of the Ayurveda sector but when it comes to formulation of annual programmes, where the plan provisions are to be implemented, Ayurveda is completely overshadowed. There is a need for vigilance on the part of Ayurveda stakeholders to ensure that the plan provisions get implemented.

Ayurveda was recognized as a national medical science as opposed to alternative medicine in 1995, but implementation is weak. Ayurveda receives step-motherly treatment from the state. Budgetary allocation for Ayurveda is a pittance. Many of the provisions of the Ayurveda Health Policy 1995 remain unimplemented.

There is insufficient publicity of Nepali Ayurveda resources and heritage globally. Ayurveda promotion can be linked with tourism promotion. Effective networking and marketing are crucial.

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Annex 1: List of countries of origin of foreign tourists visiting AHH during 2003/04-2007/08

S.N.	Country	S.N.	Country	S.N.	Country	S.N.	Country
1	Argentina	35	Indonesia	69	Salvador	82	Thailand
2	Australia	36	Ireland	70	Saudi Arabia	83	Tibet
3	Austria	37	Israel	71	Singapore	84	Taiwan
4	Bangladesh	38	Italy	72	Slovakia	85	Turkey
5	Belarus	39	Japan	73	Slovenia	86	UAE
6	Belgium	40	Jordan	74	Somalia	87	UK
7	Benin	41	Kazakhstan	75	South Africa	88	Ukraine
8	Bhutan	42	Korea	76	South Korea	89	USA
9	Bolivia	43	Kuwait	77	Spain	90	Vietnam
10	Brazil	44	Latvia	78	Sri-Lanka	91	Zimbabwe
11	Bulgaria	45	Lebanon	79	Sweden		
12	Burkina Faso	46	Lithuania	80	Switzerland		
13	Canada	47	Luxemburg	81	Syria		
14	Chile	48	Malaysia	82	Thailand		
15	China	49	Maldives	83	Tibet		
16	Columbia	50	Mali	84	Taiwan		
17	Croatia	51	Mauritius	85	Turkey		
18	Cyprus	52	Mexico	86	UAE		
19	Czech Rep.	53	Morocco	87	UK		
20	Denmark	54	Nepal	88	Ukraine		
21	Ecuador	55	Netherland	89	USA		
22	Eretria	56	New Zealand	90	Vietnam		
23	Estonia	57	Nicaragua	91	Zimbabwe		
24	Ethiopia	58	Nigeria	71	Singapore		
25	Fiji	59	Norway	72	Slovakia		
26	Finland	60	Pakistan	73	Slovenia		
27	France	61	Peru	74	Somalia		
28	Germany	62	Philippines	75	South Africa		
29	Greece	63	Poland	76	South Korea		

30	Guyana	64	Puerto Rico	77	Spain		
31	Hong Kong	65	Portugal	78	Sri-Lanka		
32	Hungary	66	Qatar	79	Sweden		
33	Iceland	67	Romania	80	Switzerland		
34	India	68	Russia	81	Syria		