

Minimum Service Standards in Nepal: Performance, Trends, and Opportunities for Continuous Quality Improvement

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Abstract

Introduction

Minimum Service Standards (MSS) provide a framework for assessing minimum service readiness and identifying gaps in health facilities. Nepal has expanded MSS across government hospitals, but assessment scores alone may not indicate whether identified gaps are addressed or improvements are sustained. Therefore, this study aimed to: (i) describe longitudinal MSS trends among tertiary and specialized hospitals; (ii) present FY 2082/83 province-level and hospital-category MSS averages; (iii) describe implementation gaps relevant to the use of MSS findings; and (iv) propose practical directions for strengthening MSS implementation.

Methods

A descriptive secondary data analysis was conducted using MSS assessment records for tertiary and specialized hospitals from FY 2076/77 to 2082/83. FY 2082/83 MSS averages by province and hospital category were obtained from the national MSS reporting platform. MSS performance and trends were summarized descriptively. Relevant government documents, scientific literature, and official sources were reviewed using a narrative and descriptive approach. Practice-based insights were considered to inform the interpretation of implementation issues and areas for improvement.

Results

MSS scores varied across hospitals, assessment years, provinces, and hospital categories. Several tertiary hospitals showed improvement over time, although progress was not consistent. Specialized hospitals remained below 70% throughout the available assessment period. Identified gaps were not always addressed, and follow-up, continuity, accountability, and verification needed strengthening. Some MSS indicators also need to be updated to reflect current health-system needs. The findings support digital tracking, stronger accountability and peer learning, regular updating of MSS, additional measures of quality of care, and expansion of MSS to remaining specialized and super-specialized public hospitals and private hospitals.

Conclusion

MSS provides an important foundation for assessing service readiness and identifying gaps. Strengthening follow-up, accountability, verification, and continuous improvement could help move MSS beyond assessment and scoring toward a continuous quality-improvement mechanism.

Introduction

Minimum Service Standards (MSS) provide a structured framework for assessing service readiness and service availability and determining whether health facilities meet the minimum requirements needed to provide their expected services (1, 2). Health facilities require adequate infrastructure, human resources, equipment, supplies and management systems to deliver the services expected at their respective levels of care. In Nepal, MSS represents the minimum level required for functional service delivery rather than an ideal or maximum standard, and covers key areas including governance, human resources, infrastructure, equipment, supplies and service management (1, 3).

The MSS approach in Nepal emerged from efforts to strengthen hospital readiness and curative services. It was initially piloted in four hospitals in 2013 and subsequently rolled out to 83 district-level hospitals (4). The Hospital Strengthening Program (HSP) was implemented under the leadership of the Ministry of Health and Population (MOHP) in partnership with the Nick Simons Institute (NSI) in 2014 (4). With the restructuring of Nepal's health system under federalism, MSS was adapted to different levels of care, with tools developed for health posts, Primary Hospitals, Secondary A and Secondary B Hospitals, and Tertiary Hospitals, as well as specialized hospitals (1, 4, 5).

Hospital MSS is organized into three broad domains: Governance and Management, Clinical Service Management, and Hospital Support Service Management (1). The assessment identifies gaps and supports prioritization, action planning and follow-up (4, 6). MSS therefore supports facilities in addressing identified deficiencies rather than focusing only on assessment scores (4, 6). The standards provide a baseline for improvement, with facilities encouraged to progress beyond the minimum requirements (1, 6).

MSS has expanded considerably within Nepal's government hospital system. According to the MSS digital platform, MSS has been implemented across 160 government hospitals, comprising 73 Primary, 49 Secondary A, 19 Secondary B, 13 Tertiary and 6 Specialized hospitals, with 888 assessments recorded since 2019 (7). The Annual Health Report Fiscal Year (FY) 2081/82 of Department of Health Services (DoHS) reports variation in average MSS scores across hospital levels (8).

Despite this expansion, MSS primarily assesses structural readiness, service availability and organizational aspects of health-care delivery. It may not fully capture other dimensions of health-care quality, including care processes, patient safety, patient experience and health outcomes (1, 9). Therefore, MSS provides an important foundation for continuous quality improvement, but should not be considered the ceiling of quality.

With MSS now widely established across Nepal's government hospital system, attention should increasingly focus on whether identified gaps are addressed and improvements are sustained. The standards and implementation processes should also evolve with changing expectations of quality. Therefore, this study aimed to: (i) describe longitudinal MSS trends among tertiary and specialized hospitals; (ii) present FY 2082/83 province-level and hospital-category MSS averages; (iii) describe implementation gaps relevant to the use of MSS findings; and (iv) propose practical directions for strengthening MSS implementation.

Methods

Study design and analytical framing

This was a descriptive secondary analysis of routinely collected MSS assessment data, including longitudinal data from tertiary and specialized hospitals and FY 2082/83 MSS averages by province and hospital category. A targeted review of relevant literature and government documents and practice-based insights from authors involved in MSS implementation supplemented the quantitative analysis. The quantitative analysis described MSS performance and trends, while the literature, documents, and practice-based insights informed interpretation of implementation considerations and potential directions for strengthening MSS implementation.

In this study, *federal hospitals* refers to tertiary and specialized hospitals included in the available MSS dataset. The analysis was descriptive and was not intended to identify causes of changes in MSS scores or rank hospitals.

Literature and document review

A targeted literature search was conducted in PubMed/MEDLINE, Scopus, Web of Science, and Google Scholar to identify relevant literature on MSS, health-facility readiness, quality of care, assessment, implementation, and Nepal. The search used controlled vocabulary where applicable and free-text terms, with Boolean operators (AND/OR), phrase searching, and truncation where appropriate. The PubMed search strategy was:

("Minimum Service Standards"[tiab] OR "Minimum Service Standard"[tiab] OR "minimum service standard*"[tiab] OR MSS[tiab]) AND ("Hospitals"[Mesh] OR "Public Hospitals"[Mesh] OR hospital*[tiab] OR "public hospital*"[tiab] OR "government hospital*"[tiab] OR "federal hospital*"[tiab] OR "tertiary hospital*"[tiab] OR "specialized hospital*"[tiab] OR "health facilit*"[tiab] OR "hospital readiness"[tiab] OR "service readiness"[tiab] OR "service availab*"[tiab]) AND ("Quality of Health Care"[Mesh] OR "Quality Improvement"[Mesh] OR "Patient Safety"[Mesh] OR "quality of care"[tiab] OR "healthcare quality"[tiab] OR "health care quality"[tiab] OR "quality improvement"[tiab] OR "patient safety"[tiab]) AND (assessment[tiab] OR assess*[tiab] OR implement*[tiab] OR "implementation gap*"[tiab] OR "gap identification"[tiab] OR "gap closure"[tiab] OR "action plan*"[tiab] OR "follow-up"[tiab] OR monitor*[tiab] OR verif*[tiab]) AND ("Nepal"[Mesh] OR Nepal[tiab] OR Nepali[tiab]).

Reference lists of relevant articles were also reviewed. Relevant Government of Nepal (GoN) policy documents, MSS tools, checklists, annual and periodic MSS reports, health-sector reports, and technical documents were reviewed to understand the development, implementation, and use of MSS in Nepal.

MSS assessment data

MSS assessment data for federal tertiary and specialized hospitals were obtained from the MSS records maintained by the Health, Food Safety and Drug Quality Regulation Division, Ministry of Health and Food Safety (MoHFS). The longitudinal trend analysis included MSS assessment records available for the period from FY 2076/77 to 2082/83.

Tertiary hospitals entered the assessment system at different times from FY 2076/77 onward, while specialized hospitals were included from FY 2079/80 onward. Thus, the longitudinal analysis reflects the assessment history of each hospital from its first recorded MSS assessment. Changes in MSS scores over time and differences in assessment coverage were examined descriptively.

Overall MSS scores were interpreted according to the national MSS classification shown in Table 1.

Table 1. Classification of overall MSS scores (1)

Overall MSS score	Interpretation
<50%	Very poor and alarming; needs to be addressed first
50-<70%	Improving status; needs specific targeted-area support
70-<85%	Acceptable level; requires careful, specific interventions
85-100%	Optimal level of readiness; requires sustained efforts to maintain the level and move towards 100%

Aggregate MSS data

For FY 2082/83, **province-level average MSS scores across assessed hospitals** and average MSS scores by hospital category (Primary, Secondary A, Secondary B, Tertiary, and Specialized) were obtained from the national MSS reporting platform (7).

These data were used to describe MSS performance across Nepal and to provide a broader perspective on the findings from federal tertiary and specialized hospitals.

Data analysis and practice-based insights

MSS data were summarized descriptively using percentages, tables, and figures. Longitudinal findings were examined at the hospital level because assessment coverage varied across hospitals and years. Province-level and hospital-category averages for FY 2082/83 were summarized as reported by the national MSS platform. No causal analyses or hospital rankings were undertaken.

Practice-based insights were drawn from the authors' direct involvement in MSS assessment and related coordination activities. These experiences informed the interpretation of practical aspects of MSS

implementation, including assessment continuity, gap identification, action-plan development, follow-up mechanisms, verification, and indicator relevance. These insights were presented as informed perspectives rather than systematically collected qualitative data.

Ethics approval and consent to participate

This study used routinely collected, aggregated MSS assessment data from government hospitals and did not involve individual-level participant data. The data were accessed through the Health, Food Safety and Drug Quality Regulation Division, Ministry of Health and Food Safety, Government of Nepal.

Results

Longitudinal MSS trends among federal hospitals

Reported MSS scores among federal (tertiary and specialized) hospitals varied across facilities and assessment years. Some hospitals showed sustained improvement over successive assessments, whereas others showed fluctuations or lower scores in the most recent assessment.

Longitudinal reported MSS scores among tertiary hospitals

In FY 2082/83, Bharatpur Hospital (89%) recorded the highest MSS score, followed by PAHS (83%) and BPKIHS (77%), while GNSH (42%) recorded the lowest. Overall, MSS scores among assessed tertiary hospitals in FY 2082/83 ranged from 42% to 89%.

Longitudinally, several hospitals showed notable increases in reported MSS scores. Bharatpur Hospital increased from 50% in FY 2076/77 to 89% in FY 2082/83, while BPKIHS increased from 53% to 77%, PAHS from 66% to 83%, and RAHS from 36% to 67%. Improvement was not consistent across all hospitals; Bheri Hospital declined from 83% in FY 2081/82 to 69% in FY 2082/83. (Figure 1)

Assessment coverage varied across years, as several hospitals were not assessed in some years. Therefore, the longitudinal findings describe hospital-specific assessment trajectories rather than directly comparable year-to-year averages across all hospitals.

Longitudinal reported MSS scores among specialized hospitals

Reported MSS scores among specialized hospitals varied across assessment years. Among recorded assessments, MSS scores for specialized hospitals remained below 70% throughout the available assessment period. In FY 2082/83, National Trauma Center (67%) recorded the highest reported score, followed by STIDH (63%), Kanti Children's Hospital (62%), PMWH (62%), and SGNHC (59%). Mental Hospital recorded the lowest score (41%).

Among hospitals with repeated assessments, several showed improvement over time. Kanti Children's Hospital increased from 46% in FY 2080/81 to 62% in FY 2082/83, STIDH from 44% in FY 2079/80 to 63% in FY 2082/83, and Mental Hospital from 27% in FY 2079/80 to 41% in FY 2082/83. PMWH increased from 57% in FY 2079/80 to 64% in FY 2081/82 before declining slightly to 62% in FY 2082/83.

Assessment coverage varied across hospitals and years. SGNHC and National Trauma Center were first assessed in FY 2082/83, while some other hospitals had intermittent assessments. Therefore, a first recorded assessment represents the hospital's available baseline measurement and should not be interpreted as evidence of improvement. (Figure 2)

Province-level MSS averages in FY 2082/83

Province-level MSS data provide a broader picture of MSS performance across **all assessed hospital categories in Nepal**. The reported province-level average MSS scores in FY 2082/83 ranged from 45.00% in Madhesh Province to 77.27% in Koshi Province, with an overall average of 64.95%. (Figure 3)

MSS averages by hospital level/category in 2082/83

The hospital-level/category data show different average MSS scores among assessed hospitals: 57.49% for Primary Hospitals, 76.30% for Secondary A Hospitals, 71.74% for Secondary B Hospitals, 66.25% for Tertiary Hospitals and 59.00% for Specialized Hospitals (Figure 4).

Overall, the findings show variation in MSS scores across hospitals and assessment years, as well as across provinces and hospital categories. Looking at changes over time and areas where scores remain low gives a clearer picture than looking at individual annual scores alone.

Discussion

MSS assessments provide a structured approach to identifying gaps in hospital readiness and supporting improvement. However, identification of gaps does not necessarily result in their timely closure or sustained improvement. Therefore, MSS performance should be considered not only in terms of the current score, but also in relation to changes over time, whether priority gaps have been addressed, and whether improvements are sustained.

Gap identification and closure

MSS joint assessment helps hospitals identify deficiencies and develop action plans to address them. The HSP has linked assessment findings with prioritized actions, responsible persons, timelines, resources, and follow-up (4). However, identifying a gap does not necessarily mean that it has been

addressed. Evidence from health facilities in Nepal found that only 38% of action plans were completed at follow-up, with limited resources and inconsistent follow-up identified as important barriers (10). This highlights the importance of tracking whether identified gaps are actually addressed.

Therefore, unresolved and partially addressed gaps should be reviewed in subsequent MSS cycles. Actions taken and the status of each priority gap should be clearly documented to allow progress to be monitored over time.

Continuity and learning across assessment cycles

MSS can better support continuous improvement when each assessment builds on the previous one. Reviewing previous action plans can help identify what has improved, what remains unresolved, and what barriers continue to affect implementation. This can help make MSS part of a continuous improvement process rather than a series of separate scoring exercises.

Continuity across assessment cycles can also support learning between hospitals. Assessment teams can observe how different hospitals address similar gaps and share practical approaches. Hospitals with persistent gaps could receive more targeted support based on the specific areas requiring improvement.

Resources, institutional sustainability, and accountability

MSS makes deficiencies in infrastructure, equipment, staffing, and service availability visible and can inform planning and budgeting (4,10). However, not all gaps can be addressed at the hospital level. Some require action from higher-level authorities, such as staffing, procurement, infrastructure, or financing, while others can be addressed through facility-level management and operational changes.

The long-term sustainability of the MSS program also depends on sustained government ownership, financing, technical capacity, and institutional mechanisms for regular assessment and follow-up. The HSP has benefited from government-partner collaboration, including support from the NSI (4). As MSS continues to expand, its core functions should be increasingly embedded within routine government planning, budgeting, monitoring, and quality-assurance systems to support continuity beyond individual projects or partner-supported periods.

Therefore, MSS action plans should distinguish between gaps that can be addressed at the facility level and those that require action from higher-level authorities. Responsibilities, required resources, and timelines should be clearly identified for each priority gap.

Interpreting MSS performance beyond the current score

MSS scores are useful for describing current readiness, but a single score does not capture the full picture of a hospital's progress. Improvement from an earlier assessment, closure of priority gaps, and the ability to maintain improvements over time are also important considerations.

For example, a hospital that improves from 40% to 65% has demonstrated improvement, even though its current score remains lower than that of a hospital scoring 75%. Similarly, an increase from 70% to 72% may not indicate that a specific priority gap has been addressed. MSS reporting should therefore consider the current score together with improvement over time, priority-gap closure, and sustainability rather than relying only on the current score.

Updating MSS indicators to reflect changing health-system needs

Health-system needs continue to evolve with changes in clinical practice, technology, regulation, organizational structures, and patient expectations. As these changes occur, existing MSS indicators may not fully capture emerging areas of health-care quality. Therefore, MSS tools need regular review to remain relevant to current health-system needs. For example, recent work on hospital pharmacy practice has identified areas that may not be fully captured by the existing MSS checklist (11). Regular review can help ensure that MSS indicators remain aligned with current health-system priorities and quality standards.

Expanding MSS beyond readiness

MSS primarily assesses structural readiness and service availability. However, having staff, equipment, medicines, and guidelines does not by itself show that care is delivered appropriately, safely, or effectively. Donabedian's framework describes quality of care in terms of three components: the resources and systems available to provide care (structure), how care is provided (process), and the results of care (outcome) (9).

Patient experience may also not be fully reflected in MSS scores. Evidence from Nepal found an association between MSS scores and patient satisfaction while identifying gaps in privacy, human resources, counselling, and staff behaviour (12). These findings indicate that MSS readiness scores alone may not capture important aspects of the quality of care provided by a hospital. Complementing MSS with selected measures of care processes, outcomes, safety, and patient experience could provide a broader understanding of hospital performance.

Implications for MSS Implementation

The next phase of MSS should strengthen the link between assessment findings and actual improvement. Identified gaps should lead to clear actions, follow-up, learning, and sustained improvement.

Establish a Continuous MSS Improvement Cycle with Digital Tracking

MSS should move beyond an assessment-and-scoring approach toward a continuous improvement cycle supported by digital tracking:

Assessment → Gap identification → Prioritization → Action → Follow-up → Verification → Learning → Reassessment

Each assessment should review the previous action plan, document progress, prioritize unresolved gaps, and use lessons from previous actions to inform the next cycle. Each action should have clear responsibilities, timelines, and evidence for verification. A digital system should support this process by maintaining a record of assessment findings, identified gaps, actions, follow-up, verification, and whether gaps have been addressed. Regular review of action plans can help track progress between MSS assessment cycles.

Strengthen Accountability, Peer Learning, and Targeted Support

MSS action plans should clearly identify whether each gap requires action by the hospital or by a higher-level authority. Priority actions should be linked to responsible authorities, required resources, timelines, and follow-up.

Resource persons involved in MSS assessments should have opportunities for cross-provincial and federal-level exposure through assessments or learning visits. Exposure to different hospitals and levels of care would allow assessment teams to observe how other hospitals address similar gaps and share practical solutions. This could strengthen assessment capacity and support learning across hospitals.

Hospitals demonstrating sustained improvement or effective gap closure could be recognized and encouraged to share effective practices, while hospitals with persistent gaps could receive diagnostic review and targeted support. This would help move MSS beyond identifying differences in scores toward supporting practical improvement.

Periodic Review and Update of MSS

Future MSS tools should retain essential national standards while allowing additional indicators that reflect hospital level, specialty, and service requirements. This would maintain consistency while avoiding the use of identical indicators where service requirements differ.

MSS tools should be reviewed at least every five years to ensure that standards remain aligned with changes in clinical practice, technology, regulation, patient safety, and health-system priorities. The review should assess whether existing indicators remain relevant and whether emerging areas of quality require inclusion.

Complement MSS with Selected Quality Measures

MSS should remain the framework for assessing minimum service readiness. However, it should be complemented by a feasible set of indicators covering care processes, patient safety, patient experience, and selected health outcomes. MSS can show whether a hospital has the basic staff, equipment, medicines, and guidelines needed to provide services. Additional quality measures can provide information on whether these resources are used appropriately, whether care is provided safely, how patients experience care, and what outcomes are achieved (9,13).

Expand MSS to remaining specialized, super-specialized and private hospitals

MSS tools should be developed for specialized and super-specialized public hospitals that are not currently covered. The tools should include indicators relevant to the specific services and requirements of each hospital type.

The application of MSS to private hospitals could also be considered, using the existing MSS framework with appropriate adaptation where needed to reflect their service delivery and management context. This could extend quality assessment beyond the current public-sector focus and support broader assessment of hospital quality.

Strengths and Limitations

A key strength of this study is the use of longitudinal MSS assessment data from tertiary and specialized hospitals, allowing MSS performance to be examined over time. The study also presents province-level and hospital-category MSS averages for 2082/83, providing a broader view of MSS performance. Practice-based insights from MSS implementation, together with relevant literature and policy documents, further support the interpretation of MSS findings and implementation issues.

However, assessment coverage varied across hospitals and years, limiting direct comparison of longitudinal trends. The study was descriptive and relied on routinely collected secondary data, and

practice-based insights were not systematically collected as qualitative data. Furthermore, the limited number of studies on MSS in Nepal restricted the available evidence supporting the recommendations.

Conclusion

MSS provides an important foundation for assessing minimum service readiness and identifying gaps across Nepal's government hospitals. The findings show variation in MSS scores across hospitals, hospital categories, and provinces. Several tertiary and specialized hospitals showed improvement over time, although progress was not consistent across all hospitals. Some hospitals also showed declines in later assessment years, highlighting the need to sustain improvements after initial progress.

These findings highlight that MSS should not be viewed only as an assessment and scoring exercise. Improvement over time, closure of priority gaps, accountability, follow-up, and verification are also important when interpreting MSS performance. MSS should continue to provide a foundation for minimum readiness while being implemented as part of a continuous quality-improvement process. Further expansion of MSS to remaining specialized and super-specialized public hospitals, and consideration of its application to private hospitals, could broaden quality assessment across the hospital sector. Therefore, the value of MSS should be considered not only in terms of scores, but also in whether identified gaps are addressed, improvements are sustained, and minimum readiness supports the delivery of safe, effective, and people-centered care.

Abbreviations

BPKIHS – B.P. Koirala Institute of Health Sciences

FY – Fiscal Year

GNSH – Gajendra Narayan Singh Hospital

GoN – Government of Nepal

HSP – Hospital Strengthening Programme

KAHS – Karnali Academy of Health Sciences

MoHFS – Ministry of Health and Food Safety

MoHP – Ministry of Health and Population

MSS – Minimum Service Standards

NSI – Nick Simons Institute

PAHS – Patan Academy of Health Sciences

PMWH — Paropakar Maternity and Women's Hospital

PoAHS — Pokhara Academy of Health Sciences

RAHS — Rapti Academy of Health Sciences

SGNHC — Shahid Gangalal National Heart Centre

STIDH — Sukraraj Tropical and Infectious Disease Hospital

Declarations

Ethics approval and consent to participate

This study used routinely collected, secondary MSS assessment data from government hospitals and did not involve individual-level participant data. The data were accessed through the Health, Food Safety and Drug Quality Regulation Division, Ministry of Health and Food Safety, Government of Nepal. No separate ethical approval was obtained.

Consent for publication

Not applicable.

Availability of data and materials

The datasets analysed during the current study are not publicly available because they are maintained by the Ministry of Health and Food Safety, Government of Nepal, and are subject to applicable government data-access and permission requirements.

Competing interests

The authors declare that they have no competing interests.

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No specific funding was received for this study.

Authors' contributions

ST contributed to the conceptualization of the study, methodology, data curation, formal analysis, interpretation of findings, practical aspects of MSS implementation, and writing of the original draft. RN

and NM contributed to the interpretation of MSS findings, practical aspects of MSS implementation, and critical revision of the manuscript. KR contributed to data analysis, literature and document review, and manuscript development. MR contributed to methodology, supervision, validation, and critical revision of the manuscript. All authors contributed to reviewing and revising the manuscript, approved the final version, and agreed to be accountable for all aspects of the work.

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Figures

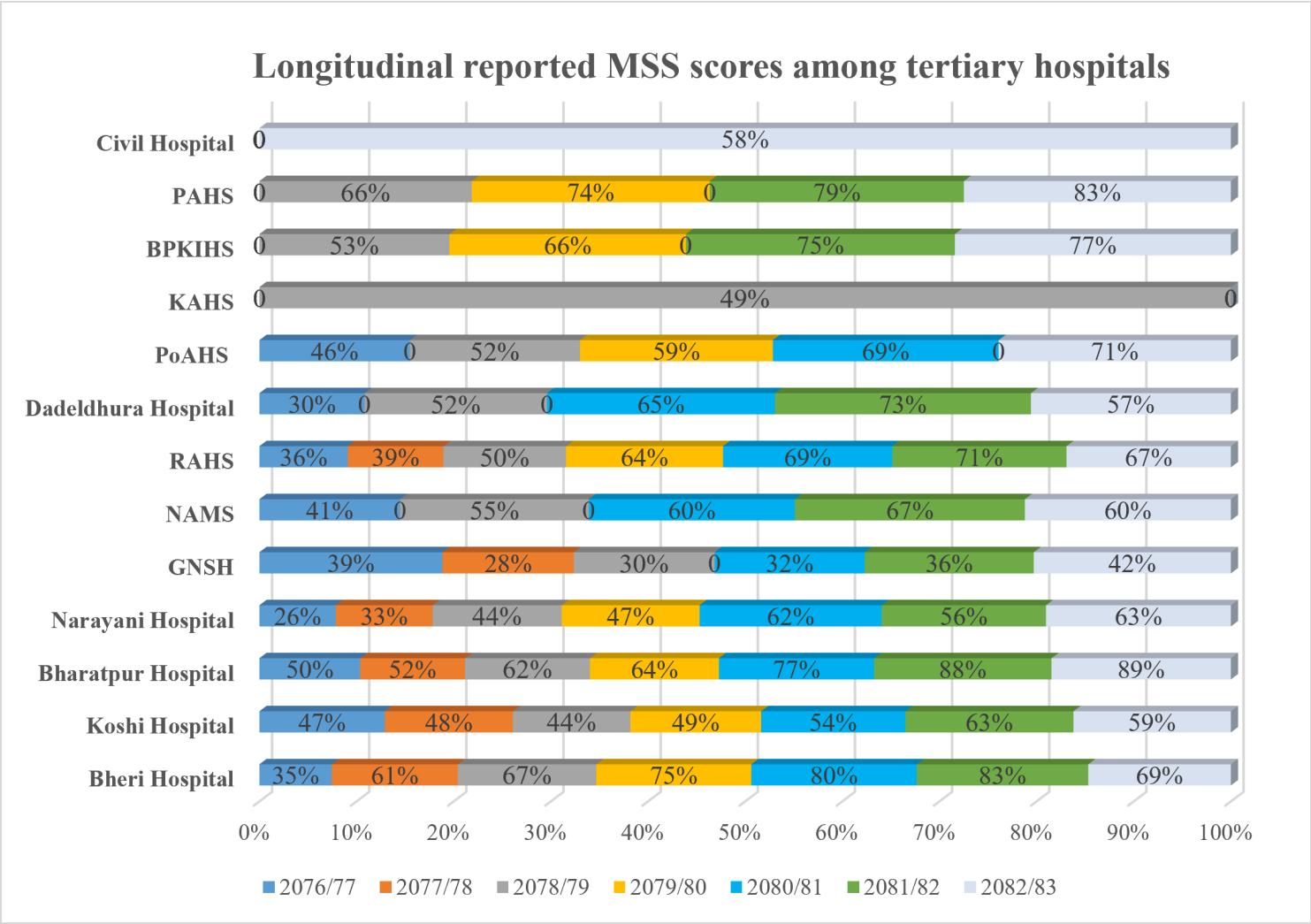


Figure 1

Longitudinal reported MSS scores among tertiary hospitals

Source: MoHFS, FY 2082/83

Note: Values are overall MSS percentage scores. A value of 0 indicates that no MSS assessment was recorded for the hospital in that year and does not represent an MSS score of 0%. GNSH, Gajendra Narayan Singh Hospital; RAHS, Rapti Academy of Health Sciences; PoAHS, Pokhara Academy of Health Sciences; KAHS, Karnali Academy of Health Sciences; BPKIHS, B.P. Koirala Institute of Health Sciences; PAHS, Patan Academy of Health Sciences.

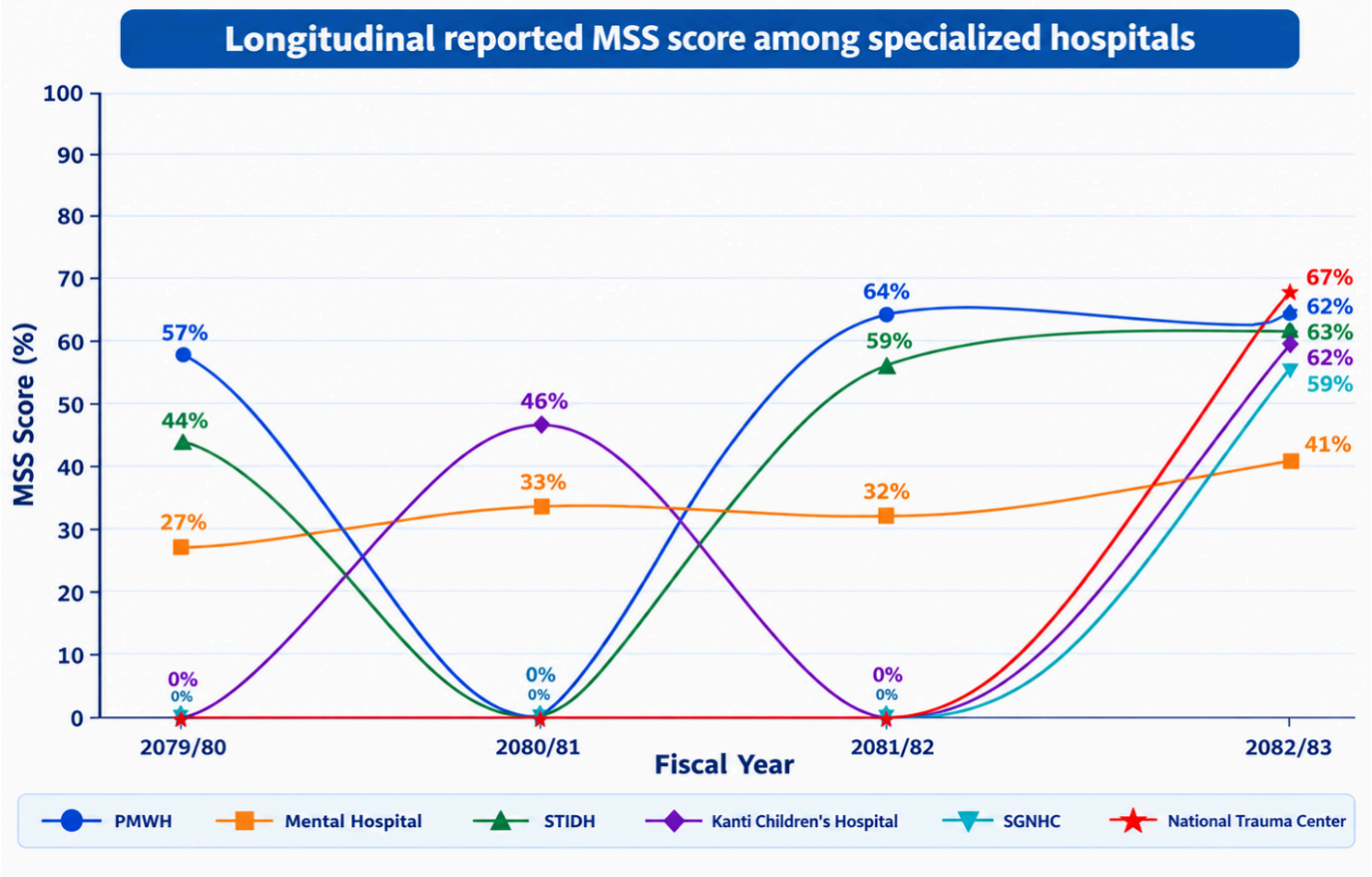


Figure 2

Longitudinal reported MSS scores among specialized hospitals

Source: MoHFS, FY 2082/83

Note: Values are overall MSS percentage scores. A value of 0 (shown as 0% in the figure) indicates that no MSS assessment was recorded for the hospital in that year and does not represent an MSS score of 0%. PMWH, Paropakar Maternity and Women's Hospital; STIDH, Sukraraj Tropical and Infectious Disease Hospital; SGNHC, Shahid Gangalal National Heart Centre.

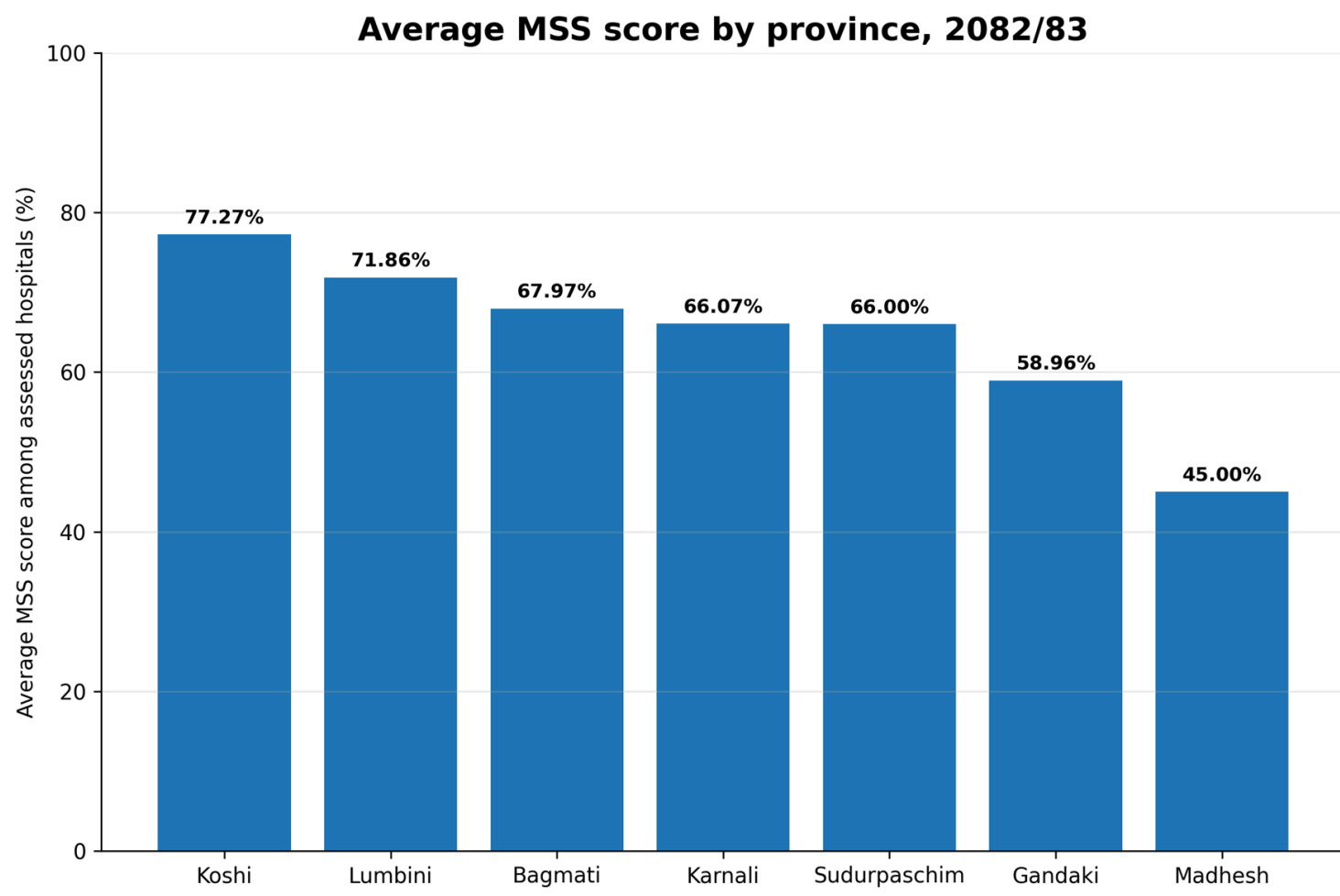


Figure 3

Reported average MSS score by province among assessed hospitals, 2082/83 (7)

(Note: Values represent average MSS scores among assessed hospitals in each province in 2082/83 and should not be interpreted as measures of overall provincial health-system performance.)

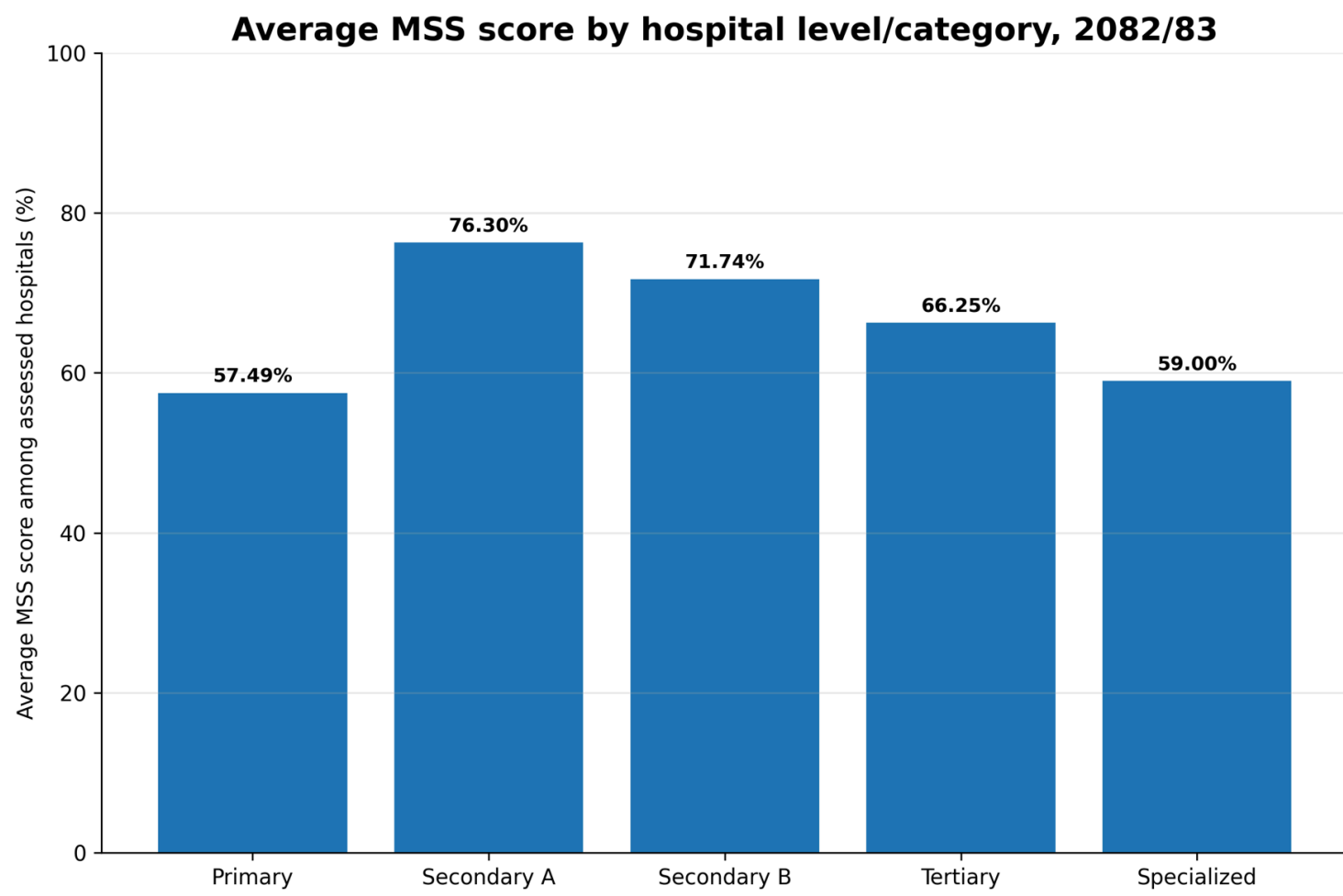


Figure 4

Reported average MSS score by hospital level/category among assessed hospitals, 2082/83 (7)

(Note: Values are average MSS scores among assessed hospitals in each category. Hospital categories use different MSS tools and service scopes; therefore, category-level averages should not be interpreted as directly comparable measures of overall hospital performance.)