World Health Organization

Health Financing Case Study No 24

BHUTAN

Bhutan: Cross-Programmatic Efficiency Analysis

POLICY BRIEF

Objectives

A cross-programmatic efficiency analysis was conducted in Bhutan to identify and analyse critical areas of functional overlap, misalignment, or duplication across the country's **tuberculosis (TB), HIV/AIDS, malaria, non-communicable disease (NCD), Expanded Programme on Immunizations (EPI),** and **Maternal, Newborn, and Child Health (MNCH)** programmes, and with the overall health system.

The cross-programmatic efficiency analysis took place between May 2019 to October 2019. This policy brief is written based on that analysis, with recognition that changes in the health system may have taken place since the study was conducted.

Bhutanese Context

Bhutan has undergone rapid economic and social development over the past three decades. With this growth, however, the country is experiencing changes in its disease burden, which will require a refocusing of investments so as to safeguard these gains and address emerging threats. Owing to the epidemiological transition, demographic shift, and urbanization, non-communicable diseases (NCDs) are increasing, while the country is still grappling with communicable diseases. All of these changes in the country stand as potential barriers to providing free basic health care services, a constitutional mandate. Recognizing these shifts, there are several current reforms and initiatives that the Ministry of Health intends to institute and initiate.

In light of this, WHO worked with the Ministry of Health (MOH) to assess Bhutan's health system as they look to restructure their health system to enable a more efficient and coherent service delivery model. Through the cross-programmatic efficiency analysis, specific areas of overlap, misalignment, or duplication that constrain implementation of effective service delivery have been identified with the aim to improve coverage of quality health care services, ensure government investment in health care is used efficiently, and to inform transition processes.

Key Findings

The five-key cross-programmatic inefficiencies, their implications, and potential intervention to mitigate each are discussed below.

1. No clear health sector-wide plan

There is no current coherent strategic plan to guide coordination across departments and health programmes across the health sector. With no clear guidelines or opportunities for joint budgeting or planning, each programme maintains largely vertical functions.

IMPLICATIONS	POLICY OPTIONS
• With no clear or institutional health sector guidelines for integration, there is no coordination amongst programmes, or across levels of care • Fragmentation of programmes results in their own reporting requirements, guidelines, and governance structures • MOH has little oversight over district budgets, given that districts interact directly with the Ministry of Finance	• Incorporate a more coordinated planning process at lower levels of the system to better enable cross-programmatic integration and organization • Coordinated approach across health levels should be streamlined between the facility, district, and Ministry to more efficiently align input functions and in turn how resources are used

2. Fragmented financial flows

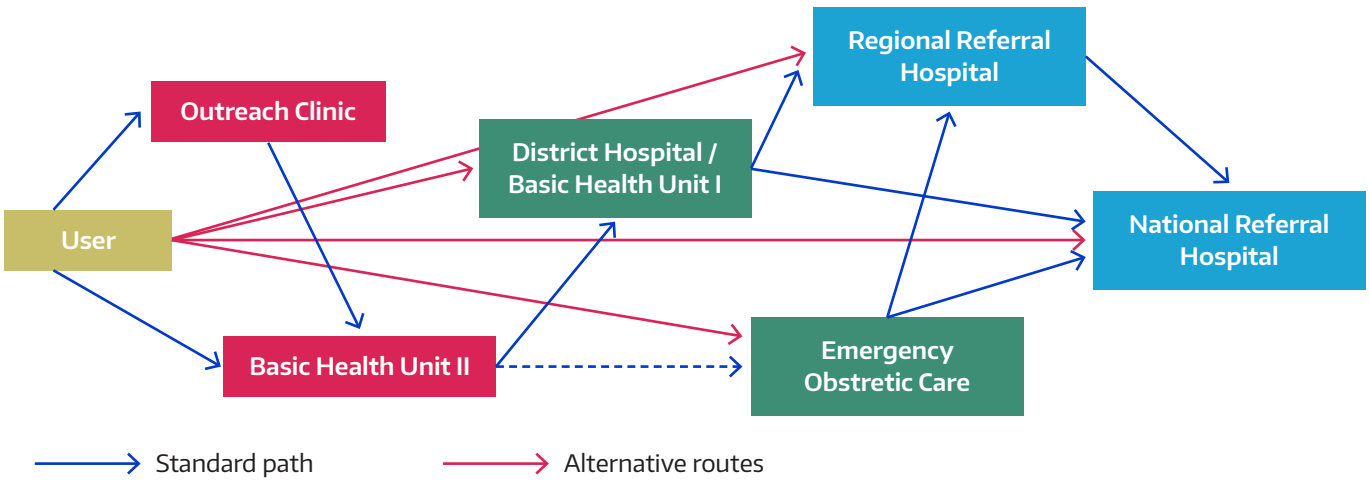
There is little coordination across donors and MOH in terms of disease programmes and across the sector. This results in significant fragmentation in terms of management, ownership, and flow of the health budget and further constrains the ability for reallocation. Additionally, budgets at all levels of government are done by line-item and are based on historic trends rather than on need.

IMPLICATIONS	POLICY OPTIONS
• Overreliance on donors for key aspects of certain health programmes and vaccines, which constrains the ability for the health system to reallocate based on need • The budgeting process does not reflect what will happen in the future or the costs of changing health care demands • Ceilings based on historic trends and not on projected need does not support effective allocation of resources	• There should be an effort to move towards a needs-based budgeting process at all levels of the sector • District and facility budget management and capacity should be re-explored to give more flexibility to reallocate across budget line items and health programmes

3. Service delivery duplications

Despite the referral system that is in place (blue arrows in Figure 1), there are no mechanisms to discourage self-referrals (red arrows in Figure 1) to the national or regional hospitals. By doing so, multiple levels of care provide the same services and quality coverage of key services are compromised. Furthermore, there is little coordination between programmes regarding the continuum of care for people living with HIV (PLHIV), sexually transmitted infections (STIs), TB, and MNCH, even though co-morbidities exist.

FIGURE 1. REGULAR AND ALTERNATIVE PATIENT PATHWAYS IN THE BHUTAN PUBLIC HEALTH SYSTEM



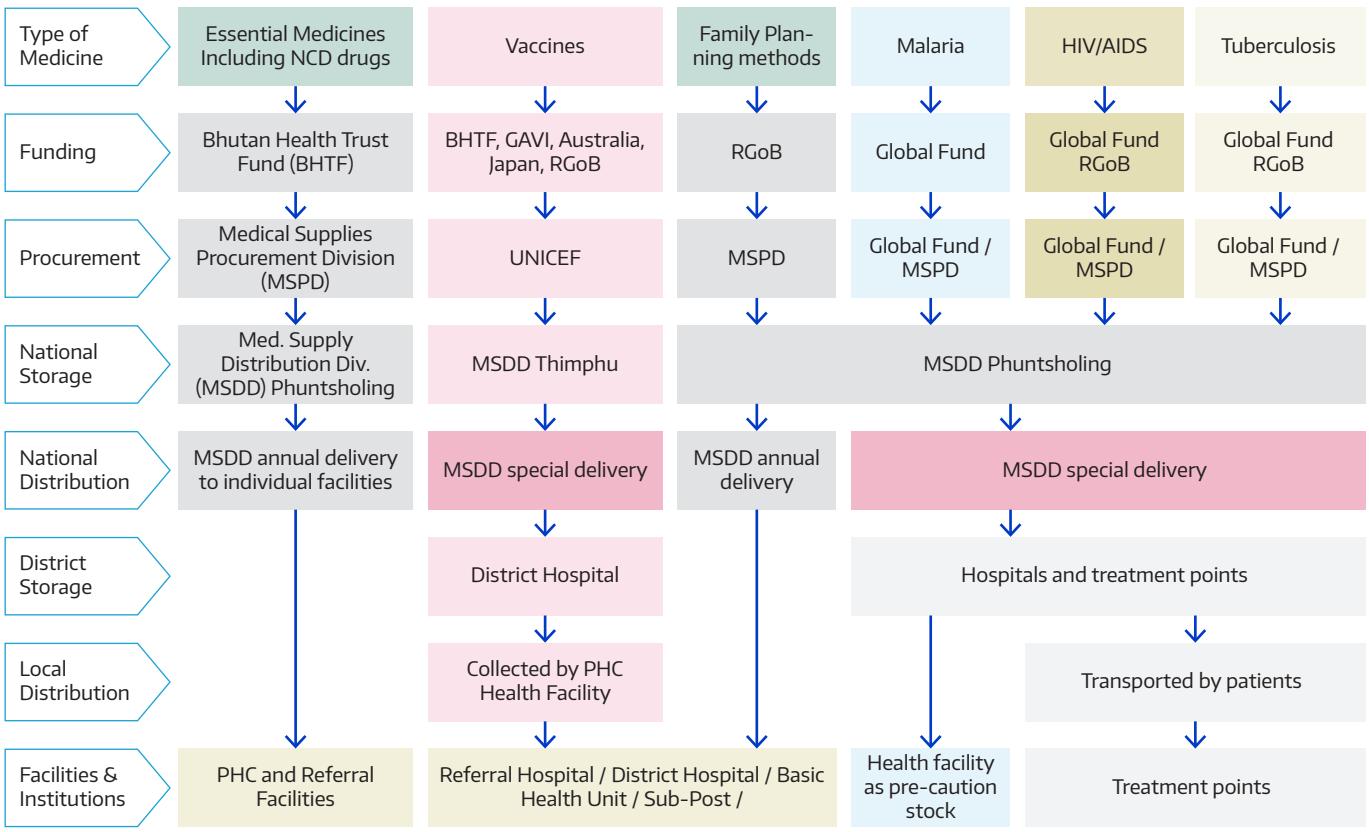
IMPLICATIONS	POLICY OPTIONS
• Lack of gatekeeping and referral system has created many overlaps and duplications of services across levels of care and an overburdened national referral hospital • Coordination challenges across disease programmes create inefficiency with patient pathways, and many patients living with co-morbidities face the risk of loss to follow-up • Constrains the quality of care upper-level facilities are able to provide due to patient overcrowding	• Reassess the current referral system and develop strategies to curb efficient "gate-keeping" mechanisms to reduce referral bypass • Capacity building at lower facility levels for emerging disease programmes (e.g., look into possibility of Basic Health Unit Health Assistants (HA's) diagnosing, prescribing, and managing NCD patients)

4. Disjointed supply chain

Fragmented donor financing has contributed to duplicative efforts with respect to procurement, storage, and distribution of medicines and supplies as shown in Figure 2. Facilities need to manage different submissions for quantification and reporting to the central level, while also managing different expected deliveries of supplies.

IMPLICATIONS	POLICY OPTIONS
• Many duplicative efforts at the central level due to the fragmented procurement and supply chain system • Places larger and unnecessary burden on health facility to manage different deliveries and quantification • Potential risk of expired medicines when there is one delivery per year	• There should be efforts put into rationalizing and integrating supply chain and procurement into a more centralized system as donor funding decreases. This system should be coordinated across programmes.

FIGURE 2. BHUTAN FINANCING, PROCUREMENT, AND SUPPLY CHAIN MANAGEMENT



LEGEND:

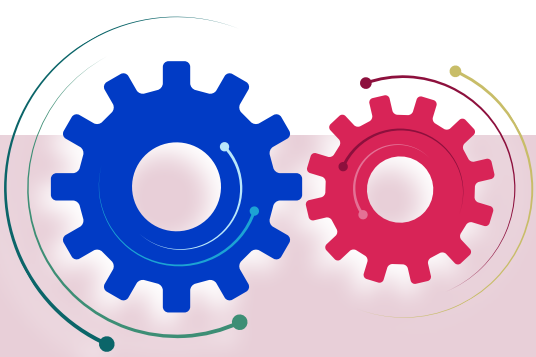
BHTF:	Bhutan Health Trust Fund
MSDD:	Medical Supply Distribution Division
MSPD:	Medical Supplies Procurement Division
NCD:	Non-Communicable Diseases
PHC:	Primary Health Care
RGoB:	Royal Government of Bhutan

= Essential drugs, family planning, and laboratory chemicals
= Government
= MSDD special delivery
= Regular distribution sites
= Vaccines
= Malaria Programme
= HIV/AIDS Programme
= Tuberculosis Programme
= Special Programme delivery and drug management

5. Fragmented & underutilized information system

A high reporting burden is placed on facilities, which is compounded by the fragmented health programme information and reporting systems. Data generated are not analysed or used effectively at all levels of the health system in terms of decision making and planning. Additionally, there is limited capacity at all levels to analyse data strategically, which further contributes to this identified area of concern.

IMPLICATIONS	POLICY OPTIONS
• Data collected by programme is not collated into actionable information and some programmes reported that they do not trust the collected numbers • Mix of data scarcity and quality at all levels • Overabundance of data that is not used to inform decision-making or planning • High administrative burden	• Data analysis capacity should be strengthened at all levels of the health system • Investigate and improve the data quality to make it more trustable • Build capacity for a consolidated and coordinated information system



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