NATIONAL HEALTH ACCOUNTS

(For financial year 2020/21, 2021/22, and 2022/23)

Ministry of Health
Royal Government of Bhutan

2025

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FOREWORD

The National Health Accounts (NHA) of Bhutan for the financial years 2020/21, 2021/22, and 2022/23 represent a significant effort to systematically track health financing flows within the country. The NHA exercise was conducted using the World Health Organization's System of Health Accounts 2011 (SHA 2011) framework and the Health Accounts Production Tool (HAPT). This report presents a comprehensive assessment of how health resources were mobilized, allocated, and utilized across Bhutan's health system during these three fiscal years.

The NHA serves as a vital tool, offering valuable insights into public and private health expenditures, sources of funding, and the distribution of resources across various health functions and service providers. The SHA 2011 methodology ensures alignment with international standards, enabling Bhutan to benchmark its health financing performance against regional and global peers.

The years covered by this report—2020/21 to 2022/23—were marked by unprecedented challenges brought about by the COVID-19 pandemic, which disrupted health service delivery and financing worldwide. However, Bhutan experienced minimal disruption in the delivery of essential health services during this period, demonstrating the resilience of its health system. This report captures the shifts in health spending patterns, including emergency responses and adjustments in health budget allocations to meet the demands of the pandemic.

By analyzing these trends, policymakers are better equipped to understand the strengths and vulnerabilities of Bhutan's health financing system and to identify opportunities for enhancing health security and sustainability.

We express our sincere gratitude to the Ministry of Finance and all key stakeholders for their valuable collaboration in the data collection and validation processes. We also extend special thanks to the World Health Organization (WHO) for their technical expertise and financial support in the development of this report.

We hope that the findings of this NHA will inform strategic planning, promote efficient resource allocation, and guide future investments in Bhutan's health sector. As we move forward, maintaining robust health financing mechanisms will be crucial to ensuring equitable and high-quality healthcare for all Bhutanese citizens.

(Kinga Jamphel)
Director General
Department of Health Services
Ministry of Health

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Lastly, we acknowledge Mr. Chana Singye from the Health Promotion and Risk Communication Division for his valuable support in the design and layout of this report.

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Abbreviations

ADB	Asian Development Bank
BDBL	Bhutan Development Bank Ltd.
BHTF	Bhutan Health Trust Fund
BHU	Basic Health Unit
BLSS	Bhutan Living Standard Survey
BNBL	Bhutan National Bank Ltd.
BOBL	Bank of Bhutan Ltd.
CDCL	Construction Development Corporation Ltd.
CFC	Consumption of Fixed Capital
CHE	Current Health Expenditures
CSO	Civil Society organization
DHI	Druk Holding and Investment
DIS	WHO classification of diseases and conditions
FP	Factors of provision
FS.RI	Financing Sources Related Institutions
FCBL	Food Corporation of Bhutan Ltd.
FY	Financial years
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
GHED	Global Health Expenditure Database
GNH	Gross National Happiness
HAPT	Health Account Production Tools
HC	Health Care Functions
HF	Health Financing Schemes
HFD	Health Financing Division
HMIS	Health Management Information System

HP	Healthcare Provider
ICD	International Classification of Diseases and Conditions
ICU	Intensive Care Units
JAB	Journalist Association of Bhutan
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
MoH	Ministry of Health
NCD	Non-Communicable Disease
NGO	Non Governmental Organization
Nu	Bhutan Ngultrum (Bhutan currency)
NHA	National Health Accounts
NPPF	National Pension & Provident Fund
NPRP	National Preparedness and Response Plan
NRDCL	Natural Resource Development Corporation Ltd.
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket
OTC	Over-the counter
RICBL	Royal Insurance Corporation of Bhutan Limited
STCBL	State Trading Corporation of Bhutan Ltd.
SEAR	South East Asian Region
SHA	System of Health Accounts
SNA	System of National Accounts
THE	Total Health Expenditures
UHC	Universal Health Coverage
WB	The World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

The National Health Accounts (NHA) of Bhutan provide a comprehensive analysis of health financing in the country, tracking expenditures and resource flows within the health sector. The latest report covers the financial years (FY) 2020/21, 2021/22, and 2022/23, offering insights into government spending, household out-of-pocket (OOP) expenses, development assistance, and private sector contributions.

The NHA exercise follows the World Health Organization's System of Health Accounts, ensuring standardized reporting and transparency in health financing. The findings support evidence-based decision-making, helping policymakers allocate resources efficiently and work toward Bhutan's goal of Universal Health Coverage (UHC). The findings of the NHA are also extensively used in formulating the 13th Five-Year Plan of the health sector.

As Bhutan grapples with rising healthcare expenditure and challenges around sustainable health financing, the NHA reports play a critical part in tracking health expenditure and in assessing if the desired impact is met through the expended resources. The NHA is essential for generating indicators for reporting at the international level and to draw the required comparative assessments.

Despite challenges such as the COVID-19 pandemic, the Ministry of Health (MoH) successfully conducted the NHA with technical and financial support from the World Health Organization (WHO). Extensive consultations with government agencies, corporations, and development partners ensured accurate data collection and analysis.

The report for the three FYs outlines that the Royal Government of Bhutan is still a predominant source for health expenditure, accounting for the largest share of the total current health expenditure and assessing whether the desire impact was achieved through the resources spent, followed by households and the funds channeled in through the development partners.

The total Current Health Expenditure (CHE) declined in FY 2021/22 compared to FY 2020/21, followed by a sharp increase in FY 2022/23 over

the course of the three FYs, with the highest in FY 2022/23 amounting to Nu. 9,414 million, highlighting growing fiscal pressure on the health system on the rising financial burden of healthcare. The total CHE for 2021/2022 was Nu 6,091 million, and for the year 2020/2021, it was Nu 6,741 million.

Total health expenditure as a percentage of GDP has increased over the course of the three financial years, with the highest being 8.29 percent for FY 2022/2023. For the year 2021/2022, the total health expenditure as a percent of GDP was 4.42 percent, and for the year 2020/2021, it was 4.35 percent.

1. BACKGROUND

The first National Health Accounts (NHA) study in Bhutan was conducted in 2011, covering the fiscal year 2009/10. Subsequent NHA exercises were carried out by the Ministry of Health for the fiscal years 2011/12 and 2012–13, followed by studies for 2014/15, 2015/16, and later for 2018/19 and 2019/20. The Ministry of Health's continued efforts in producing National Health Accounts (NHA) reports over the years underscore the critical role these reports play in strengthening and improving the health system.

In July 2023, a basic training for the new Health Accounts (HA) team was conducted in Thimphu to prepare for the current edition of the report. The data collection for the updates started in November 2023. The current NHA provides a detailed analysis of health financing, including government spending, household out-of-pocket (OOP) expenses, and revenue garnered through development assistance. Furthermore, the current NHA provides the CHE for the three FYs classified by disease, gender, healthcare functions (HC), healthcare providers (HP), and factors of provision (FP). For Bhutan, a country committed to providing free basic healthcare, NHA is particularly crucial in ensuring fiscal sustainability while maintaining equitable access to quality health services.

The NHA serves as a vital framework for systematically tracking health financing flows within a country, offering critical insights into how resources are mobilized, allocated, and utilized in the health sector. This report presents the NHA findings for Bhutan for the financial years 2020/21, 2021/22, and 2022/23, providing a comprehensive analysis of health expenditures by funding sources, services, and providers.

The NHA is instrumental in monitoring health spending patterns to ensure efficient and equitable allocation of resources, informing evidence-based policymaking for sustainable financing and Universal Health Coverage (UHC), enhancing transparency and accountability in health investments, and benchmarking Bhutan's performance against regional and global standards.

In the context of health financing, NHA plays a pivotal role in shaping national health policies and strategies. It helps identify funding gaps and inefficiencies in service delivery, track progress toward health financing targets such as Sustainable Development Goal 3 (Good Health and Well-being) and UHC, and assess financial risk protection to minimize out-of-pocket health expenditures. Furthermore, it contributes to strengthening pandemic preparedness and response by analyzing emergency health spending, as demonstrated during the COVID-19 pandemic.

1.1. Key Features of the NHA Report

1.1.1 Alignment with WHO's System of Health Accounts (SHA 2011) Framework
This report follows the World Health Organization's System of Health Accounts 2011 (SHA 2011), a globally standardized framework for tracking health expenditures. The SHA 2011 methodology enables international comparability of health financing data, provides a structured classification of expenditures by financing schemes, health care functions, and service providers, and facilitates integration with the Health Accounts Production Tool (HAPT) to ensure methodological consistency and accuracy.
1.1.2 International Best Practices and Bhutan's Commitment

Bhutan's NHA adheres to global best practices in health financing analysis, characterized by strong multi-stakeholder collaboration among government agencies, development partners, and health institutions, as well as the use of digital tools and real-time data to enhance the accuracy and timeliness of health accounts compilation.

By institutionalizing the NHA process, Bhutan reaffirms its commitment to transparent, efficient, and equitable health financing, core principles essential for achieving the nation's health development goals. This report serves as a valuable resource for policymakers, health planners, and development partners, providing the evidence base needed to make informed decisions and strengthen Bhutan's health system in the face of emerging and future challenges.

1.2. Health Care Financing System in Bhutan

As outlined in Article 9, Section 21 of the Constitution of the Kingdom of Bhutan, the healthcare financing system in Bhutan is publicly funded through taxes and supported by the Bhutan Health Trust Fund (BHTF). The country provides free basic public healthcare services in both allopathic and traditional medicine, with a strong emphasis on universal equity and access, grounded in the principles of primary health care. While government revenue and donor contributions are the main sources of funding, household out-of-pocket (OOP) expenditures still represent a form of health financing for certain groups, despite the provision of free healthcare services. Further, due to the country's free healthcare system, health insurance has not gained popularity.

Under the visionary leadership of the Monarchs, BHTF was established in 2001 to help finance a portion of the country's essential medicines and vaccines. Governed by an executive board of directors chaired by the Hon'ble Health Minister, BHTF secures its resources through donations, contributions, interest from bank deposits, and investments in shares and bonds. It plays a critical role in funding the procurement of essential medicines and vaccines for the country's free healthcare services.

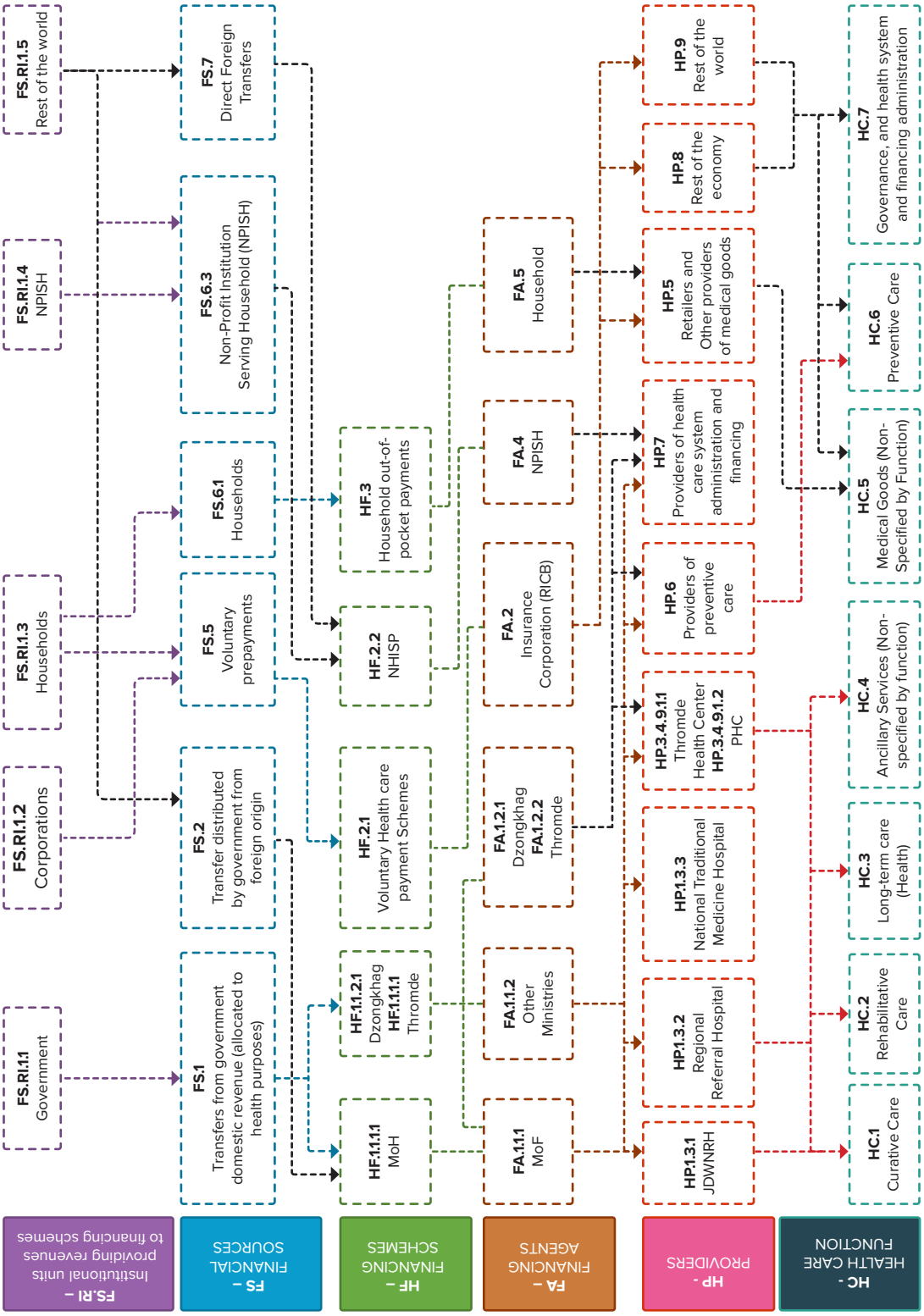

Figure 1: Fund Flow Mechanisms for Health in Bhutan

Figure 1 illustrates the flow of funds from the Ministry of Finance (MoF), individuals, development partners, including the Bhutan Health Trust Fund (BHTF), and employers to the service providers. The flow of funds from MoF to the public health facilities is channeled through the financial intermediaries: the Ministry of Health (MoH), JDWNRH, and local government administration. Purchasing of public health services is carried out by the MoF through line-item budgets, based on historical trends and proposals from the MoH and Health Facilities. The only voluntary private health insurance firm, Royal Insurance Corporation of Bhutan Ltd (RICB), usually reimburses the patients. Households also pay directly for availing services from the private pharmacies, private diagnostic centers, services availed during the special consultation service from JDWNRH, and for availing cabin services, certain dental care services, privately paid health services from overseas clinics and hospitals, and traditional Rimdro/Puja activities. Employers either purchase insurance premiums for their employees, reimburse the health expenditure of their employees, or maintain their health centers. Few Non-Governmental Organizations (NGOs) also receive grants from the government or development partners for the delivery of health-related activities. There are hospitals and clinics financed and managed by the Indian Military Training Team (IMTRAT) and Project DANTAK, which are based in Bhutan. These hospitals provide health services to Bhutanese in addition to their employees.

1.3. Impact of COVID-19 on Health Financing

The impact of COVID-19 on health financing in Bhutan was significant, given the country's commitment to providing free healthcare to all its citizens. However, it also served as an important lesson in the need for resilient health financing, especially in a resource-constrained country like Bhutan.

2. METHODOLOGY

The NHA exercise was carried out using the System of Health Accounts 2011 (SHA 2011) guidelines. The data was analyzed using the Health Account Production Tool (HAPT) (V4.0.0.6).

2.1. Financial Years and Classification

This study covers three fiscal years: 2020/21, 2021/22, and 2022/23. Bhutan follows the June to July financial year cycle. In line with the SHA 2011 guideline, 13 financial classifications were chosen for the exercise. These include:

1. Institutional Units Providing Revenues to Financial Schemes - FS.RI
2. Revenues of Health Care Financing Schemes - FS
3. Financing Schemes - HF
4. Financing Agents - HA
5. Health Care Providers - (HP)
6. Health Care Functions - HC
7. Factors of Health Care Provision - FP
8. Sub-National - SNL
9. Age - AGE
10. Gender - GENDER
11. Classification of diseases/conditions - DIS
12. Capital Account - HK
13. Traditional Complementary and Alternative Medicine (TCAM)

2.2. Data Sources

Table 1: List of agencies for NHA data collection sources (FY 2020/21, 2021/22, 2022/23)

Sl#	DHIs	Corporate/ Private	CSOs	Development partners
1.	BPC	Bhutan Livestock Development Corporation Limited	Bhutan Cancer Society	WHO
2.	Bhutan Telecom Ltd.		Lhak-Sam	UNDP
3.	CDCL		Disabled People's Organization of Bhutan	UNFPA
4.	Dungsam Cement Corporation Limited		Draktsho Vocational Training Centre for Special Children and Youth.	SNV

Sl#	DHIs	Corporate/ Private	CSOs	Development partners
5.	STCBL			ADB
6.	Druk Air			JICA
7.	NRDCL			SAARC Development Fund
8.	Menjong Sorig Pharmaceuticals Corporation Limited.			
9.	BDBL			

** From the Ministry of Finance: Income and expenditure report for MoH (department-wise, JDWNRH and LGs 20 districts).*

2.3. Data Collection

The data collection for NHA started from October 2023 until January 2024.

2.4. Data Processing and Import

The healthcare expenditure data were sorted and cleaned using the Excel sheet. Under each expenditure line, qualitative information is required for recognizing the membership in respective classification categories, and codes related to FSRI, FS, HF, FA, HP, HC, FP, HK, DIS, and SNL were also entered. In addition, special coding columns were maintained to facilitate the repeat mapping procedures, where relevant. Once processed, double-checking for coding consistencies was carried out, and then these data files were imported into NHA 2021, 2022, and 2023 HAPT under relevant data sources and actors. The total expenditures and other descriptive data related to Donor, NGO, Employer, Insurance, and Household were organized in the Excel sheets and imported as the secondary data. None of the expenditure data were collected using the survey form of HAPT. All the data were imported to the HAPT tool for analysis.

2.5. Application of SHA 2011 and HAPT Tool

SHA 2011 is a collection of standards, definitions, and guidelines for producing NHAs. SHA 2011 facilitates the production of comparable health accounts across countries and between different periods in the same country. SHA 2011 principles comprise three dimensions: consumer interface, provider

interface, and financing interface. HAPT is a public domain Windows-based software program used to systematically digitalize health account details and produce various health account reports. HAPT is designed to be used with SHA 2011 guidelines and has built-in classifications that can be customized to represent specific country contexts. Users of HAPT can determine the classifications to be used in the country and identify data sources. Data from various sources can be gathered, processed, and entered into the HAPT. This will enable a process called "mapping" to collate these data by different SHA classification characteristics. Successful completion of mapping allows the creation of tables and graphs related to health accounts. This is the fourth NHA study conducted in the country using SHA 2011 guidelines. Similar NHA studies have been done previously for FYs 2014/15 & 2015/16 and FYs 2016/17 & 2017/18 and 2018/19 & 2019/20.

2.6. Data Mapping and Categorization

Data mapping and categorization of the NHA of Bhutan involves organizing expenditure data into internationally recognized classifications, typically based on the SHA 2011 framework developed by the Organisation for Economic Co-operation and Development (OECD) and WHO. The nature of data record arrangement in the government health system enabled the identification and direct coding of FSRI, FS, and HF, FA, FP, and HP classifications in most expenditure files. Mapping of HC, SNL, and disease classifications was carried out using disease keys derived based on morbidity statistics. The morbidity data were available for each government institution separately, and they were disaggregated by dzongkhag, type of institution, type of care within an institution (inpatient, outpatient, and preventive), age, sex, and disease.

Household expenditure data for FY 2020/21, FY 2021/22, and FY 2022/23 were estimated by forecasting these amounts based on the Bhutan Living Standard Survey (BLSS) survey data in 2022. Initially, outpatient, delivery, and inpatient per capita health expenditures incurred by Bhutanese people in 2022 were estimated. The estimates for future years were obtained by calculating the respective national estimates based on the per capita expenditures (inflated for annual inflation) and estimated national populations. BLSS survey data also included data on background variables

such as age, sex, etc., so that adequate filtration of estimates could be carried out when finding out the percentages of the relevant cost required for creating age- and gender-related distribution keys. Data also provided provider information and healthcare function so that distribution keys for HP, HC, and DIS classifications could be derived.

Donor data were mainly retrieved from the government expenditure reports. Donor data was also supplemented by the reports directly obtained from the donor database. These records contained adequate information to identify FSRI, FS, HF, FA, FP, and HC classifications. In some cases of donor expenditures related to preventive care, SNL, age, and gender coding were not available. Hence, it was assumed that these funds for which data were not available were mostly aimed at overall population preventive work. Hence, they were mapped using distribution keys created based on national population characteristics. Coding for FSRI, FS, HF, and FA for employer data was implied from the nature of the information. No details on coding related to FP, HC, and HP classifications were available. Therefore, they were coded into respective unidentified categories. The overall distribution keys derived from the SNL, age, gender, and disease cost distributions of government data were used for coding employer data on SNL, age, gender, and disease classifications. It was assumed that SNL, age, gender, and disease patterns among employees who fall ill would also be similar to the normal population, who fall ill.

2.7. Data Validation, Triangulation, and Report Production

After following the above estimation techniques, data file preparations, data entering activities, and mapping, the NHA accounts were generated in the HAPT. Then data files imported in the HAPT were perused to check for completeness of data under all actors of the health financing system. The data maps of each data source were checked for completeness to ensure all entered files were mapped. The preliminary results were validated for consistency and accuracy, after which a report was produced.

3. KEY FINDING, INTERPRETATION, AND POLICY IMPLICATION

3.1. Overall Health Expenditure Trends (FY 2020–21 to 2022–23)

The total health expenditure (CHE and CF) was approximately Nu. 8,901 million in FY 2020/2021, Nu. 10,065 million in FY 2021/2022, and Nu. 20,670 million in FY 2022/2023. Correspondingly, these expenditures represented 4.35 percent, 4.42 percent, and 8.29 percent of Gross Domestic Product (GDP). The estimates incorporated the health-related expenditures incurred by the government, corporate sector, and households, as well as the consumption of capital assets within the government health system.

Current Health Expenditure (CHE) showed an overall increasing trend over the recent years, especially the last two fiscal years, reaching its highest level at Nu. 9,414 million in FY 2022/2023. Such an increase reiterates the government's growing concern regarding the rising financial burden of healthcare.

In terms of public financing, the share of CHE borne by the Royal Government of Bhutan (RGoB) accounted for 2.19 percent of GDP in FY 2020/2021 and 1.93 percent in FY 2021/2022, before increasing to 3.04 percent of GDP in FY 2022/2023.

3.2. Current Health Expenditure (CHE) and Capital Formation

The total CHE for the FY 2020/2021, 2021/2022, and 2022/23 were Nu. 6,741 million, Nu. 6,091 million, and Nu. 9,414 million, respectively. The total current health expenditure has substantially increased in FY 2022–2023, showing an increase of 54 percent from the previous FY. In parallel, the capital formation for FY 2020/2021, 2021/2022, and 2022/23 was estimated at Nu. 2,160 million, 3,974 million, and 11,256 million, respectively. This sharp increase in capital financing could be a result of major infrastructure investments in FY 22/23, namely the eastern Bhutan MCH, GJPMCH, and the construction of satellite clinics in Thimphu and Phuntsholing.

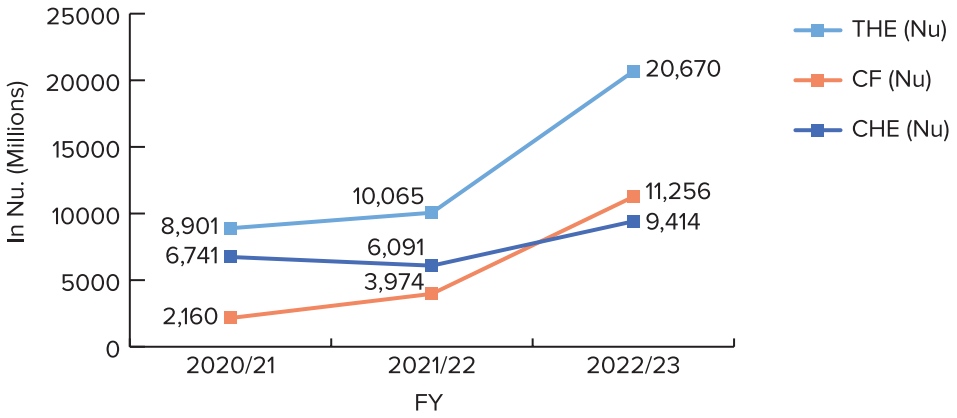

Figure 2: Trends in CHE, CF and THE in Bhutan FY 2020/21 to FY 2022/23

3.3. Health Expenditure as a Percentage of GDP

The CHE from the RGOB as a percentage of GDP was 2.19 percent in 2020/2021, 1.93 percent in FY 2021/2022, and 3.04 percent in FY 2022/2023, and the total health expenditures (CHE+CF) were 4.35 percent, 4.42 percent, and 8.29 percent of GDP in 2020/2021, 2021/22, and 2022/23, respectively, as given in Table 2. The WHO recommends that at least 5% of a nation's GDP must be allocated to health to make realistic progress towards achieving the UHC goals.

Table 2: GDP, Health Expenditure Types, and their relative sizes in relation to GDP in FY 2020/21, FY 2021-22, and FY 2022-23

Indicator	FY 2020/2021	FY 2021/2022	FY 2022/2023
GDP (Nu)	204,664	227,810	249,388
CHE (Nu)	6741	6091	9,414
CHE RGoB (Nu)	4481	4,389	7,574
CF (Nu)	2160	3,974	11,256
Total (CHE + CF)	8,901	10,065	20,670
CHE as % of GDP	3.29%	2.67%	3.77%
CHE RGoB as % of GDP	2.19%	1.93%	3.04%
Total (CHE+CF) as % of GDP	4.35%	4.42%	8.29%

3.4. Per Capita Health Expenditure Trends

In Table 3, per capita health expenditure shows an increase over the three fiscal years, despite a slight decline in per capita CHE between FY 2020/21 and FY 2021/22. Per capita CHE rose from Nu. 8,915 in FY 2020/21

to Nu. 12,222 in FY 2022/23, while per capita CHE financed by the Royal Government of Bhutan increased from Nu. 5,926 to Nu. 9,833 over the same period.

Similarly, the per capita capital formation (CF), which increased from Nu. 2,857 in FY 2020/21 to Nu. 14,613 in FY 2022/23, indicates significant investment in health infrastructure and capital assets. Consequently, total per capita health expenditure (CHE + CF) more than doubled, rising from Nu. 11,772 in FY 2020/21 to Nu. 26,835 in FY 2022/23. Overall, the trend indicates a marked increase in per capita health spending, driven largely by higher capital investments in the health sector.

Table 3: Per capita Health Expenditure During FY 2020/21 till FY 2022/2023

Indicator	FY 2020/21	FY 2021/22	FY 2022/23
Per capita CHE (Nu)	8,915	7,980	12,222
Per capita CHE RGoB (Nu)	5,926	5,750	9,833
Per capita CF (Nu)	2,857	5,207	14,613
Per capita Total (CHE+CF)	11,772	13,187	26,835

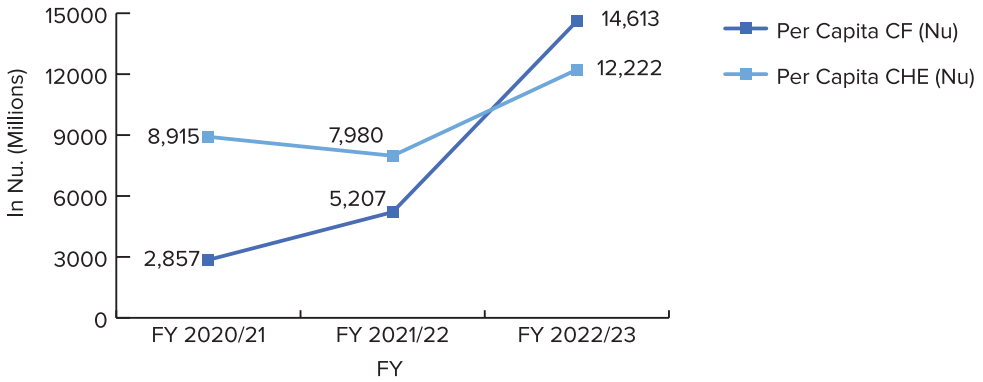

Figure 3: Per-capita CHE and CF from FY 2020/21 to FY 2022/23 (Nu)

Figure 3 shows the trend in per capita current health expenditure (CHE) and capital formation (CF) from FY 2014/15 to FY 2022/23. Per capita CHE showed a gradual increase from Nu. 6,053 in FY 2014/15 to a peak of about Nu. 10,223 in FY 2019/20, followed by a decline in FY 2020/21 and FY 2021/22, likely reflecting fiscal constraints during the COVID-19 period. In FY 2022/23, per capita CHE rebounded sharply to Nu. 12,222 exceeding pre-pandemic levels.

On the other hand, per capita CF remained relatively low and stable up to FY 2019/20, fluctuating between Nu. 933 and Nu. 1,761, indicating limited capital investment in earlier years. From FY 2020/21 onwards, CF increases, rising to Nu. 2,857 in FY 2020/21, and surging to Nu. 14,613 in FY 2022/23 given the huge investment into the construction of Gyaltsuen Jetsun Pema Wangchuck Mother and Child Health Hospital in Thimphu.

3.5. CHE by Consumer Interface

This section presents the CHEs disaggregated by healthcare functions, age, gender, disease and geographical distribution in the three financial years: FY 2020/2021, 2021/22, and 2022/23

3.5.1 CHE by Health Care Functions (Consumer Interface)

Current Health Expenditure (CHE) is disaggregated by healthcare functions to reflect specific needs, including curative care, preventive care, long-term care, and governance and health system administration. The sub-constituents of the broader thematic areas with which healthcare functions are categorized can be examined in table 4.

As detailed in Figure 4 and Table 4, curative care—which includes hospital administration costs—consistently accounted for the largest share of CHE across all three fiscal years. Governance and health system financing represented the second-largest expenditure, followed by preventive care. Spending on preventive care stood at 16.84 percent, 14.71 percent, and 8.95 percent, respectively; these figures remain significantly below the ministry's strategic target of increasing preventive care spending to 30 percent of CHE.

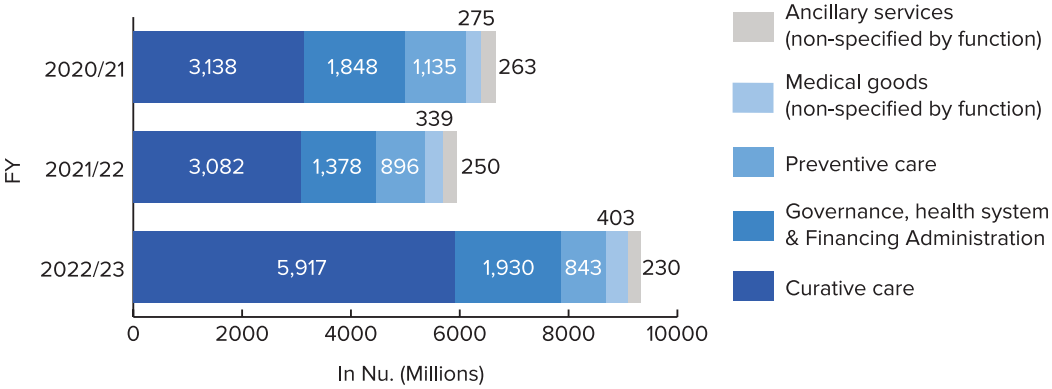

Figure 4: Distribution of CHE in the last three FYs by Healthcare Function

Table 4: Distribution of Amount (Nu.) and % of CHE in 2020/21, 2021/22, and 2022/23 by Healthcare Functions

Health care functions				2020/21		2021/22		2022/23	
				Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
HC.1			Curative care	3138	46.55	3082	50.60	5917	62.85
	HC.1.1		Inpatient curative care	2226	70.93	2558	82.99	5225	88.30
		HC.1.1.1	General inpatient curative care	338	15.18	674	26.35	827	15.83
		HC.1.1.2	Specialized inpatient curative care	1748	78.53	1712	66.93	4152	79.46
		HC.1.1.nec	Unspecified inpatient curative care (n.e.c.)	140	6.29	172	6.72	246	4.71
	HC.1.3		Outpatient curative care	903	28.78	518	16.81	639	10.80
		HC.1.3.1	General outpatient curative care	760	84.16	355	68.53	488	76.37
		HC.1.3.2	Dental outpatient curative care	10	1.11	13	2.51	16	2.50
		HC.1.3.3	Specialized outpatient curative care	69	7.64	71	13.71	41	6.42
		HC.1.3.nec	Unspecified curative care (n.e.c.)	64	7.09	79	15.25	94	14.71
	HC.1.nec		Unspecified curative care (n.e.c.)	9	0.29	6	0.20	52	0.90
HC.3			Long-term care (health)	10	0.15	13	0.21	15	0.16
	HC.3.3		Outpatient int-term care (health)	10	100	13	100	15	100
HC.4			Ancillary services (non-specified by function)	263	3.90	250	4.10	230	2.44

Health care functions				2020/21		2021/22		2022/23	
				Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
	HC.4.1		Laboratory services	131	49.80	87	34.8	38	16.52
	HC.4.3		Patients transportation	132	50.20	163	65.2	192	83.48
HC.5			Medical goods[1] (non-specified by function)	275	4.08	339	5.57	403	4.30
	HC.5.1		Pharmaceuticals and other medical non-durable goods	162	58.90	200	58.99	237	58.80
	HC.5.2		Therapeutic appliances and other medical goods	113	41.1	139	41.01%	166	41.20
HC.6			Preventive care	1135	16.84	896	14.71	843	8.95
	HC.6.1		Information, education and counselling (IEC) programmes	118	10.40	178	19.87	127	15.06
		HC.6.1.2	Nutrition IEC Programmes	00	00	9	10.34	00	00
		HC.6.1.nec	Other and unspecified IEC programmes (n.e.c.)	118	100	169	89.66	127	100
	HC.6.2		Immunization programmes	202	17.80	362	40.40	69	8.18
	HC.6.3		Early disease detection programmes	4	0.35	4	0.45	2	0.24
	HC.6.4		Healthy condition monitoring programmes	495	43.61	228	25.45	373	44.25

1 The expenditure estimates for medical goods in the Current Health Expenditure (CHE) by healthcare functions table do not align with the budget and expenditure report of the Ministry of Finance, as expenses related to medical goods incurred under inpatient (HC 1.1) and outpatient (HC 1.3) curative care are accounted for within those respective service categories.

Health care functions				2020/21		2021/22		2022/23	
				Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
	HC.6.5		Epidemiological surveillance and risk and disease control programmes	272	23.97	111	12.38	257	30.49
		HC.6.5.1	Planning & Management	16	5.88	00	00	00	00
		HC.6.5.2	Monitoring & Evaluation (M&E)	2	0.74	1	0.90	1	1.22
		HC.6.5.3	Procurement & supply management	34	12.5	2	1.80	00	00
		HC.6.5.nec	Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)	220	80.88	108	97.30	255	98.78
	HC.6.6		Preparing for disaster and emergency response programmes	30	2.64	00	00	00	00
	HC.6.nec		Unspecified prevention care (n.e.c.)	14	1.23	13	1.45	15	1.78
HC.7			Governance, health system, and financing administration	1848	27.41	1378	22.62	1930	20.50
	HC.7.1		Governance and health system administration	1848	97.00	1378	100	1930	100
	HC.7.2		Administration of health financing	72	1.07	133	2.19	76	0.80
HC.9			Other health care services not elsewhere classified (n.e.c.)	6741	100	6091	100	9414	100
			Total HC	**6741**	**100%**	**6091**	**100%**	**9414**	**100%**

3.6. CHE by Region

The CHE at dzongkhag levels was estimated by linking the healthcare cost to the place of expenditure. However, the cost for preventive interventions was determined by considering the specific geographical areas where the interventions were targeted. The cost of medical supplies centrally done was apportioned to the Dzongkhags based on the annual indent records of the respective facilities.

Thimphu consistently dominated the Western region, accounting for 79.12 percent, 86.65 percent, and 85.68 percent of the region's total Current Health Expenditure (CHE) over the 2020/21 to 2022/23 fiscal years. Similarly, Sarpang recorded the highest CHE shares in the Central region (48.19%, 44.56%, and 43.69%), while Mongar led the Eastern region (37.44%, 41.09%, and 36.90%). These spending concentrations directly correlate with the national health service delivery structure, as these districts host the country's three major referral hospitals: JDWNRH in Thimphu, CRRH in Sarpang, and ERRH in Mongar.

Table 5: CHE in FY 2020/21, 2021/22, and 2022/23 by Regions and Dzongkhags

Sub-National Level			2020/2021		2021/2022		2022/2023	
			Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
SNL. 1		Central Region	745	11.05	772	12.67	865	9.19
	SNL.1.1	Bumthang	24	3.22	27	3.49	80	9.25
	SNL.1.2	Dagana	108	14.49	111	14.39	109	12.60
	SNL.1.3	Sarpang	359	48.19	344	44.56	378	43.69
	SNL.1.4	Trongsa	76	10.20	83	10.75	80	9.25
	SNL 1.5	Tsirang	94	12.62	103	13.34	112	12.95
	SNL.1.6	Zhemgang	84	11.28	104	13.47	106	12.26
SNL.2		Eastern Region	828	12.28	584	9.59	824	8.76
	SNL.2.1	Lhuntse	57	6.88	62	10.62	61	7.40
	SNL.2.2	Mongar	310	37.44	240	41.09	304	36.90
	SNL.2.3	Pema Gatshel	94	11.35	102	17.47	62	7.52
	SNL.2.4	Samdrup Jongkhar	113	13.65	118	20.20	130	15.78
	SNL 2.5	Trashigang	178	21.50	46	7.88	206	25
	SNL.2.6	Tashi Yangtse	76	9.18	16	2.74	18	2.19
	SNL.2.nec	Other Eastern					43	5.21
SNL.3		Western Region	3789	56.21	4157	68.25	6898	73.27
	SNL.3.1	Chhukha	199	5.25	116	2.79	322	4.67
	SNL.3.2	Gasa	24	0.63	27	0.65	23	0.33
	SNL.3.3	Haa	22	0.58	22	0.52	22	0.31
	SNL.3.4	Paro	121	3.19	58	1.39	60	0.87
	SNL.3.5	Punakha	40	1.06	52	1.25	127	1.85

Sub-National Level			2020/2021		2021/2022		2022/2023	
			Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
	SNL.3.6	Samtse	209	5.52	83	1.99	231	3.35
	SNL.3.7	Thimphu	2998	79.12	3601	86.65	5910	85.68
	SNL.3.8	Wangdue	176	4.65	198	4.76	203	2.94
SNL.4		BHUTAN	1379	20.46	578	9.49	827	8.78
ALL SNL			**6741**	**100**	**6091**	**100**	**9414**	**100**

(Note: SNL.4—These are expenditure data where dzongkhag-level data are not available.)

3.7. CHE by Dzongkhag

Current Health Expenditure (CHE) across Dzongkhags is heavily concentrated in those with the national and regional referral hospitals, with Thimphu consistently accounting for the largest share throughout the FYs (55.91% in 2020/21, 65.34% in 2021/22, and 69.17% in 2022/23). Sarpang and Mongar followed as significant expenditure hubs, with Sarpang maintaining a share between 4.42 percent and 6.12 percent and Mongar ranging from 3.56 percent to 5.78 percent over the three fiscal years.

In stark contrast, Dzongkhags such as Gasa and Haa recorded some of the lowest expenditure shares in the country, with Gasa's share fluctuating between 0.27 percent and 0.45 percent and Haa remaining consistently low at 0.26 percent to 0.41 percent. While these distributions indicate the effect of factors such as population distribution, disease burden and case loads, a significant spending gap between urban referral centers and smaller, more remote districts also merits further assessments and due policy attention.

Table 6: CHE in FY 2020/21, 2021/22, and 2022/23 by Dzongkhags

Dzongkhag	2020/2021		2021/2022		2022/2023	
	Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
Bumthang	24	0.45	27	0.49	80	0.94
Dagana	108	2.01	111	2.01	109	1.28
Sarpang	359	6.70	344	6.24	378	4.42
Trongsa	76	1.42	83	1.51	80	0.94
Tsirang	94	1.75	103	1.87	112	1.31
Zhemgang	84	1.57	104	1.89	106	1.24
Lhuntse	57	1.06	62	1.12	61	0.71
Mongar	310	5.78	240	4.35	304	3.56
Pema Gatshel	94	1.75	102	1.85	62	0.73
Samdrup Jongkhar	113	2.11	118	2.14	130	1.52
Trashigang	178	3.32	46	0.83	206	2.41
Tashi Yangtse	76	1.42	16	0.27	18	0.21
Chhukha	199	3.71	116	2.10	322	3.77
Gasa	24	0.45	27	0.49	23	0.27
Haa	22	0.41	22	0.40	22	0.26

Dzongkhag	2020/2021		2021/2022		2022/2023	
	Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
Paro	121	2.26	58	1.05	60	0.70
Punakha	40	0.75	52	0.94	127	1.49
Samtse	209	3.90	83	1.51	231	2.70
Thimphu	2998	55.91	3601	65.34	5910	69.17
Wangdue	176	3.28	198	3.59	203	2.38
	5362	**100**	**5513**	**100**	**8544**	**100**

3.8. CHE by Provider Interface

This section presents the analysis of CHE by provider institutions and factors of provision.

3.8.1 CHE by Providers

The SHA 2011 has classified health care providers as hospitals (general and specialized), providers of ambulatory health services, retailers and other providers of medical goods, providers of preventive care, providers of health system administration and financing, and the rest of the economy. Figure 4 and table 7 present the disaggregation details of CHE in financial years 2020/2021, 2021/22, and 2022/23 by providers.

Hospitals consistently received the largest share of funding, although their proportion of the total CHE fluctuated from 44.86 and 46.02 percent in 2020/21 and 2021/22 to 48.76 percent in 2022/23. Within this category, a notable shift occurred as spending for specialized hospitals increased significantly, while general hospital expenditures declined from 31 percent to just 10 percent over the same period.

However, regardless of the dip in the spending on general hospitals, primary health centers (BHU II) within the general hospitals category experienced decline in their share of CHE, from 14.84 percent in 2020/21 to 12.44 percent by 2022/23, which aligns with the introduction of community-based initiatives such as SCCI, NCD screening initiatives, and other initiatives in the sphere of immunization and reproductive, maternal, and child health.

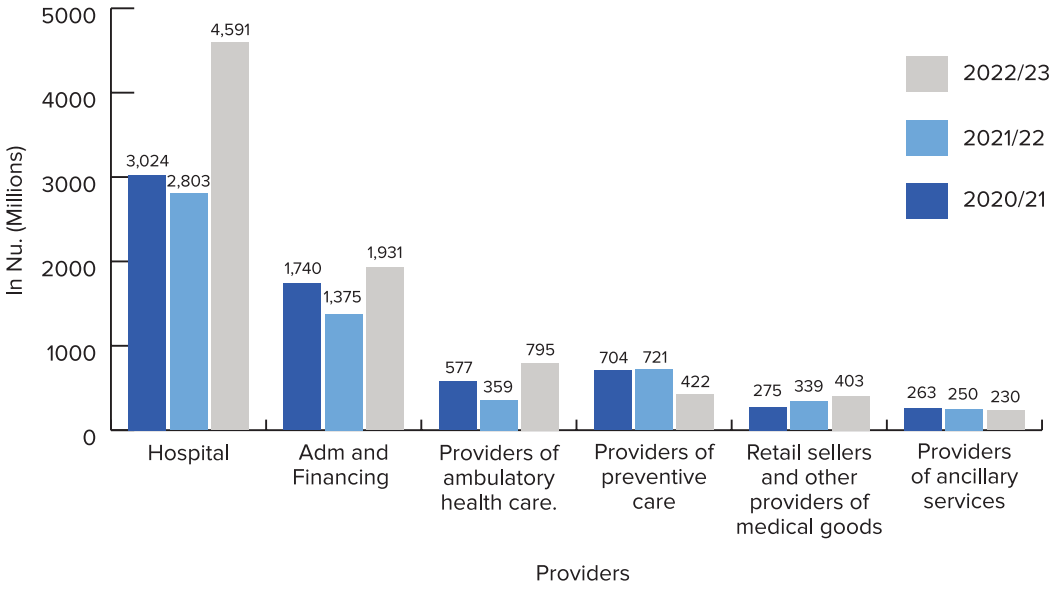

Figure 5: Distribution of CHE in FY 2020/21, 2021/22, and 2022/23 by Providers

Table 7: CHE in FY 2020/21, 2021/22, and 2022/23 by Healthcare Providers

Health care providers						2020/2021		2021/22		2022/23	
						Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
HP.1			Hospitals			3024	44.86	2803	46.02	4591	48.76
	HP.1.1		General hospitals			950	31.42	666	23.76	796	17.34
		HP.1.1.1	Dzongkhag hospitals		60-bedded	181	19.05	165	24.77	287	36.06
		HP.1.1.2			40-bedded	260	27.37	157	23.57	224	28.14
		HP.1.1.3			20-bedded	361	38	240	36.04	175	21.98
		HP.1.1.4			10-bedded PHC, Sub-post	141	14.84	95	14.27	99	12.44
		HP.1.1.nec	Other general hospitals			7	0.74	9	1.35	11	1.38
	HP.1.3		Specialized Hospitals		Specialized Hospital	2060	68.12	2124	75.78	3779	82.31
		HP.1.3.1	JDWNRH		National Referral Hospital	1491	72.38	1608	75.70	3129	82.80
		HP.1.3.2	RRH		Regional Referral Hospital	506	24.56	453	21.33	588	15.56
		HP.1.3.3			National Traditional Hospital	63	3.06	63	2.97	62	1.64
	HP.1.nec		Unspecified hospitals (nec)			14	0.46	13	0.46	16	0.35

Health care providers						2020/2021		2021/22		2022/23	
						Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
HP.3			Providers of ambulatory health care.			577	8.56	359	5.89	795	8.44
	HP.3.4				Ambulatory health care centers	576	100%	359	100	795	100
		HP.3.4.9			All other ambulatory centers	576	100%	359	100	795	100
			HP.3.4.9.1		Non-specialized ambulatory health care centres	566	98.26	347	96.66%	780	98.11
				HP.3.4.9.1.1	Thromde Health Centers	23	4.06	26	7.49	39	5.0
				HP.3.4.9.1.2	Primary Health Center (BHU II)	543	95.94	321	92.51	741	95
			HP.3.4.9.nec		Unspecified other ambulatory centres (n.e.c.)	10	1.74	12	3.34%	15	1.89
HP.4			Providers of ancillary services			263	3.90	250	4.10	230	2.44

Health care providers						2020/2021		2021/22		2022/23	
						Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
	HP.4.1		Providers of patient transportation and emergency rescue			132	50.20%	163	95.29	192	83.48
	HP.4.2		Medical and diagnostic center			131	49.80%	87	4.71	38	16.52
HP.5			Retail sellers and other providers of medical goods			275	4.09	339	5.57	403	4.28
	HP.5.1		Pharmacies			162	58.91%	200	59	237	58.80
	HP.5.2		Retail sellers and other suppliers of durable medical goods and medical appliances			113	41.09%	139	41	166	41.20
HP.6			Providers of preventive care			704	10.44	721	11.84	422	4.48
HP.7			Providers of healthy system administration & financing			1740	25.81	1375	22.57	1931	20.51

Health care providers						2020/2021		2021/22		2022/23	
						Amount (in million)	%	Amount (in million)	%	Amount (in million)	%
HP.8					Community health workers	1	0.01%	2	0.03	00	00
HP.9					Rest of the world	148	2.20%	230	3.78	1031	10.95
HP.nec			Unspecified health care providers			9	0.13%	12	0.20	13	0.14
All HP			**Total**			**6741**	**100%**	**6091**	**100**	**9414**	**100**

3.9. CHE by Factors of Provision

Disaggregation of CHE by factors of provision allows us to understand the distribution of current health expenses on various constituents of production. They include expenditure incurred for paying compensations for employees in the health system, cost of drugs and other medical goods, cost of non-health care services, and cost of consumption of fixed capital in the government health system. Table 7 presents the disaggregation details of CHE in the three financial years of the NHA by factors of provision.

The largest share of CHE in the FY 2020/21, 2021/22, and 2022/23 (69.85%, 63.47%, and 30.13% respectively), was spent on purchasing material and services related to health care. The second largest for the same FY share was attributed to the compensation of employees in the three financial years (30.15%, 36.48% and 65.87%).

Table 8: CHE in FY 2020/21, 2021/22, and 2022/23 by factors of health care provision

Factors of health care provision					2020/21		2021/22		2022/23	
					Amount	%	Amount	%	Amount	%
FP.1				Compensation of employees	2033	30.15	2222	36.48	6201	65.87
	FP.1.1			Wages and salaries	1695	83.37	1714	77.13	2771	44.69
	FP.1.2			Social contributions	47	2.31	207	9.31	10	0.16
	FP.1.3			All other costs related to employees..	291	14.32	301	13.56	3420	55.15
FP.3				Materials and service used	4709	69.85	3866	63.47	3213	30.13
	FP.3.1			Health care services	403	8.56	647	16.73	530	16.49
		FP.3.1.1		Laboratory & imaging services.	15	3.72	19	3	23	4.34
		FP.3.1.nec		Other health care services (n.e.c.)	388	96.28	628	97	507	95.66
	FP.3.2			Health care goods	916	19.45	1654	42.78	1251	38.94
		FP.3.2.1		Pharmaceuticals	769	83.95	1169	71	1039	83.05
			FP.3.2.1.nec	Other pharmaceuticals (n.e.c.)	756	98.31	1169	100	1033	99.42
			FP.3.2.1.4	Vaccines	13	1.69	0	0	6	0.58
		FP.3.2.2.nec		Other health care goods	147	16.05	485	29	212	16.95
	FP.3.3			Non-health care services	1675	35.57	889	23	835	25.99
		FP.3.3.1		Training	59	3.52	334	37.57	15	1.80
		FP.3.3.2		Technical Assistance	686	40.96	327	36.78	436	52.21
		FP.3.3.nec		Other non-health care services (n.e.c.)	930	55.52	228	25.65	384	45.99
	FP.3.4			Non-health care goods	889	18.88	332	8.59	223	6.94

Factors of health care provision					2020/21		2021/22		2022/23	
					Amount	%	Amount	%	Amount	%
	FP.3.nec			Other materials and services used (n.e.c.)	826	17.54	344	8.90	374	11.64
FP.5				Other items of spending on inputs	**0**	**0**	**3**	**0.05**	**0**	**00**
All FP			**Total**		**6741**	**100**	**6091**	**100**	**9414**	**100**

3.10. Financial Flows Related to CHE in Bhutan

Table 9: The financial flows related to current health expenditure in Bhutan..

Institutional units providing revenues to financing schemes [FS.RI]	Revenues of Financing Schemes [FS]	Health Financing Schemes [HF]	Financing Agents [FA]
Government	Internal transfers and grants	MOH Scheme	MOH
Rest of the world	Transfer from external origin		
		Dzongkhag Scheme	Dzongkhag Administration
Insurance	Voluntary prepayment	Voluntary health insurance scheme	Insurance corporations
Corporations	Revenue from corporation	Enterprise financing schemes	Corporations (Other than insurance corporations) (part of HF.RI.1.2)
Households	Revenue from household	Household out-of-pocket payment	Households
NPISH	Other revenue from NPISH	NPISH financing schemes (including development agencies)	Non-profit institution serving households (NPISH)
Rest of the world	Direct Foreign Transfers		

3.11. CHE by Institutional Unit Providing Revenues to Financing Schemes

Institutional Units Providing revenues to financing schemes refers to the different sources of funds that are allocated to and spent on health care services in the country. As evident from the following table, the government still is the predominant source of funds for providing health services in the country. The share of CHE that can be sourced to the government is 66.48 percent, 72.06 percent, and 80.45 percent for the FYs 2020/21, 2021/22, and 2022/23, respectively. Households provided 9.61 percent, 13.13 percent, and 10.08 percent of the total CHE for the three financial years. Donor contributions stood at 23.75 percent, 14.51 percent and 9.25 percent, with the multilateral donors playing a more significant role compared to bilateral donors.

Currently, government funding covers most of Bhutan's health spending, while donor contributions are declining. This shows strong national commitment to health and progress toward UHC but also means the government must take on more financial responsibility, especially after graduating from LDC status in 2023. With external support likely to become smaller and less predictable with the evolving international development landscape, there is a need to design result-based and impactful health plans, use resources efficiently, integrate donor-supported programs into domestic financing, and focus future external support on strengthening health systems architecture rather than routine service delivery.

Table 10: CHE in FY 2020/21, 2021/22, and 2022/23 by institutional units providing revenues to financing schemes

Institutional units providing revenues to financing schemes				2020/21		2021/22		2022/23	
				Amount	%	Amount	%	Amount	%
FS.RI.1.1			Government	4481	66.48	4389	72.06	7574	80.45
FS.RI.1.2			Corporations	8	0.12	9	0.15	11	0.11
FS.RI.1.3			Households	648	9.61	800	13.13	948	10.08
FS.RI.1.4			NPISH	3	0.04	9	0.15	10	0.11
FS.RI.1.5			Rest of the world	1601	23.75	884	14.51	871	9.25
	FS.RI.1.5.1		Bilateral donors	6	0.38	0	0	0	0
	FS.RI.1.5.2		Multilateral donors	1374	85.82	542	61.31	397	45.58
		FS.RI.1.5.2.4	ADB	686	49.93	1.	0	0	0
		FS.RI.1.5.2.7	GAVI	7	0.51	0	0	6	1.51
		FS.RI.1.5.2.8	Global Fund	52	3.78	50	9.23	26	6.55
		FS.RI.1.5.2.15	UNFPA	0	0	6	1.11	4	1.00
		FS.RI.1.5.2.16	UNICEF	0	0	12	2.21	21	5.30
		FS.RI.1.5.2.20	WHO	457	33.26	334	61.62	340	85.64
		FS.RI.1.5.2.24	COVAX Facility	0	0	140	25.83	0	0
		FS.RI.1.5.2.nec	Other & unspecified multilateral donors (n.e.c.)	172	12.52	0	0	0	0
	FS.RI.1.5.nec		Other & Unspecified multilateral donors (n.e.c.)	221	13.80	342	38.69	474	54.42
All FS.RI				**6741**	**100**	**6091**	**100**	**9414**	**100**

3.11.1 External vs. Domestic Financing Contributions

In both FY 2020/21 and FY 2022/23, government financing remained the dominant source of total revenues, accounting for 66.48 percent and 80.45 percent, respectively. The financing pattern, however, shifted markedly towards greater domestic public financing in FY 2022/23, reflecting an increased reliance on government resources.

Household contributions accounted for almost 10 percent of total revenues in FY 2020/21 and increased slightly to 10.08 percent in FY 2022/23. In contrast, the share from the Rest of the World declined sharply from 23.75 percent to 9.25 percent over the same period, indicating a reduced dependence on external funding and a stronger emphasis on domestically financed health spending, particularly through government sources.

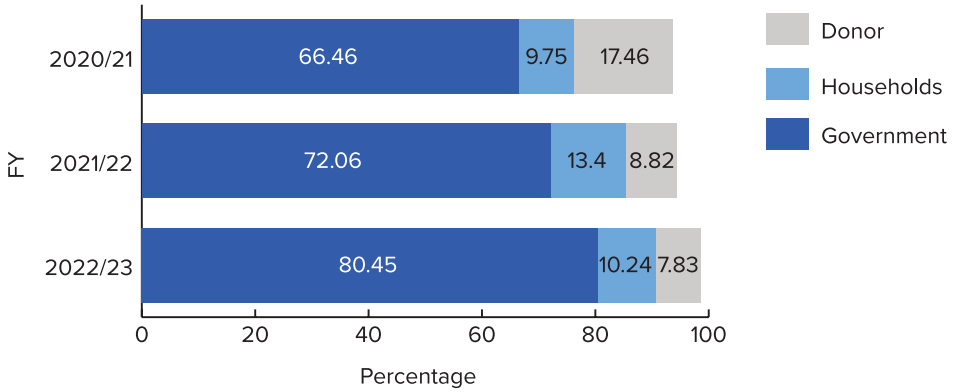

Figure 6: Share of CHE by Institutional units providing revenues to financing schemes from 2020-2023

3.12. CHE by Revenues of Health Care Financing Schemes

Driven by a strong constitutional commitment to public health, the primary financing mechanism for Current Health Expenditure (CHE) remains domestic government transfers, which accounted for 66 percent, 72 percent, and 80 percent of total revenue in fiscal years 2020/21, 2021/22, and 2022/23, respectively. The second-largest funding source was other domestic revenue—comprising households, corporations, and non-profit institutions—which contributed between 13 percent and 10 percent in FY 2021/22 and 2022/23 respectively. However, in FY 2020/21, direct foreign transfers accounted for a higher share of 17 percent.

Table 11: CHE in FY 2020/21, 2021/22, and 2022/23 by revenues of health care financing schemes

Revenues of health care financing schemes				2020/21		2021/22		2022/23	
				Amount	%	Amount	%	Amount	%
FS.1			Transfers from government domestic revenue (allocated to health purposes)	4480	66.46	4389	72.06	7574	80.45
	FS.1.1		Internal transfers and grants	4480	100	4389	100	7574	100
FS.2			Transfers distributed by government from foreign origin	424	6.29	345	5.67	133	1.41
FS.5			Voluntary prepayment	3	0.04	3	0.05	6	0.07
	FS.5.2		Voluntary prepayment from employers	3	100	3	100	6	100
FS.6			Other domestic revenues n.e.c	657	9.75	815	13.40	964	10.24
	FS.6.1		Other revenues from households n.e.c	648	98.63	800	98.16	949	98.44
	FS.6.2		Other revenues from corporations n.e.c	6	0.91	6	0.74	5	0.52
	FS.6.3		Other revenues from NPISH n.e.c	3	0.46	9	1.10	10	1.04
FS.7			Direct foreign transfers	1177	17.46	539	8.82	737	7.83
	FS.7.1		Direct foreign financial transfers	1177	100	539	100	737	100
		FS.7.1.2	Direct multilateral financial transfers	1177	100	539	100	737	100
All FS			**Total**	**6741**	**100**	**6091**	**100**	**9414**	**100**

4. REGIONAL COMPARISON

Broadly, a nation's health financing ecosystem is reflected in Current Health Expenditure (CHE) as a percentage of Gross Domestic Product, Domestic General Government Health Expenditure (GGHE-D), and Out-of-Pocket Spending (OOPs). These indicators serve as critical markers of a government's commitment to building an equitable, resilient, and inclusive healthcare system.

A high proportion of GGHE-D within CHE signals strong public investment, which is foundational to achieving Universal Health Coverage (UHC). Such systems pool financial risk across the population, reducing or eliminating direct costs for individuals and ensuring that access to care is not determined by income. Conversely, elevated OOPs levels indicate heavy reliance on household payments, often resulting in financial hardship, catastrophic health expenditures, and medical impoverishment and indicating weak financial protection.

The table below shows a comparative overview of the CHE as a % of GDP, GGHE as a % of CHE and OOPs among WHO SEAR countries in 2022.

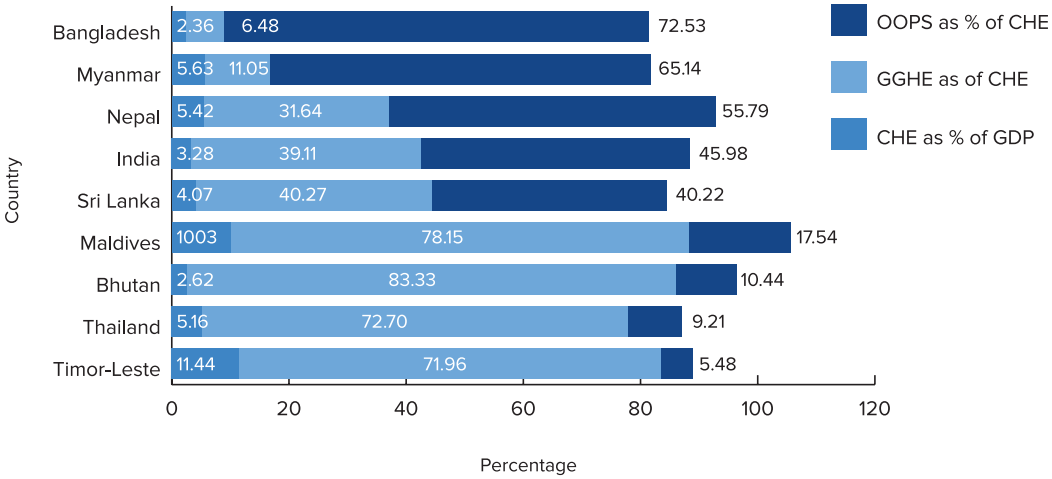

Figure 7: Overview of CHE among SEAR Countries, 2022

In 2022, health financing patterns across the WHO South-East Asia Region (SEAR) revealed striking disparities in both the scale of investment and the distribution of financial responsibility between governments and households.

While Timor-Leste recorded the highest overall health spending at 11.44 percent of GDP, Bhutan distinguished itself through its exceptional financing structure. Despite allocating only 2.62 percent of GDP to health, among the lowest in the region. Bhutan allocated a remarkable 83.33 percent of its total health expenditure through domestic government funding, the highest share in SEAR. This reflects an unwavering political commitment to public health and underscores how strategic prioritization can yield transformative outcomes even under fiscal constraints.

Bhutan's OOPS burden stands at just 10.44 percent of CHE, placing it among the lowest in the region and well below the WHO-recommended safety threshold of 15-20 percent. It also falls significantly beneath the SEAR regional average of approximately 35 percent, affirming that cost is rarely a barrier to essential care for Bhutanese citizens. In contrast, countries such as Bangladesh (OOPs: 72.53 percent; GGHE-D: 6.48 percent) and Myanmar (OOPs: 65.14 percent; GGHE-D: 11.05 percent) exhibit the inverse pattern.

5. LIMITATIONS

The analysis faced several data limitations. First, pay and allowances could not be segregated for some Dzongkhags across all three financial years, which constrained the ability to conduct disaggregated expenditure analysis at the subnational level.

Consistent with previous National Health Accounts (NHA) exercises, obtaining expenditure data from non-governmental organizations (NGOs) proved challenging due to low response rates. Moreover, the expenditure figures reported by NGOs lacked consistency across the reference years, affecting the reliability of the findings. Similarly, access to information on insurance refunds provided to employees by corporate organizations implementing such schemes was limited, resulting in insufficient coverage of private insurance-related expenditures.

Morbidity data availability was also constrained. While disease mapping is an important analytical tool used to link health spending with disease burden and to inform the allocation of health funds, this exercise could only be conducted for FY 2021/22 due to data limitations for the other two years.

Following Health Sector Transformation 1.0, the Health Financing Division—previously under the Planning and Policy Division—was restructured and placed under the Department of Health Services. As a result, responsibility for implementing the National Health Accounts (NHA) was transferred to a new office, where officials with limited prior experience in conducting NHA were assigned to undertake the exercise. This transition posed challenges, particularly in relation to data collection, data analysis, and timely publication of the NHA report.

6. CONCLUSION AND POLICY IMPLICATIONS

In line with the constitutional mandate to provide free basic healthcare services, the government remains the primary source of funding for the health system, contributing an average of 76 percent of total health spending in the three financial years of the NHA exercise. Household or out-of-pocket expenditures saw a drop from 16 percent in the FY 2019/20 to an aggregate of 11.12 percent in the three financial years when NHA was conducted. This reveals that a large section of the population is protected from financial hardship and that the government's efforts to enhance health services are yielding good results. While more empirical assessments are needed to understand the determinants of the decline in OOPs, this is generally a good indication in view of the national commitment to achieve universal health coverage.

International Development Assistance still plays a key role in sustaining free health services, with multilateral support accounting for 23.75 percent, 14.51 percent, and 9.25 percent of the overall current health expenditure in the three financial years.

The Sustainable Development Goals (SDGs) highlight the importance of health financing assessments in monitoring progress toward Universal Health Coverage (UHC). As such, the National Health Accounts (NHA) exercise provides essential data on health spending, serving as a crucial input for health policy and planning and supporting the achievement of both national and global health objectives. Additionally, two important national indicators on the health financing for 13 FYP in the Healthy Drukyul program are generated from the National Health Accounts.

ANNEXURES

Annexure 1: Gantt Table on NHA Data Collection

Activities	Oct 2023	Nov 2023	Dec 2023	Jan 2024
Planning and Scheduling of Meetings				
Dissemination of Data request letters and questionnaires to CSO/DHIs/ Private/Corporate				
Follow-ups with CSO/DHIs/Private/ Corporate				
Data receipts and primary validation				
Data Entry				
Follow up with UN agencies				
Data collection finalization				

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