The Current Model of Bhutan's Health Care System is Unsustainable

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Background

Through generations of munificent Monarchs of the country, the health and welfare of people always enjoyed the highest priority. As Bhutan embarked on planned development from the 1960s, health and education received significant shares of development investment.

As a result, by 2024 there were 55 hospitals, 187 Primary Health Care Centers (known in the past as Basic Health Units, BHU), and 557 Outreach Clinics, with 72.9 percent of the population living within travel time of less than 30 minutes to these health facilities. The expansion of health physical infrastructure was designed to deliver primary health care services based on the principles laid out in the WHO/UNICEF declaration on Primary Health Care, Alma Ata, 1978.

These efforts led to a dramatic improvement in the health of the population. Life expectancy increased from 32.4 years in 1960 to 69.5 in 2015. Universal childhood immunisation was achieved in 1991, infant mortality and under-five mortality rates were reduced by 70 and 77 percent respectively, goitre was eliminated; so was polio, to mention a few significant public health achievements.

All of these were done totally by the government, ensuring free access to all health care services for all people. And when Bhutan became a Constitutional Monarchy in 2008, free health care was mandated and enshrined in the Constitution: "The State shall provide free access to basic (sic) public health services in both modern and traditional medicines" (Article 9, para 21).

Not only is health care free in the country, it extends beyond Bhutan's borders, with patients referred to India, Thailand, Singapore and other

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countries, for those conditions requiring advanced health care. For example, in the last fiscal year (2024-2025) a total of 1,244 patients were referred to India alone for treatment.

Transition

Bhutan is now at a crossroads. Disease profiles are changing from a predominantly infectious epidemiology to that of rapidly increasing chronic health conditions. With increased expertise and advanced technologies, more diseases are diagnosed which often require sophisticated and expensive treatment. This is fuelling rising health care costs.

The question then is whether the current model of health care is sustainable. And looking at all aspects of it, the answer is clearly "no".

First, let us examine health financing. The health sector allocation in the ninth Five Year Plan (2002-2007) was Nu. 6,418.07 million, which rose to Nu. 19,125.19 million in the 13th Five Year Plan (2024-2029), reflecting a 34 percent increase over 22 years, but this may seem like undramatic cost escalation.

The rising cost of health is best demonstrated by the rising cost of referrals outside the country for advanced treatment (see Fig 1).

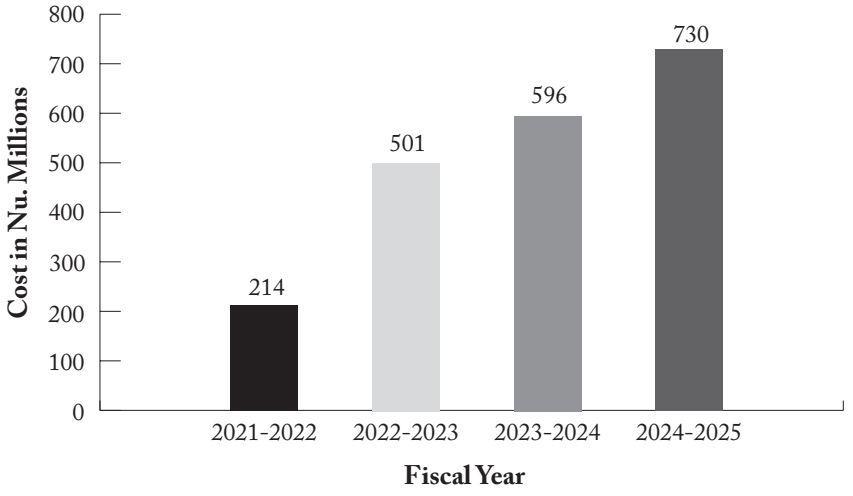

Fig. 1: Rising Cost of Referrals

Between the fiscal years 2021-2022 and 2024-2025, the cost of referrals to India alone tripled from about 214 million to 730 million Ngultrums. This does not include the cost of referrals to countries other than India, as these are outside the Jigme Dorji Wangchuk National Referral Hospital [JDWNRH] system.

Another cost driver of health care in Bhutan is the cost of drugs. Bhutan has an essential drugs list (see Fig 2). The National Essential Medicines (NEM) list 2023 has 428 drugs on it — 173 drugs listed as vital, 224 as essential, and 31 as necessary. The rising cost is shown in Fig 2.

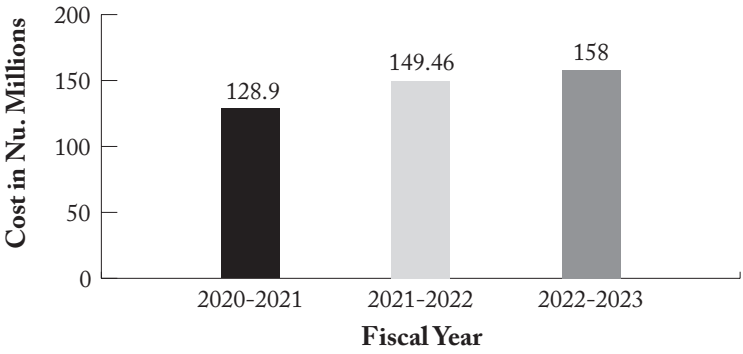

Fig. 2: Cost of Essential Drugs

The steady rise of the cost of medicines is clear, and since essential drugs are provided free of charge, future costs will only rise.

In addition to the NEM list, there is the named-patient's drugs list. This is for those patients who either were referred outside the country for treatment and were prescribed medicines not on the current NEM list, or those that were diagnosed with rare disorders for which the needed drugs are not on the NEM list. Looking at this cost too, it is clear that the trajectory is upwards (see Fig 3).

The rationale of NEM is to ensure the availability of the most critical life-saving drugs which are purchased as generics and not proprietary, to keep costs down. The provision of free named-patients' drugs, therefore, defeats the purpose of NEM, as the cost of these drugs is 44 percent of the cost of NEM, and usually these are proprietary drugs. The responsibility of the individual patient in terms of costs for medicines is nil.

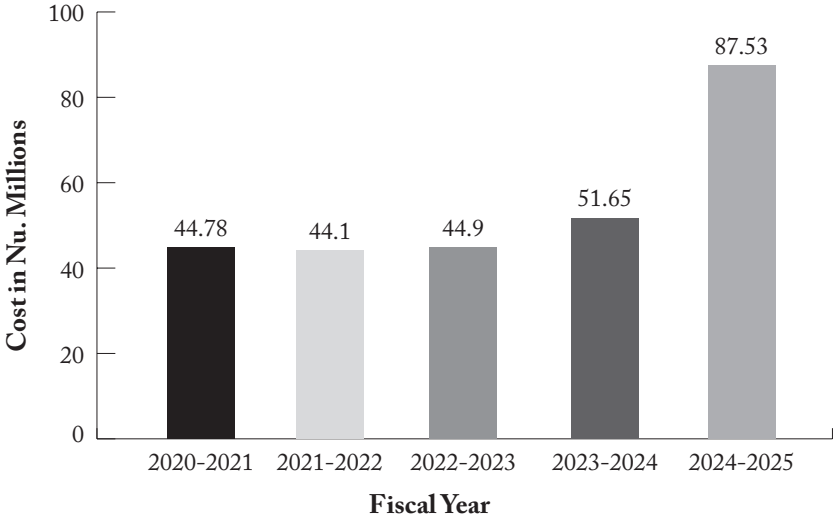

Fig. 3: Cost of named patients drugs

Second, apart from the rising costs of everything, there is also rising demand for services and rising expectations.

The perception seems to be that responsibility for individual health is now entirely on the Health Ministry, given that the Constitution guarantees free health for all our citizens. It is almost as if one can drink oneself to the stage where one's liver is no more functional, and then the government is responsible for fixing that end stage! It is not uncommon for patients to demand that they be referred to or given treatments of their choice because it is their right as guaranteed in the Constitution.

Third, there are no guardrails for the services offered — everything is free. What no one reads is that the founders of the Constitution have worded it very carefully to say "..free access to basic public health services…", not free access for every clinical illness.

The government (specifically the Ministry of Health) should have defined a package of critical health interventions or basic services that are critical to the overall health of the nation, to be covered under the Constitutional mandate of "free basic public health services". In the absence of that, the current situation is free for all, and for everything.

Fourth, even a conservative estimate of the health workforce at present is barely sufficient to deliver the expected level of services to the people. This is complicated by the large attrition rate of trained health workers, be it doctors, nurses or health technicians, who have emigrated, primarily to Australia, in recent years.

For example, as reported by Kuensel on November 22, 2025, the gap between approved and existing health workforce stands at 1,200. If we are to beef up services to match the demand, this estimate will require significant upward revision.

Fifth, what is unique in Bhutan is that these are occurring against the backdrop of a single service provider, i.e., the government. We have no private sector engagement in health care services; we have no significant insurance systems in place. Therefore, the government remains the only provider of health care services to the entire nation. A totally State-managed health care systems has unique issues, and in this, Bhutan is no different from other countries like Canada or the United Kingdom.

Sixth, the technical degradation of health leadership is a major cause of concern as we move into the 21st century. Health is a technical subject with an ever expanding horizon for scientific evolution in health sciences. Health management is not the same as general stores management. Discouraging technical experts from leading health programmes and health planning undermines health systems development, by deliberate suppression of futuristic thinking in health development.

A Solution

The obvious question is what next, or what can we do differently? We can do many things to change the trajectory we are currently on and to put in place effective and agile adaptation to meet emerging needs effectively. I summarise a few of the possible next steps below. The first is to look at health financing. The average health allocation in successive five-year Plans ranges between five percent and six percent of the total, with the exception of the 12th FYP, when health allocation (or expenditure) rose to 11 percent, probably largely driven by COVID 19 demands.

As a proportion of GDP, Bhutan's health expenditure averages four percent or less of total GDP. There is no specific level of recommendation of the proportion of GDP that a country should spend on health, but the general belief is that it should be close to 10 percent or higher. The different levels in various countries are reflected in Fig 4.

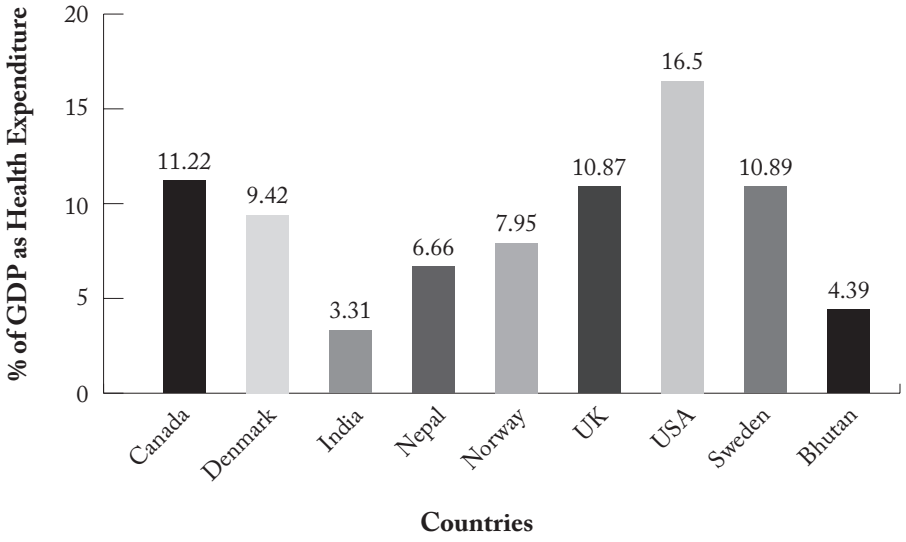

Fig. 4: Health Expenditure as % of National GDP

However, a larger share of GDP does not necessarily give you the best health care, both in terms of access or the range of services. The United States of America spends the maximum on health (16.5 percent) as a proportion of GDP (see Fig 4), but their health situation and access are not comparable to other industrialised countries who actually spend less.

Similarly, countries such as Canada or UK, where national health services monopolise health care, the system cannot rise to meet demands rapidly enough. For example, in the UK, the average waiting time for knee replacement is at least one year, if not more. In Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) we can do it in less than a few months!

Nevertheless, Bhutan can enhance health services if we can raise our health allocation to around 10 percent of the GDP. Given the small GDP, the five-

year plan allocation is pretty close to the proportion of health expenditure to GDP.

Secondly, good public health care services should be a calibrated package of essential health care services that should be mandatory for the State to provide to its citizens to produce maximum public health returns for the money spent, not unlimited free health care services for everyone.

The WHO/UNICEF Alma Ata Declaration on Primary Health Care held at Alma Ata, (now Almaty) Kazakhstan, was very effective as it focused on eight very specific interventions that had the biggest "bang for the buck".

In a welfare society like Bhutan's, it is necessary to put in place mechanisms to identify those that are truly indigent and where State welfare is critical, so that State intervention is well targeted, while creating opportunities for individuals to partake in their own health care. The irony in a welfare society is that it is often the better-off echelons of society that benefit more than those who truly need such State largesse.

It may also be said that a good public health care system is not necessarily a totally free health care service for all, and that the State must define what is that package of essential public health services that the State will deliver to the citizens.

The health workforce shortage is real and if nothing is done urgently, surely a crisis is brewing in the health sector. The health workforce faces both supply as well as retention issues.

In terms of supply, there are Bhutanese graduates from India, Sri Lanka and Bangladesh, but not sufficient and quick enough. The Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB) started a MBBS programme but it will be another three years before the first cohort of medical graduates joins the work force.

Similarly, we are not getting enough postgraduates (PG) from outside and, although PG courses have started in the Khesar Gyalpo Medical School of Bhutan (KGUMSB) at present, we cannot train them in sufficient numbers.

The supply shortage is complicated by retention challenges. For example, in 2025 alone, we lost 92 health workers from the National Referral Hospital in Thimphu. A survey carried out last year showed that, while financial incentives are the main reasons why health workers emigrate to greener pastures, there are other reasons.

Issues such as RCSC's bond system, which locks people into service without opportunity to exit, a poor work-life balance, lack of support for staff wellness and welfare, management and leadership issues, etc. are highlighted as reasons why people want to emigrate or leave government service. The underlying major issue is managing the health workforce like any other workforce under the Royal Civil Service.

Some of the above issues may be difficult or take time to address, but there are many that can be resolved, with policy and resource support. Pay and allowance adjusted to the type of work and the hours of work are critical. Some policies that are clear disincentives to retaining health workforce need to be changed or dropped. Health workforce management and organisation need to be relevant to the nature and demands of the work of health workers, and not simply aligned to organisations that work from nine to five.

The elephant in the room, in the last three decades or more of health development discourse, is that of private sector participation in health. It is laudable and remarkable for our country's singular focus to keep health services totally a government effort, now further cemented by ensuring that free health is enshrined in the Constitution.

However, countries such as Canada and UK also have government-run health services, but the people contribute either in tax or through insurance, so that the government is not left to carry the total burden of providing health care services to its citizens. Not so in our case; the government funds everything!

While the objective is admirable, there are two major issues with having only one service provider. First is the lack of choices for the people, as there is no alternative but to depend on the single source provider for everything, from an aspirin for a headache to a kidney transplant. This frustrates those who can pay and who would like to put a premium on their time,

rather than waiting in long queues in the clinics, and also to seek a more comfortable experience.

The second problem is that no matter how much resources are pumped into the system, there will never be enough to meet the needs and the expectations of all the people. This leads to a shabby setting, inadequate staffing, and long waiting lines. There are often shortages of drugs, or equipment failure that cannot be fixed quick enough, because there are bureaucratic processes that must be adhered to, even for the purchase of a toilet bowl.

Therefore, private participation is not only to defray the costs of health care services for the government, but also to inculcate responsible appreciation of such arrangements in patients, having choices for those who can afford them, and to allow private sector to take care of those services that they can easily manage. More importantly, private sector involvement would generate jobs and increase government revenue through taxes.

Finally, it is important to consider the technical leadership for health at the highest level. It goes without saying that we must have capable leaders, but health is a technical profession and, therefore, the leadership must also have a deep understanding of the technicalities of health, to be able to envision future directions.

Health is an ever-evolving science, and new technologies and pharmaceuticals are developing at breakneck speeds. There was a time when we had far fewer doctors and yet the leaders invested heavily in building the technical capacity of public health leadership, whose legacy is still largely what has driven health achievements to the current level.

Now we have capable leaders, be it nurses or doctors or allied health workforce. If we continue on this path of total lack of technical capacity at the highest leadership level, the eventual result will be mediocrity at best.

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