Ministry of Health
Royal Government of Bhutan

World Health Organization

9 June 2016

Final Report

Review of trends in health spending, national budgets and the future funding gap

WHO Reg. 2016/632514-0

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List of Abbreviations and Acronyms

BHTF	Bhutan Health Trust Fund
BHU	Basic Health Unit
BTN	Bhutan Ngultrum (national currency of Bhutan)
CCM	Country Coordinating Mechanism
CMH	Commission on Macroeconomics and Health
DP	Development Partner
ED	Essential Drugs
FYP	Five-Year Plan
GF (or GFATM)	Global Fund to Fight Aids, Tuberculosis and Malaria
GNHC	Gross National Happiness Commission
HLTF	High-Level Taskforce
LFA	Local Fund Agent
KPI	Key Performance Indicator
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
Mn	Millions
MoF	Ministry of Finance
MoH	Ministry of Health
MYRB	Multi-Year Rolling Budget
OPD	Out-Patient Department
PFM	Public Financial Management
PHC	Primary Health Care
PLaMS	Planning and Monitoring System
PPD	MoH Planning Unit
RGoB	Royal Government of Bhutan
RSSH	Resilient and Sustainable Systems
STCF	Sustainability, Transition and Co-financing (Policy)
TA	Technical Assistance
ToR	Terms of Reference
USD	United States Dollars
VPDP	Vaccine Preventable Disease Program

Government Fiscal Year: 1 July to 30 June

Currency unit: Bhutanese Ngultrum (BTN)

USD 100 = BTN 6.700

BTN 100 = USD 1.50 (as of 20.5.2016)

1. Introduction

This report presents the major findings and recommendations of the review of trends in health spending, national budgets and the future funding gap. It was written by Mr. Esben Sonderstrup, independent consultant to WHO SEARO.

The consultant worked in Bhutan from 24 May till 9 June 2016 and met with Honourable Minister of Health, Secretary (Health), senior management and staff of the Ministry of Health (MoH), Ministry of Finance (MoF), Bhutan Health Trust Fund, Gross National Happiness Commission, Bhutan Trust Fund for Environmental Conservation, and the WHO Country Office for Bhutan.

This report represents the findings and opinions of the consultant and does not necessarily represent the views of the Royal Government of Bhutan (RGoB) or WHO.

The consultant wishes to thank all persons met for their kind participation and contributions to the review.

2. Background

Free basic health care in Bhutan is a social good enshrined in the constitution of 2008. However, health care cost and health care demand has risen over the last decade. At the same time funding for health is declining not least due to the withdrawal of a number of external donors, as Bhutan's GDP is rising and the country moves from a least developed to a lower-middle income country. In fact, external financing of health has dropped from around 28% in 1996 to about 12% in 2012.This has put considerable strain on the health system finding it difficult to meet the expectations of the people and to provide the services that it would need to offer.

This decline in funding from the national budget allocated by Royal Government of Bhutan (RGOB), expressed as % of nominal GDP is well documented as budget data show that this figure has dropped from 5.70% to 3.55% from year 2000 to year 2012. The average of lower middle-income countries stands at 4.4%.

At the same time costs are rising with inflation, increasing demand and expansion of service. As an example cost of referral outside Bhutan – all borne by Government funding – has escalated from BTN 122 mn to BTN 184 mn from 2010 to 2014.

The Bhutan Health Trust Fund was established in 1998 with the aim of accumulating sufficient funds to finance vaccines and essential drugs from the interest accrued from the capital. Currently the target is to reach USD 30 mn but the capital of the fund currently stands at 19.8 mn USD subject to currency fluctuation between the BTN and the USD, since most of the capital is invested within Bhutan. The BHTF is currently only able to finance a fraction of the cost incurred by MOH for Vaccines and essential drugs.

The Global Fund for AIDS, TB and Malaria (GFATM) has provided substantial support to Bhutan for a number of years. However, as the national GDP is increasing Bhutan will not be eligible for Global Fund

support very soon. Therefore Bhutan has to plan how to sustain the GF supported programmes and start transition well in time well before GFATM phases out its support.

3. Current Status and Trends in Health Funding

Public health expenditure (as defined by WHO and the World Bank) consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds. Public Health Expenditure should not be taken to mean expenditure on Public Health in the classical sense[1], or the expenditure of the Public Health Department of the MoH. Put simply, it means total government expenditure on health.

In Bhutan, public health expenditure is overwhelmingly government funds. In 2012-13 the RGoB (including grants from Development Partners (DPs) provided around 75% of Total Health Expenditure, insurance schemes provided 0.75% while Out Of Pocket (OOP) expenses provided by private citizens stood at around 25%. Half of the OOP was expenditure on transportation.

Grants from DPs constituted around 12% of the government funds. This percentage has fluctuated over the past decade and represents mainly capital expenditure.

The trend in public health expenditure as a percentage of GDP in Bhutan since the turn of the century[2] is shown in the graph in Fig.1 below:

[1] I.e.the science and art of preventing disease, prolonging life and promoting health through organized efforts and informed choices of society, organizations, public and private, communities and individuals

[2] The figures used to create the graph were taken from World Health Organization Global Health Expenditure database (see http://apps.who.int/nha/database) as presented at http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS (accessed on 20 MAY 2016)

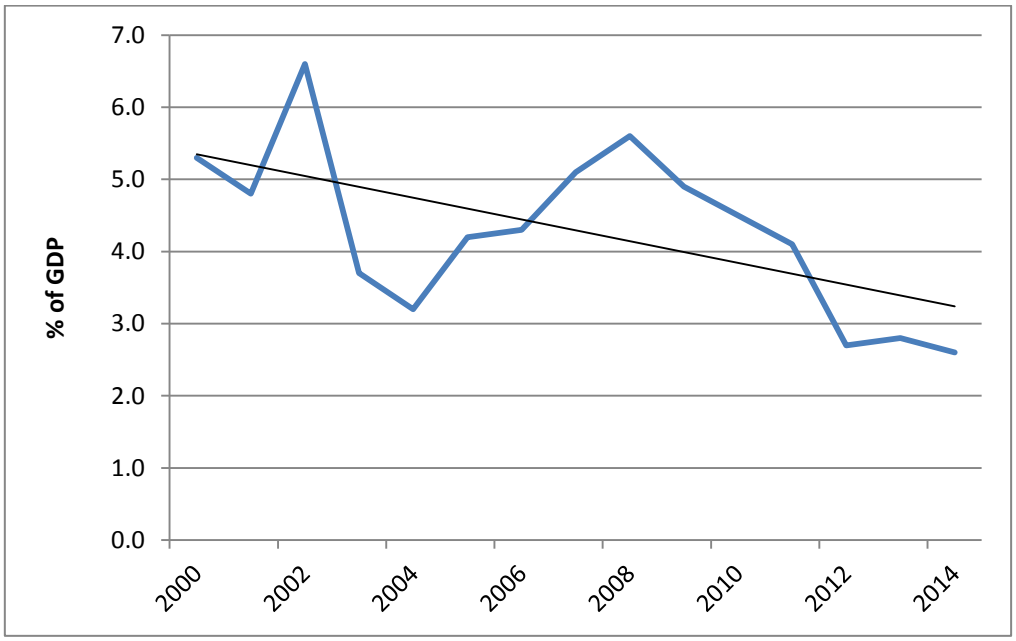
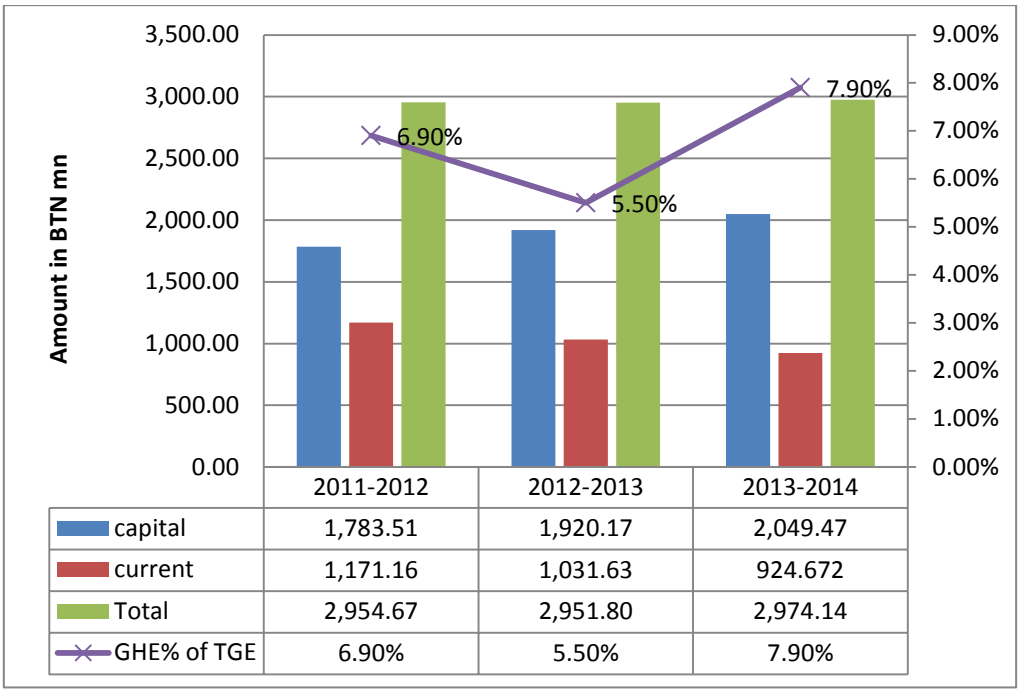


Fig. 1 Public health expenditure as a percentage of GDP

The graph shows a clear downward trend from 2000 till today. Until around 2000 the health budget's share of the GDP fluctuated around a figure of 5%. From then on, as the graph shows, the development has shown a downward trend, most clearly from 2008. The reduction from 5.3% in year 2000 till today, where the WHO database shows a figure of 2.6%, amounts to 50%.

The figures shown in the graph for 2013 and 2014 are lower than the figures of the National Health Accounts (3.8% of GDP (2012-13) and 3.6% of GDP in 2011-12). It is uncertain what the figures from the first 14 years would have shown, had they been calculated in the same rigorous and standardized way as the recent NHA figures. They might have been one percentage-point higher than the recent figures calculated by the NHA method, and in this case the average decline would have been the same as the one shown in the graph. If we assume that the 5.3% of 2000 are correct and compare this figure with the NHA figure for 2013 (3.8%), the reduction amounts to 23%, a substantial decline by any standard.

Public health expenditure as a percentage of total government expenditure has remained fairly constant at around 8% over the period. The figures for the most recent years (where the figures are more reliable than earlier years), namely 2011-12 till 2013-14, are shown in Fig. 2[3]



	2011-2012	2012-2013	2013-2014
capital	1,783.51	1,920.17	2,049.47
current	1,171.16	1,031.63	924.672
Total	2,954.67	2,951.80	2,974.14
GHE% of TGE	6.90%	5.50%	7.90%

Fig. 2 Public health expenditure in absolute figures and as % of total RGoB expenditure

The dive in the percentage in the financial year of 2012-13 is not due to a drop in the health expenditure, rather it is caused by an unusual rise in the overall RGoB budget.

The trend in the public health expenditure in BTN mn is shown in Fig.3.

[3] Source: Annual Financial Statements, Department of Public Accounts, Ministry of Finance 2013-2014

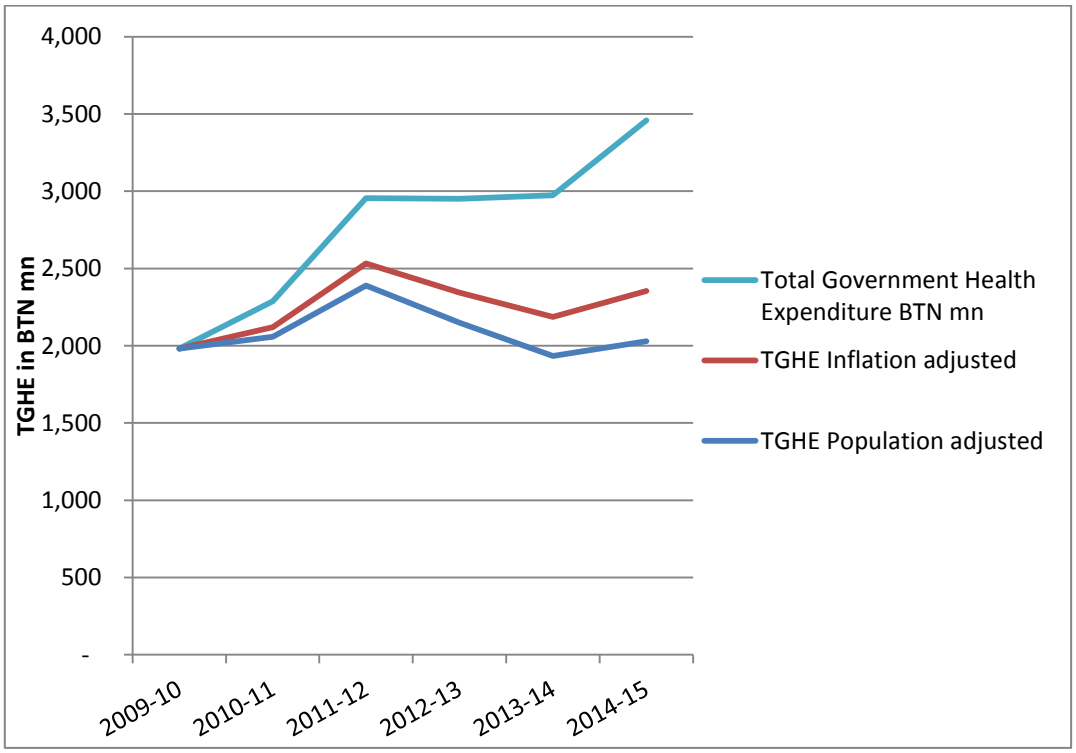


Fig. 3. Trend in public health expenditure in BTN mn. Nominal, Inflation-adjusted and population-adjusted

Along with the positive development in GDP, the public health expenditure has grown in nominal terms[4]. This is shown in the uppermost (light blue) curve in Fig.3. However, because of the annual inflation rate[5] of around 8% p.a., the real expenditure is not growing (middle curve, brown). Furthermore, seen in relation to the growing population[6] (lower curve, blue), government health expenditure is decreasing.

The trend in financing from Development Partners has been falling in the past decade, cf. Fig.4. below[7]:

[4] Source: Annual Financial Statements, Department of Public Accounts, Ministry of Finance. The MoH budget shown is the revised budget.
[5] Bhutan at a Glance, National Statistical Bureau, RGoB 2006-2015
[6] Bhutan at a glance, National Stastical Bureau, RGoB 2006-2015
[7] WHO Global Health Observatory at http://apps.who.int/gho/data/node.main.484?lang=en accessed on 5 JUN 2016

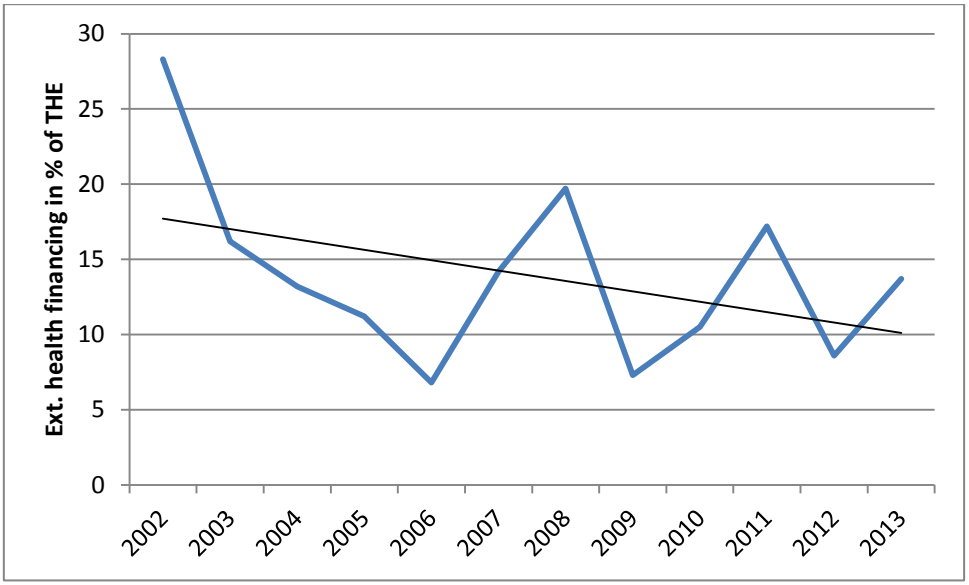


Fig. 4. Trend in external financing of health

The graph shows that concurrently with Bhutan's economic growth, Development Partners have reduced their assistance to the health sector to the point where it constitutes around 12-13%. This development was expected, and the fact that it has not caused major problems is a sign that Bhutan's economic development is sound and that the country follows the policy of self-reliance.

The trend in public health expenditure per capita in USD is shown in Fig. 5 below. The annual per capita expenditure has on average been USD 72; this is the highest in the South Asia Region except for the Maldives.

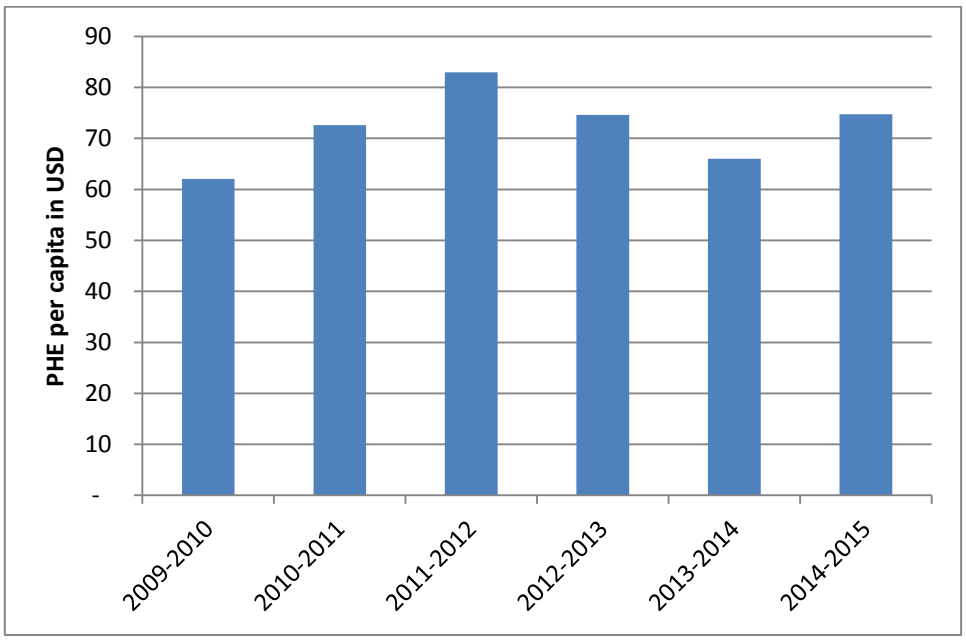
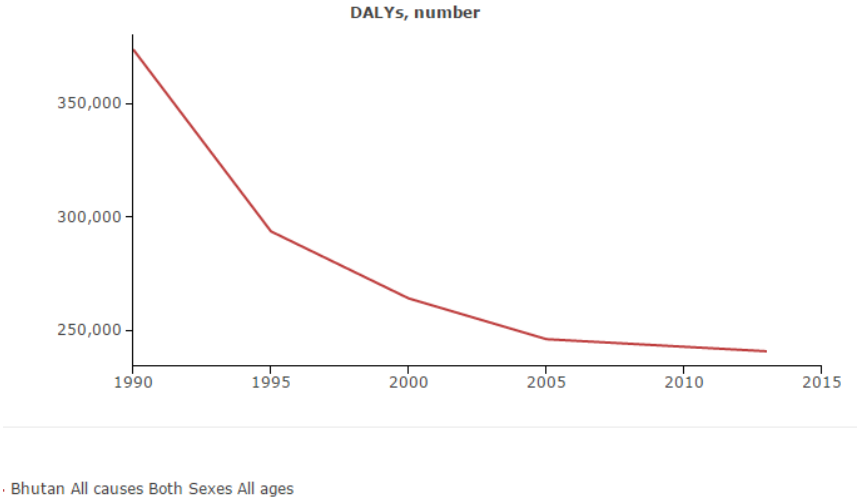


Fig. 5 Public health expenditure per capita in USD

4. Bhutan's Health Status and Future Challenges

4.1 Burden of Disease

The health status of the population has changed tremendously in the past 25 years. The determination of the government in pursuing sustained investment in health and education, combined with the favourable economic development, has meant that the burden of disease has been substantially reduced. The development in the burden of disease measured in Disability-Adjusted Life Years (DALYs[8]) is shown in the graph below:



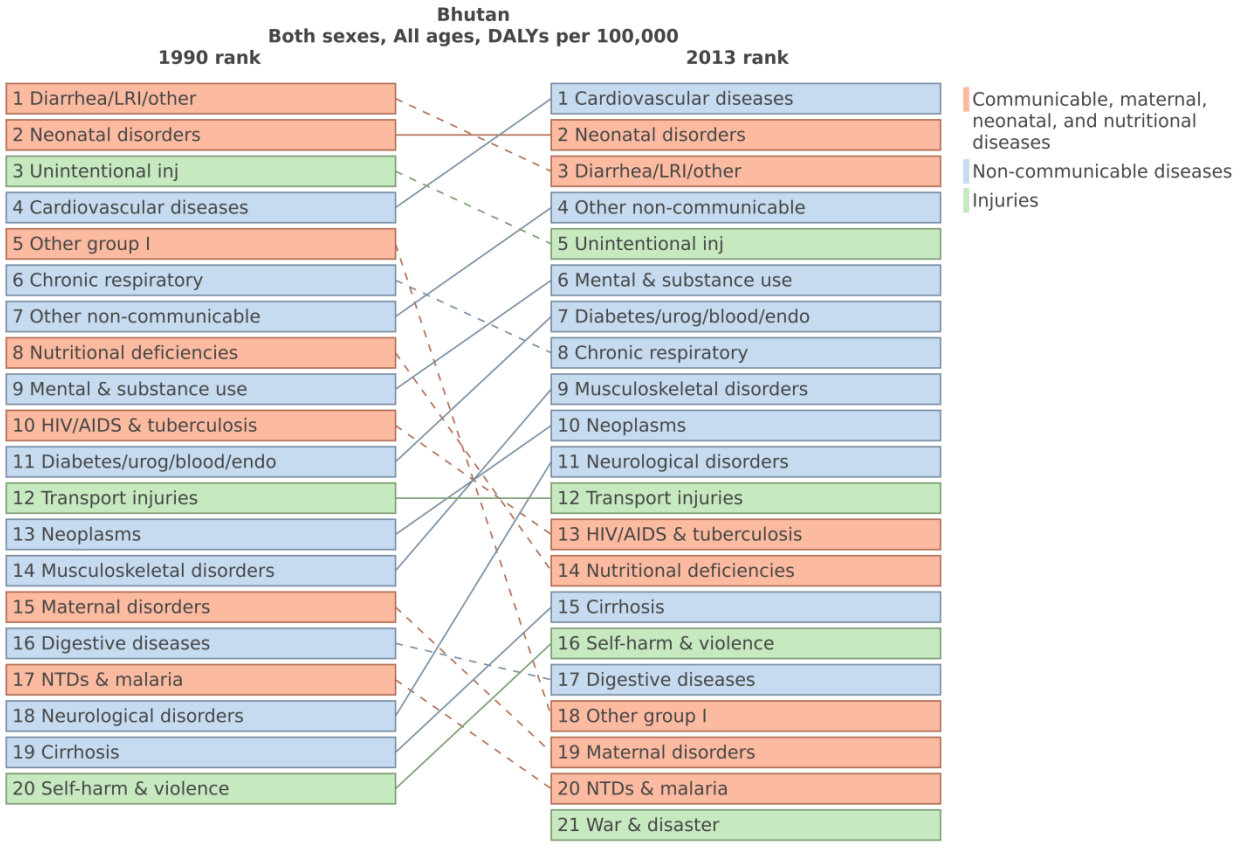
This development is very impressive. The reduction in total burden of disease is 37%[9]. With population growth factored in, the burden of disease per capita is less than half of what it was in 1990. For comparison, the global reduction in burden of disease per capita in the period 1990 to 2013 is 27%[10].

4.2 The Epidemiological Transition

The arrow-diagram below[11] shows the development in the relative ranking of diseases from 1990 till 2013, and the epidemiological transition comes out clearly inasmuch as all the diseases that move upward in the ranking are Non-Communicable Diseases (NCDs) whil e most of those that move downwards belong to the infecious disease category. In other words, Bhutan (like many other developing countries) is experiencing a double burden of disease, having to fight the epidemic of NCDs while still having to deal with the infectious diseases.

NCDs are more prevalent among older citizens, and the aging population (the demographic transition) means that the share of older citizens will grow.

[8] DALYs are a measure of burden of disease**.** DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences. One DALY can be thought of as one lost year of "healthy" life
[9] http://www.healthdata.org/gbd-data-tool accessed on 17.5.2016
[10] http://www.healthdata.org/gbd-data-tool accessed on 27.5.2016
[11] http://ihmeuw.org/3tlw. Accessed on 27.5.2016



The NCDs have several things in common, one of them being that they are expensive to treat; hence, the epidemiological change is likely to become costly. Prevention is cheaper than cure, and investments in curbing the epidemic are good value for money.

The cost of providing health care will increase for other reasons as well. While technological development may lead to savings on standard devices (such as stick test etc.), new high-tech equipment and new medicines become more and more expensive.

One of the consequences of the introduction of democracy in Bhutan is that the population is becoming more vocal and demands better service. Expectations grow quickly, and politicians cannot ignore the public demand for better services. An indication of this is that the cost of referrals abroad has increased from BTN 87 mn in 2005-06[12] to 185 mn[13] in 2014-15.

The sector is particular in the sense that health gains are reversible. This is not the case in e.g. the education sector; if a child learns to read and write, that achievement is permanent and benefits the child for the rest of his or her life even if an education programme should stop. In contrast to this, vaccination has to be continued for the disease not to re-emerge. The truly notable gains of Bhutan's malaria control programme (malaria is near elimination as a public health problem with only 46 cases last year) could be reversed if malaria control does not continue. AIDS patients have to continue their treatment to survive,

[12] Final Report Health Sector Review Bhutan 30.4.2007
[13] PPD direct communication 26.5.2016

and diabetes patients face grave consequences if they do not continuously receive their medication. In other words, the foot must remain on the accelerator to avoid a re-emergence of many diseases that are now under control.

5. Future Government Health Budget Needs

As outlined in the two previous chapters, Bhutan's public health expenditure as a percentage of GDP is on a downward trend while the challenges to the sector are growing. Determining the gap between what is available in the future and what is needed can be done in several ways. Some countries have a costed health sector strategy that may be compared with the public health budget, but this is not the case in Bhutan.

Internationally agreed targets related to government spending on health care do not exist. The only target that has been agreed by a group of countries is the Abuja target from 2001. A meeting of African heads of state called for at least 15% of government spending to be allocated to the health sector, but for many reasons the target never became effective (one being that it implied that spending on other sectors such as for instance education should decline).

There is general agreement that a target that relates to GDP is preferable, although there is no uniform opinion on how many percent of GDP should be set aside for health. The global average is 5.1%, high-human-development countries spend 3.6% of GDP while very-high-human-development countries spend 8.2% of GDP.

Two major analyses have given indications on the estimated cost of providing a set of key basic health services. One is the Commission on Macroeconomics and Health (2001)[14], the other is The High-Level Taskforce on Innovative Financing for Health Systems (2009)[15] .

Based on these, a recent publication from Chatham House[16] suggests that countries should strive over time to achieve government health spending levels of at least 5% of GDP, supplemented by a minimum target of USD 86 per capita in low-income countries in order to ensure basic PHC services in cases where meeting the 5% target alone would be insufficient. The main argument is that significantly improving health status indicators (e.g., reducing the average Infant Mortality Rate to 10 per 1.000 live births) requires government spending of more than 5% of GDP.

Bhutan currently spends 3.6 - 3.8% of GDP, and the per capita government health expenditure is 75 USD per capita.

In conclusion, reaching the level suggested above should be a realistic aim for Bhutan within the 12th Five Year Plan. Given the challenges outlined in chapter 4, reversing the downward trend in public health expenditure as a percentage of GDP and raising the level to at least 5% of GDP, which is the level that was

[14] Commission on Macroeconomics and Health (CMH) 2001, Macroeconomics and Health: *Investing in Health for Economic Development* (Geneva: WHO)
[15] HLTF (High-Level Taskforce on Innovative International Financing for Health Systems) 2009, *Constraints to Scaling Up and Costs.* WG1 Technical Report (Geneva: WHO)
[16] Di McIntyre and Filip Meheus (March 2014) *Fiscal Space for Domestic Funding of Health and Other Social Services.* (Chatham House, London)

the norm some 15 years ago, would certainly be a good investment. It would also be in line with the intention expressed already in the Eleventh Five Year Plan[17] as well as the GNH principles.

6. Bhutan Health Trust Fund

6.1 Main features

BHTF is an endowment fund and the management of the Fund is based on a Royal Charter. Overall, the BHTF is intended to generate sufficient return on investments to cover all annual expenditures on vaccines and essential medicines. The BHTF capitalizes funds from contributions from RGoB (the main contributor) and development partners.

BHTF was established in 1998, and the Royal Charter (RC) was issued in 2000. The Fund started to disburse money in 2003.

The purpose of the fund is to ensure the sustainability of primary health care services including reproductive health through the assurance of continued and uninterrupted supply of critical vaccines, essential drugs, needles, syringes, cold chain equipment and other related drugs/equipment (art. 2.1 of the RC).

The full wording of article 2.2 of the Royal Charter states that the proceeds of the Trust Fund shall be used for the following activities:

a) Procurement of drugs from the RGOB Essential Drug List;
b) Procurement of assured quality vaccines for the National lmmunisation Programme;
c) Procurement of auto destruct syringes and safety disposal boxes and cold chain equipment to ensure safe injections;
d) Strengthen programme management and human resources development through staff training in the storage and management of drugs and vaccines , repairs and maintenance of health equipment, etc.;
e) Develop and implement management plans for drugs and vaccines;
f) Strengthen monitoring capacity on the proper use of drugs and vaccines; and
g) Other activities related to primary health care that the Board may recommend.

Article 2.3 states: The Board may change or modify the themes of the programme activities as and when required provided that in doing so all funding is used, in order of priority, for the purposes enumerated under Article 2.1 of the Charter, for activities under Article 2.2 of the Charter and thereafter for other health care services including reproductive health.

The RC states that programme activities shall be funded out of the investment income. In the event that the investment income is insufficient to fund the programme activities, the RGoB shall provide funds to meet the shortfall.

[17] 11th FYP Main Document Vol. 1 pp 154 and 156

The audited accounts for The Fund at the end of the fiscal year 2014-15 show a capital of BTN 1.402.554.077. With an approximate exchange rate of 65 BTN to the USD this is equivalent to USD 21.6 mn. The capital grew by BTN 60.145.746 (USD 925.000) during the year, corresponding to a return on investment of 4.4% p.a.

The stated aim of BHTF is to reach a capital of USD 30 mn.

6.2 Performance of the Fund till today

The BHTF has been the object t of several reviews[18]. The 2015 review provides cost estimates, income projections and expenditure estimations for the coming decade and, most importantly, it comprises a roadmap that outlines the directions for the Fund for the coming ten years.

Table 1 below shows the expenditure report from the beginning till today.

Financial Year	Programs	Amount in USD
2003-04	Hepatitis B	3,000
2004-05	Hepatitis B and Anti-rabies	25,000
2005-06	Measles and Rubella Campaign	70,000
2006-07	N.A.	
2007-08	N.A.	
2008-09	Pentavalent vaccine	7,500
2009-10	Tetravalent vaccine	7,700
2010-11	Pentavalent vaccine	16,500
2011-12	Pentavalent vaccine	48,000
2012-13	Pentavalent vaccine	53,000
2013-14	Pentavalent vaccine	82,000
2014-15	Pentavalent vaccine	93,000
	Essential Drugs	3,000,000
2015-16	Pentavalent vaccine	100,000
	Essential drugs	4,000,000

Table 1. All disbursements from BHTF. Source: BHTF

The total disbursement from BHTF till today is USD 7,505,700. The predominant part of this amount, 7 mn, was paid out in this and the previous financial year. The low initial disbursement is due to the fact that the

[18]1. Bhutan Health Trust Fund. The Review Report 2015. BHTF, RGoB, WHO 2015
2. Report on the review of the Bhutan Health Trust Fund February 2013. WHO, GAVI.
3. GAVI Secetariat, Sabin Vaccine Institute, and WHO. *Report on Immunization Financing and Sustainability and Vaccine Product, Price and Procurement (V3P Project) In-country Assessment Mission*. Bhutan, April 2012 (Report Cover Page says April 2011)
4. The Mission Report on GAVI-Graduation Situational Analysis, Bhutan 2014. WHO, GAVI, Unicef
5. Health Sector Situation and Gap Analysis in Bhutan, 2012

capitalization of the fund was seen as the most important activity in the initial years; the aim was to reach a target of USD 24 mn as stated in the RC.

The large disbursement in this and the last financial year is due to the decision of the RGoB to transfer the 1% Health Contribution paid by civil servants and employees in large corporations to BHTF. The amounts received were directly used to purchase essential drugs and pentavalent vaccine. This decision is, however, not in line with the basic principle of the Fund. The principle is that any contribution is added to the principal, and only interest is used for disbursement.

The fact that the basic principle of the Fund is not respected means that a golden opportunity for increasing the principal is missed. Had the health contribution of the last two years (USD 7 mn) been added to the principal (USD 21.5 mn), the fund would have almost reached the new level determined by the Board, namely USD 30 mn.

6.3 Potential of the BHTF

The review reports of 2011-2012 (see footnote p12) have indicated that BHTF has a great potential for becoming an important factor in increasing the sustainability of health care services in the country. Especially the Roadmap prepared as part of the 2015 review gives a good outline of what should be done to modernize and increase the effectiveness of the Fund. Reference is made to the Roadmap, but two actions stand out as particularly important: The de-linking of the Fund from the RGoB, which will allow the Fund to determine its own procedures and employ staff with the necessary qualifications unhampered by civil service rules, and the employment of an investment manager with skills in international investment.

The Fund must possess investment management skills in order to increase the yield of the principal and ensure that a portfolio of international investments provide a return on investment that is commensurate with that of other investments funds. The present portfolio of investments in national instruments (such as for instance Druk Air) may give an average of 8-10%, but because the rate of inflation is of the same order of magnitude, the investment does not grow in dollar terms, which is a problem since most of the commodities financed by the Fund are paid in USD.

The money in the fund can be put to better use and give a return on investment that is higher than today, and investing (part of) the fund in international markets would enable the fund to grow as opposed to today, where the returns are hollowed out by inflation. The money would have to be invested conservatively in low-risk instruments spread across sectors; the Fund is a public good, and aggressive investment strategies would not be appropriate.

An idea of the possible rate of return can be seen in Annex 1. The MSCI index reflects the financial performance of international companies in 23 developed markets, and passive investments in instruments tied to this index have yielded 6,57% p.a. in the past five years, 4,71% in the past ten years (which include the 2008 financial crisis) and 7,00% since May 1994. Other indices like S&P 500 have similar performances, so it is not unrealistic to expect an average of 5% p.a. on low-risk investments over a number of years.

If the basic principle of BHTF as expressed in the Royal Charter is upheld, and the 1% Health Contribution is added to the principal instead of just transiting in the Fund, the principal will grow by at least USD 4 mn annually and will double in five years' time even if the Fund continues to distribute the interest earned. In only five years, the Fund will then be able to distribute 5% p.a. of a capital of USD 40 mn corresponding to an annual disbursement of USD 2 mn.

6.4 Global Fund's Transition Grant to Bhutan

On April 26-27 this year the GF Board approved a new Sustainability, Transition and Co-financing Policy that outlines how GF will assist countries that are becoming ineligible for further funding to successfully transition to a situation where GF no longer supports national AIDS, TB and Malaria programmes. This policy includes possibilities for:

a. Investing in and providing support for the development of national health strategies, disease-specific strategic plans and health financing strategies;
b. Aligning requirements to ensure that Global Fund financed programs can be implemented through country systems in order to build resilient and sustainable systems for health;
c. Supporting countries to assess their readiness to transition both programmatically and financially, and ensure robust planning; allowing transition work plans to serve as the basis for funding requests;
d. Providing transition funding for up to one allocation period upon becoming ineligible.
e. Applying graduated co-financing requirements and associated application focus requirements.

Planning for sustainability includes investing in health systems, capacity building, advocacy and service delivery interventions while at the same time evaluating options for progressively increasing domestic financing for health and for the three diseases in particular. It also includes supporting domestic advocacy for health spending, and improving procurement processes and access to ensure that countries can purchase key commodities such as second line ARVs and MDR TB drugs at efficient prices.

The Transition Readiness Assessment, according to the new policy, should be an inclusive (including key and vulnerable populations), multi-stakeholder, and country-owned process including communities and civil society, led by the CCM or other multi-stakeholder coordinating body. The aim of the transition readiness assessment is to serve as a tool to stimulate dialogue at country level around transition related needs from both a programmatic and financial perspective, identify key gaps in programming that can be planned for, and highlight areas where technical assistance may be required.

The findings from the transition readiness assessment should feed into an inclusive country-led Transition Work Plan addressing key bottlenecks and opportunities for successful transition. Critical issues for successful transitions should be addressed, which often include capacity building and support for key and vulnerable populations, interventions that respond to human rights and gender related barriers and vulnerabilities to health, and procurement and supply-chain management issues that are essential for ensuring strong national unified systems.

6.5 Issues for Discussion in Relation to the Transition Planning

The elaboration of the Transition Readiness Assessment and the Transition Work Plan should be done in a process that is closely coordinated with the development of the new National Strategic Plans for the HIV/AIDS and the Tuberculosis programmes (which both expire on 31.12.2016) to secure that sustainability is built into these two plans from the start.

In order to increase the sustainability of health care financing, MoH would like to see Development Partner funds channeled through the BHTF. This is also the case for the envisaged transition grant from the Global Fund. This idea is analysed further below.

Preliminaries: It is suggested that it should be a precondition for a meaningful implementation of the proposal to channel a part of GF transition funds through the BHTF that the Roadmap formulated in the 2015 review is being followed. Fully implementing the Roadmap will take some time, but substantial realization of the five goals will be a big step forward towards professionalizing BHTF and making it an effective part of the country's health system. Especially the de-linking - and the employment of an investment manager with an understanding of international investment strategies, who could work in co-operation with the BETF and ensure a robust, inflation-proof return on investment for the fund - are essential elements.

Outline of the proposal: The basic idea is to split the GF transition grant into two parts. The larger part should be used for direct support to the transitioning of the three disease programs as per the modality used in the present phase, following elaboration of the transition readiness assessment and the transition work plan.

The other part of the transition grant could be channeled into BHTF with the objective of ensuring financial sustainability. BHTF is primarily designed as a vehicle for securing PHC commodities, and it would only call for a decision of the Board to widen the scope of the Fund to also comprise ATM drugs and commodities.

If part of the transition grant went into BHTF, it would strengthen the sustainability of the programmes in the time after transition through the interest earned "for all time to come". This would be an innovative way of supporting the transition process as called for in section 9 p11 of the GF new STCF Policy, where it says that "To encourage increased co-financing and program sustainability, the Secretariat will explore the use of innovative financing mechanisms". It would also be in harmony with the objective of supporting the creation of Resilient and Sustainable Systems for Health (RSSH) as expressed in Part 2 section 1a of the Policy, where it says that "There are no restrictions on the programmatic scope of funding for HIV, TB or malaria requests by LICs and applicants are strongly encouraged to include RSSH interventions, as appropriate". BHTF is a good example of an RSSH. Besides, the money put into the Fund is safeguarded and will without doubt be spent exclusively on health.

The proposal is also in line with other objectives of the new GF STCF Policy, e.g. ensure that countries can purchase key commodities such as second line ARVs and MDR TB drugs (p5); and encourage progressive up-take of recurrent costs of key program components including procurement of essential drugs and commodities for the three diseases (p5 and footnote 7).

Other arguments in favour of the proposal include the following:

1. The purpose of BHTF (to ensure the sustainability of primary health care services) corresponds with the aim of GF transition funding. The Gross National Happiness Commission and the Ministry of Finance both emphasize this important aspect of BHTF in view of the downward trend in donor funding and the rising costs of providing health care

2. In line with the Paris Declaration the GF is keen that programmes funded by GF grants should be aligned with national strategies and implemented through the national health system. This has always been the case and will continue to be so for BHTF's contributions to the MoH
3. Any investment is leveraged 1:1 by RGOB as per §3.2 of the Royal Charter
4. If the GF channels funds through BHTF, this may persuade other donors to do the same and provide reassurance to ADB (and perhaps others) that this is the thing to do.

It is therefore **recommended** that the proposal of channeling part of the GF transition funds into BHTF becomes part of the discussions on the establishment of the Transition Readiness Assessment and the Transition Work Plan.

It is also **recommended** that the implementation of the BHTF Roadmap be intensified and that the setting-up of the new organization be accomplished as soon as possible with assistance from a consultant with private sector and business consultancy experience. The Roadmap gives a good outline of what is needed, but the process must be accelerated in order to start generating a proper rate of return on the capital.

It is **recommended** that the principles for running the Fund be normalized in the sense that the Health Contribution be invested rather than paid out in the same year that it enters the Fund. This will ensure a very fast growth, and it represents the most obvious way of quickly reaching the target of USD 30.

After reaching the target the Fund may well continue for some years in order to grow and achieve a higher level of sustainability. In view of the rapid pace of growth that will result if the Health Contribution is added to the principal, the future of the Fund is a matter for political discussion.

Annex 1

Terms of reference for Agreement of Performance of Work with Mr. Esben SONDERSTRUP, Independent Consultant

Project Title: Review of trends in health spending, national budgets and the future funding gap

Background

Free basic health care in Bhutan is a social good enshrined in the constitution of 2008. However, health care cost and health care demand has risen over the last decade. At the same time funding for health is declining not least due to the withdrawal of a number of external donors, as Bhutan's GDP is rising and the country moves from a least developed to a lower-middle income country. In fact, external financing of health has dropped from around 28% in 1996 to about 12% in 2012.This has put considerable strain on the health system finding it difficult to meet the expectations of the people and to provide the services that it would need to offer.

This decline in funding from the national budget allocated by Royal Government of Bhutan (RGOB), expressed as % of nominal GDP is well documented as budget data show that this figure has dropped from 5.70% to 3.55% from year 2000 to year 2012. This makes Bhutan one of the countries in the entire world that spends least on health care. The average of lower middle-income countries stands at 4.4%.

At the same time costs are rising with inflation, increasing demand and expansion of service. As an example cost of referral outside Bhutan – all borne by Government funding – has escalated from 122 Mill. Nu to 184 Mill Nu from 2010 to 2014.

The Bhutan Health Trust Fund was established in 1998 with the aim of accumulating sufficient funds to finance vaccines and essential drugs from the interest accrued from the capital. Currently the target is to reach 30 Mill USD but the capital of the fund currently stands at 19.8 Mill. USD subject to currency fluctuation between the NU and the $, since most of the capital is invested within Bhutan. The BHTF is, therefore only able to finance a fraction of the cost incurred by MOH for Vaccines and essential drugs.

The Global Fund for AIDS, TB and Malaria (GFATM) has provided substantial support to Bhutan for a number of years. However, as the national GDP is increasing Bhutan will not be eligible for Global Fund support very soon. Therefore Bhutan has to plan how to sustain the GF supported programmes and start transition well in time well before GFATM phase out its support.

The RGOB has a well-developed financial system that allows for monitoring of budget allocation and spending trends. The Ministry of Health monitor spending through its National Health Account, which provide a comprehensive analysis of the health care cost and budget allocations.

In view of the crunch in budget allocation for health that the Ministry of Health (MOH) is facing, MOH is seeking a consultant to review trends in health budget, spending and the need for future financing to uphold the level of services currently provided.

Specifically the consultant should review the current allocation to the health budget from BHTF and the potential for future allocations given a few likely scenarios for enhancing the current allocation.

Objectives:

- Study the current status of health funding from RGOB and determine the gap in financing the health system and estimate future gaps with specific reference to GFATM graduation.
- Determine the % of GDP that needs to be allocated to health from RGOB to fill potential projected gaps.
- Assess the % of total allocation that should be considered by GFATM in their last allocation in order for BHTF to reach US 30 Mill target

Methodology:

The consultant will work with the planning unit (PPD) in MOH and the BHTF Director, reviewing available financial situation. He will review trends in budget allocations to health, spending on health and contributions made by BHTF.

Further the consultant will review current allocations to health from GFATM and estimate – to the extent possible with currently available information – future trends in GFATM funding until this is completely faced out.

Output:

- A report with recommendations that will include future financing of health from RGOB budget and from BHTF.
- Recommendations as to additional analysis that may be required to secure a firm financial basis for health services in Bhutan in the future.

Duration and Timing:

The technical support will required for a duration of 2 weeks (May 24 to June 7) and an additional 2 days to participate in the Workshop on Sustainability, Transition and Co-financing (June 8-9, 2016).

Annex 2

List of persons met

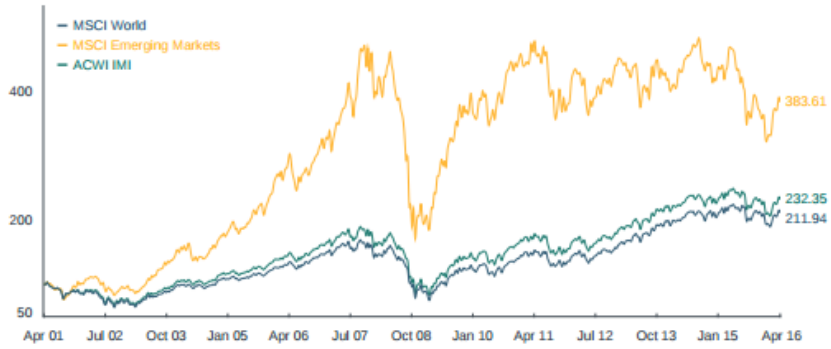
Name	Position
WHO Bhutan	
Dr. Ornella Lincetto	WR
Dr. Suraj Man Shresta	Health Officer
Mr. Ugyen Wangchuk	
Dr. Nima Wangchuk	
Ministry of Health	
Hon'ble Tandin Wangchuk	Minister of Health
Dr. Dorji Wangchuk	Secretary Health
Mr. Jayendra Sharma	Ag. Head, Policy and Planning Division (PPD)
Ms.Tashi Chozom	Assistant Planning Officer, PPD
Mr. Namgay Tshering	Programme Coordinator, National HIV/AIDS Programme
Mr. Phurba Tshering	Programme Coordinator, National TB Programme
Mr. Tobgyel	National Malaria Programme
Mr. Tchewang Tamang	Dy. Chief Programme Officer, VPDP
Ministry of Finance	
Mr. Gyembo	Chief Budget Officer
Gross National Happiness Commission	
Mr. Sherub Gyeltshen	Sr. Planning Officer, Planning, Monitoring & Coord. Div.
Bhutan Health Trust Fund	
Dr. Sonam Phuntsho	Director
Mr. Dawa Gyeltshen	Programme Officer
Global Fund	
Dr. Tandi Dorji	Local Fund Agent
Ms. Suneeta Chhetri	Ag. CCM Coordinator
Ms. Dechen Wangmo	Consultant, Grant Management Solutions
Bhutan Trust Fund for Environmental Conservation	
Dr. Pema Choephyel	Director (CEO)
Mr. Singye Dorji	Chief Finance Officer

Annex 3

MSCI and S&P 500 Performance

The MSCI World Index captures large and mid cap representation across 23 Developed Markets (DM) countries*. With 1,644 constituents, the index covers approximately 85% of the free float-adjusted market capitalization in each country.

CUMULATIVE INDEX PERFORMANCE - GROSS RETURNS (USD) (APR 2001 – APR 2016)



ANNUAL PERFORMANCE (%)

Year	MSCI World	MSCI Emerging Markets	ACWI IMI
2015	-0.32	-14.60	-1.68
2014	5.50	-1.82	4.36
2013	27.37	-2.27	24.17
2012	16.54	18.63	17.04
2011	-5.02	-18.17	-7.43
2010	12.34	19.20	14.87
2009	30.79	79.02	37.18
2008	-40.33	-53.18	-42.01
2007	9.57	39.82	11.66
2006	20.65	32.55	21.49
2005	10.02	34.54	12.06
2004	15.25	25.95	16.93
2003	33.76	56.28	36.18
2002	-19.54	-6.00	-17.26

INDEX PERFORMANCE — GROSS RETURNS (%) (APR 29, 2016)

	1 Mo	3 Mo	1 Yr	YTD	ANNUALIZED 3 Yr	5 Yr	10 Yr	Since May 31, 1994
MSCI World	1.65	7.88	-3.61	1.45	6.86	6.57	4.71	7.00
MSCI Emerging Markets	0.56	13.72	-17.56	6.35	-4.23	-4.28	2.69	5.03
ACWI IMI	1.64	8.88	-4.93	2.08	5.77	5.29	4.63	6.77

FUNDAMENTALS (APR 29, 2016)

Div Yld (%)	P/E	P/E Fwd	P/BV
2.65	19.81	15.88	2.10
2.83	13.77	11.85	1.40
2.59	19.80	15.66	1.95

S&P 500:

The S&P 500® is widely regarded as the best single gauge of large-cap U.S. equities. There is over USD 7.8 trillion benchmarked to the index, with index assets comprising approximately USD 2.2 trillion of this total. The index includes 500 leading companies and captures approximately 80% coverage of available market capitalization.

FACTSHEET | METHODOLOGY | ADDITIONAL INFO

RELATED INDICES

S&P MidCap 400®

1,493.05 0.98 0.07% ▲

The S&P MidCap 400® provides investors with a benchmark for mid-sized companies.

Percent change in 10 years: (2.096 – 1.311)/1.311x100 = 60%