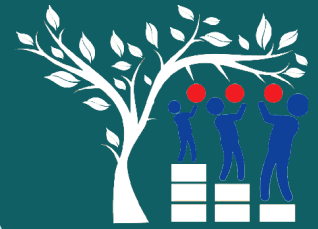


HEALTH EQUITY IN BHUTAN: POLICY OPTIONS AND RECOMMENDATIONS

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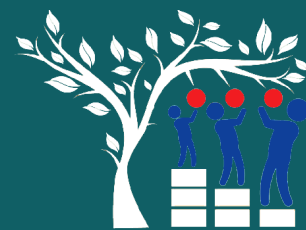


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HEALTH EQUITY IN BHUTAN: POLICY OPTIONS AND RECOMMENDATIONS



CONTEXT

The WHO defines health equity as “the absence of unfair and avoidable or remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries.”¹ Health systems performance on health equity per se is not discussed often within the Bhutanese health service policy implementation and therefore a great deal remains unknown. Disaggregated health outcome information by equity stratifier such as social strata, gender, income, education, geographical locations is scarce. For example, a pertinent health equity question policy maker should ask is, “are there differences in health outcomes by gender, social groups, age or geographical locations?”² A 2017 report on Benefit Incidence Analysis found that Bhutanese health system is only weakly pro-poor.³

The contemporary medical service in Bhutan was introduced in early 1960s under the benevolent leadership of the visionary Kings. Healthcare system has developed into a tiered network of 49 hospitals, 186 PHCs, 53 sub-posts and 542 outreach clinics. There are 376 doctors and 1364 nurses along with other cadres of health professionals.⁴ Frontline services are managed by 620 health assistants deployed in geospatially well distributed PHCs.^{5,6} Access to health services has remarkably improved over the years with

more than 90% of the population living within two hours walking distance from a health facility.^{4,5,7} The Constitution of Bhutan (Article 9, Clause 21) ensures free basic public healthcare services to the people at all times.⁸

Health equity is an important measure of a resilient health system. Bhutan has ascribed to advance health equity and “leave no one behind” through the SDG target 3.8 of achieving universal health coverage.⁹ As national plans and programmes are routinely implemented and undergo constant reforms, it is necessary to understand whether any systematic amenable disparities exist in health outcomes in the population. To promote health equity discussion and public dialogue, the Faculty of Postgraduate Medicine, Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB) hosted a policy dialogue on 23 October 2020. The six eminent speakers included: (1) Her Excellency Dechen Wangmo, Minister for Health, Bhutan, (2) Dr. Don Priso, London School of Hygiene and Tropical Medicine, (3) Dr. Pem Namgyal, Director, Program management, WHO-SEARO, (4) Dr. Karma Phuntsho, Bhutanese social science researcher, (5) Hon’ble Ugyen Namgay, Member of Parliament, National Council of Bhutan, and (6) Dr Diki Wangmo, Registrar, KGUMSB. Approximately, 150 participants including heads of the agencies attended the online session through Zoom conferencing platform.

THEMES

The presentations and deliberations were recorded and transcribed by the organizing team at the university. The recordings were analyzed for clustering of ideas. The following themes emerged from the rich discourse.

Theme 1

Free healthcare is not adequate to promote health equity, pay attention to accessibility and quality of services

“ I took my mother to the hospital to treat her Deep Vein Thrombosis a few years ago. She needed an ultrasound scan and at JDWNRH there was a waiting list of two months. The nurse then advised us to go to private diagnostic Centre at nearby Changangkha, where it was done in two hours with the most courteous treatment. I enquired whether the ultrasound waiting list has gotten any better and the saddest thing is that it has not. While we make big claims of free health services, the services may not always be available in the most efficient and quick manner ”

- Dr Karma Phuntsho

Access alone can be misleading without including the quality dimensions of health services. Poor quality of health services is wasteful as well as unethical. The Bhutanese health services should provide service that is free, fast and unequalled. However, free care does not always necessarily mean quality healthcare.¹⁰

The migration of Bhutan's population from rural to urban settings has resulted in overcrowding in some of the health facilities (Table 1).^{4,5,11} While some centers saw an overwhelming number of patients, on the contrary others remained underutilized with only 1-2 patients a day. In the current system, individuals seeking health care for a simple

Sl#	Dzongkhag	Total admission	Hospital Discharged
1	Bumthang	882	600
2	Chhukha	5067	4381
3	Dagana	1343	1224
4	Gasa	0	0
5	Haa	397	333
6	Lhuntse	861	718
7	Monggar	5211	5143
8	Paro	2349	1929
9	Pemagatshel	1770	1583
10	Punakha	1807	1376
11	SamdrupJongkhar	1984	1744
12	Samtse	3167	2758
13	Sarpang	4096	3641
14	Thimphu	18372	18234
15	Trashi Yangtse	660	668
16	Tashigang	3329	2895
17	Trongsa	710	527
18	Tsirang	1708	1531
19	Wangdue	2094	1660
20	Zhemgang	502	423
	Total	56309	51368

*Total in-patient admissions in 20 districts
(Courtesy, Annual Health Bulletin, 2020)*

issue such as a headache or a common flu, tend to visit larger facilities. Facilities such as the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) is experiencing an increasing burden of general care patients and compromise on the quality of specialist care.¹⁰⁻¹² At the same time, rural community face difficulty in access due to lack of specialist services even when the requirements were real and urgent. All Bhutanese citizen irrespective of place of resident and societal status should have equal access to a decent quality health service.

Due to the changing epidemiological landscape to chronic diseases, services such as palliative care services are either lacking or suboptimal. New cadres of health workers such as palliative care nurses, community care nurses are required to provide the services.¹³

Theme 2

Discrepancy between workload and health workforce deployment can impact health equity

“There is mismatch in distribution of health workforce and health infrastructure. At least 12 out of 49 hospitals attended less than 10,000 cases in a year (old+new) - 32 patients visit per day, whereas six primary health care centers (BHU I & BHU II) saw 10,000 patients in a year. Likewise, 18 sub-posts out of 53 attended more than 1000 cases in a year. Whereas at least 15 BHUs out of 186 saw less than 1000 cases in a year. For example, Phipsoo PHC saw only 201 patients (ie, 1 patient every 2 days or so) whereas Pangbisa sub-post attended 3551 cases. Where there is no demand to keep 3 or 4 staff waiting for patients to come is inefficient use of resources”

- Dr Pem Namgyal

There are two issues with apparent underutilization. In some remote and sparsely populated locations, it will be necessary to keep open a facility with low utilization because travel to an alternative site may not be feasible. Conversely, “are patients bypassing facilities to get to those they perceive as better?” If so, what can be done to keep patients who are “self-referring” at the primary health care level. This can particularly be a problem as transportation improves (roads are built, and people acquire cars). One of the important tasks in improving equity will be to look at these issues separately.

A pilot study conducted in 2019 on workload on staffing in Bhutan documented variation in work load across tiers of health facilities. The

country’s health workforce of 0.5 doctors and 18.3 nurses per 1000 population.^{4,5} Bhutan’s overall health workforce distribution is 14.5 health workers per 10 000 population, lower than the WHO’s regional threshold of 22.8 per 10 000 population.⁵ Investment in the health workforce should continue to close the gaps between the need and the supply.

Inefficient deployment practices of health workforce can hamper the quality of care and impact health outcomes resulting in inequity.^{4,5} The current staff deployment appears to be rigidly driven by infrastructure-based allocation; a traditional norm of allocating 2-3 health assistants per primary health care centre still exists.^{12,13} Retention of health workforce in rural areas is a growing challenge as well. Innovative and strategic policies to incentivize and attract rural services are required for retention of health workers.

A flexible human resource deployment practice adjusted for population size, expected workload and population mobility is required.¹⁴ The Ministry of Health should introduce a system of vigilant system of workload-based deployment where district health managers provide real time updates on staff movement, availability and effect a prompt replacement and reinforcement of staff. Establish a nationalized health staff registry audit at the Ministry of Health and district levels to monitor staff distribution in real time. The Health Sector should focus on equity-based interventions through careful and strategic deployment of human resources, distribution of health services between urban and rural, and design the practice policies of health workforce in the capital and in the rural areas.

Theme 3

Paradox of free health services: a high out-of-pocket payment

“A patient referred to India will be easier for richer families because when they leave their jobs to provide help for the patient it will not affect the whole family. However, if it's poorer family whose father has to work for the children and the mother has to go for cancer care in India, it will totally affect the whole family. Thus, in some aspect we have now to discuss this kind of health care system on how we can improve it.”

- Dr Don Prisno

Healthcare affects differently according to the social background even when the care is supposedly free and equal for everyone. A steady rise in out of pocket payment despite health services being free, is a concern for health equity. Out of pocket payment for health was 12% of the current health spending in 2014.^{2,4,5,11} Reducing financial barriers to health care and avoidance of financial toxicity in seeking healthcare is a key tenet of a well performing health system. An equity question “is how different is the out-of-pocket payment for rich and poor people?”. There is no clear information on this question.¹¹ While this may not be the biggest equity issue in Bhutan, at least for now. It still merits a comprehensive study on out-of-pocket payment to understand whether the low-income families disproportionately bear the burden.

OOPs

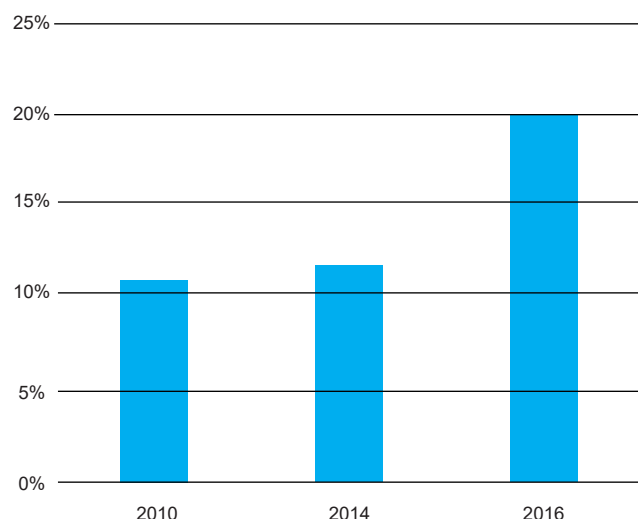


Figure 1: Out-of-pocket expenditure of the total health spending in Bhutan. (Courtesy, Dr. Pem Namgyal, WHO SEARO)

Theme 4:

Enhancing Care coordination and referral path Ways

“Our free healthcare system has no adequate gate keeping mechanisms. Somebody with headache can see a neurologist; somebody with just a diarrhea can see a medical specialist.”

- Her Excellency Dechen Wangmo

Bhutan has a good practice for forward-referrals of patients registered at health facilities and hospitals with free ambulance support. However, the counter-referrals and case handovers of referred patients from “referred-to” to “referred-from” centres are equally important. This practice is less formalized in the current referral systems. Dynamic and bidirectional referrals are necessary to provide optimal care. A pregnant woman referred from Bumthang to Thimphu referral hospital upon discharge needs to inform the Bumthang team to ensure follow up care.¹²

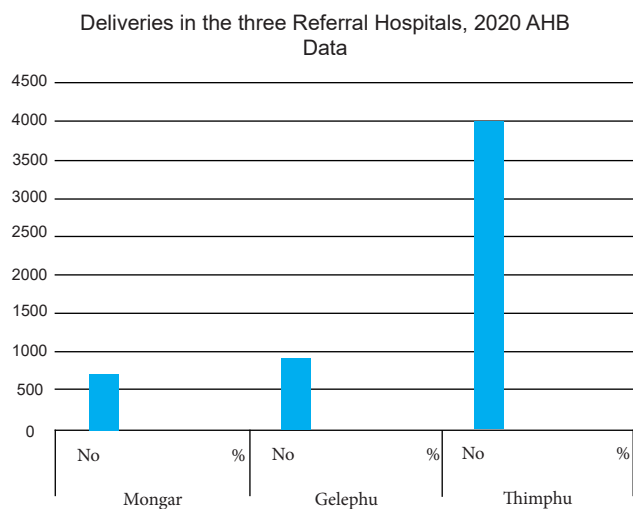


Figure 04: Referral pathways. (Courtesy, Dr. Pem Namgyal, WHO SEARO)

Hospitals and primary health care services cannot work in isolation but require a dynamic relationship to provide coordinated care. To strengthen healthcare services at all levels to respond to current and emerging population health needs particularly to manage complex chronic care.¹³ Health workers need to learn new public health and clinical competencies and perform new roles, e.g., how to be patient-centred and work in teams to provide a satisfactory care. This situation is clearly expressed by a panelist, “We need to look at the patients not just from the technical lens but also need to look at their social and emotional aspects of life and consider the issues. For example, a mother from remote Laya or Lunana has to overcome number of difficulties to reach a hospital. She must ensure that she has enough money to go to hospital, somebody remains at home to take care of her children and has to worry about the transportation.”¹⁵

While effective gatekeeping of primary healthcare facilities is called for, it must be acknowledged that the bypass of services mostly occurs when services such as tests, and medicines are not available or are of poor quality that users lose confidence of the services at the lower levels of health facilities. Not that a PHC has to stock every drug and do every test, but it should be able to arrange for these. The PEN HEARTS initiatives in four districts of Punakha, Wangdue, Tsirang and

Zhemgang where health assistants provide refills of antihypertensive and antidiabetic medicines to patients in PHCs is emerging as a potential model of gatekeeping practice.¹⁶ PHC-oriented model of care should be further deepened to ensure continuous and well-coordinated people-centred high quality care through continuous mentoring and coaching by hospital teams and specialists. In the same vein, hospital teams also should be fully oriented to guide the PHC teams on clinical and quality improvement processes.

Theme 5:

Restructure care for people-centred delivery

“Consider two-unfortunate scenarios- a child birth related hemorrhagic woman living in the rural area during a referral trip from Bumthang to Thimphu referral hospitals and another woman living near these tertiary hospitals with the same condition. It is obvious that the rural woman has lesser chance of survival than her urban counterpart. Applying this scenario at a population level, there is a clear inequity because of woman’s residence from the distance from health facility.”

”
- Dr. Diki Wangmo

Approximately 40% of new borns in the country occurred at JDWNRH in 2018. Similarly, all the related resources are also pooled to Thimphu resulting in crowding and an increase in the load of preventable referrals at JDWNRH. The centralizing of specialist care at Thimphu needs a serious revisit as this can negatively impact health equity and access.¹¹ Furthermore, effectiveness of the service timings of JDWNRH merits a deeper analysis to account for the patterns of patient flow as

overcrowding seems to occur only in the first half of the day. Possibly this could be due to timing for blood collection and diagnostics services which are provided only before 1 PM. The existing satellite clinics in Thimphu city can be reinforced as filter facilities by posting a team led by a doctor, pharmacy and laboratory services for medicine refills to decongest JDWNRH.

The current service rationalization of a three-tiered health facilities allows better command and control systems. However, this may also be a hindrance to equitable access to rural communities who are economically disadvantaged.¹⁵ The arrangement provides better access to advanced hospital-level health care facilities than rural population. Essential tertiary care services are still somewhat inaccessible. To promote greater equality and access to preventive and clinical services, stepped-up cluster care services assigned to “health blocs” not necessarily bounded by administrative districts is required. These cluster-care referral centres should provide specialist services for internal medicine, obstetrics, surgery, pediatric and dentistry. Approximately, six such cluster-care referral centres will be needed: (i) **Trongsa hospital** for districts of Bumthang, Trongsa and upper zones of Zhemgang; (ii) **Wangdue hospital** for Gasa, Punakha, and Wangdue; Dagana and Tsirang; (iii) **Phuntsholing hospital** for lower Chukha and Samtse; (iv) **Paro hospital** for Haa and Paro; (v) **Dewathang hospital** for Samdrupjongkhar, Pemagatsel and lower Tashigang; and (vi) **Tashigang hospital** for Trashiyangtse, Tashigang and neighbouring areas of Mongar. These centres should also be assigned to mentor the district hospitals and primary healthcare teams within the health blocs.

Theme 6:

Private practice without privatizing public healthcare services

“From the economic perspective, private participation can minimize the burden on the government system and supplement the public healthcare service considering the high recurring cost related to health infrastructure and health workforce development.”

- Hon'ble Ugyen Namgay,
Member of Parliament

Debate on introducing private practice in healthcare in Bhutan is drawn by ideological perspectives rather than being guided by objective pragmatic systems assessment and evidence.¹¹ The dialogue must focus on whether private health services can address health disparities and contribute to overall improvement of health services and enhancing equity.

Excessive skepticism on private healthcare appears to stem from the long dependence on a single provider free national public healthcare system and uncertainties surrounding ill-managed private healthcare services. There is no doubt that current public healthcare system is pro-poor and is still the best approach and must be protected to enhance the universal health coverage for the population. However, there is need to relook into how best to diversify, sustain and improve the current healthcare services based on the economy, emerging choices and epidemiological conditions.¹⁵

Privatization is a matter of choice in the development scale as consumer's ability to pay will increase in demand for choices. A sizeable number of Bhutanese are accessing healthcare outside the country. Lack of privatization suppresses the opportunity of a certain segment of the population who can and

are willing to pay for the medical expenses.¹¹

The historical argument and hesitation based on limited doctors (<40 doctors) is becoming more obsolete as the numbers continue to grow and have now crossed 400. Many doctors are already outside the system and providing care across the border to Bhutanese clients. The services of these professionals could be harnessed within the country.^{10,11,15} Fear of loss of doctors is another argument against establishing private practice. Barring doctors to practice the trade also raises a fundamental question of equitable treatment of its citizens to practice the trade. Structural changes, career prospect and job opportunities could be improved to encourage retention of doctors within the government services rather than imposing a restrictive approach.

That considered, introducing private services should not exacerbate health inequity. For example, stopping of the same service in government facilities and outsourcing to the private sector will lead to inequity favouring those who can pay. Risks of diversion to private practice of patient who cannot afford is eminent which requires proper regulatory mechanisms.¹³ Furthermore, it must be remembered that out-of-pocket payment is the worst form of provider payment. Health providers often tend to get this equation missed in the policy dialogue. Setting up a clear purchasing and provider payment system such as co-payment practices, exemption of the poorest and the sickest in conjunction with risk pooling measures should be a precondition to liberalize private practice.

The current practice of “paid off-hour clinics” established at JDWNRH is an incentive for health care teams and it also enables those with jobs and resources to be seen at their convenience. However, the same clinicians in other regional hospitals are deprived of such opportunity. This disbalance should be corrected by providing compensatory incentives to retain the specialists in other

hospitals. Few private diagnostic centres that have been authorized in the country are based on the out-of-pocket payment for services. The government and health policy makers should engage in in-depth dialogue to clearly understand the modalities and mechanisms of private healthcare in the country.

A well-regulated healthcare is essential for the current public healthcare system as well as private healthcare services and pharmacies. Current understanding and support for the regulatory system for healthcare is apparently weak. The Bhutan Medical and Health Council is not adequately empowered to regulate the services and the roles have been relegated as a registration house for health workforce. The Council’s capacity should be built to dispense independent regulatory functions for healthcare services in the country.

Theme 7:

Measurement of equity and resource allocation based on inequity

Health equity involves normative judgement of fairness which is often difficult to measure. Understanding the profile of distribution of the impacts by gender, age, rural and urban locations and economic status is fundamental. Current approaches do not have systematic data collection and analytical work on health equity. Hence the impacts of the long-implemented policies and programmes on health equity is still not well understood in the country.

Health equity assessment tools and capacity and structures of policy implementers to undertake health equity assessments should be built for policy development. Inclusion and wide use of health equity information should be advocated among policy arena to promote creation of shared understanding and practice.¹⁴ Health equity-orientated research is necessary to build minimal level of capacity for evidence-based decision in Bhutan. The National Statistical Bureau of Bhutan conducts

regular consumption of household surveys which can be a potential source to glean information on household spending for health. Information and data on health outcomes and social equity should be advocated for use for justification for resource allocation. Utilization of health services should be closely reviewed to understand consumption patterns of health services. More affluent and better educated tend to consume more health services in the country.¹³ The current budgeting system is usually based on historical perspectives of the past expenditure. Equity information when available should be advocated to use for issue-based and social equity-based budgeting across the ministries. Parliament should be sensitized to include social and health equity evidences as the criteria for budget approval.¹⁵

Whether or not health equity is achieved is dependent on numerous social determinants or the “causes of the causes”. The health sector may be best positioned to address only the proximal factors and have no influence on the upstream factors of health inequity. Strong collaboration, coordination and communication with stakeholders including community-based organization is necessary to improve health equity.

Theme 8:

Build health sector leadership for design and delivery of pro-equity policies and healthcare services

While health-equity is primarily driven by macro-policies and requires a multi-stakeholder approach, health sector is commonly perceived as the custodian of the subject. The Ministry of Health is called upon to lead constant reforms and transitions to design pro-equity people-centred health services or manage unpredictable situations such as the pandemics, epidemics and humanitarian emergencies. The Ministry of Health should be agile and be prepared to lead under any situation.¹³

The core function of a Health Ministry pertains to disease prevention, control, management, rehabilitation, health promotion and protection of population and efficient planning and delivery of preventive, promotive, curative and rehabilitative healthcare services. Health managers should be trained in globally tested disciplines that include planning, health service management, health promotion, epidemiology and disease control, disease management, rehabilitation. Current portfolios in the health management are not defined by these competencies and have mostly become generalized clerical positions. This approach undermines the depth of relevant professionalism required by the Ministry of Health. The root problem seems to arise from the Royal Civil Service’s erroneous policy that tend to disregard competency-based appointments for portfolios that are highly specific to disease control which require sound training on clinical and preventive health and medical disciplines.¹¹ Learning from the COVID-19 pandemic experience, investment in the professionalism of health management is urgent as much as the clinical services in hospitals and health facilities.¹³ The Ministry of Health in coordination with the RCSC must undertake management reforms in rethinking health management portfolio with right balance of core professionals to manage national programmes and projects geared towards enhancing health equity and access in Bhutan.

CONCLUDING KEY MESSAGES

“*If we need to achieve health equity, I feel we must reach the unreached, hear the unheard and we must feel the unfelt. If we can do that I believe, we will not have any issue in achieving the goal of leaving no one behind.*”

*Hon'ble Ugyen Namgay,
Member of Parliament*

- 1. Free health care does not necessarily mean equity in care.** Institute health equity-based services and set up health equity monitoring system to ensure that those most in need are accounted. The indicators to measure the health equity in the current health system is missing. Identify and integrate health equity indicators in the healthy policy and the proposed Health Bill of Bhutan. Institute culture and capacity for health equity-oriented services in design and delivery of health services.
- 2. Design flexible human resource deployment policies to improve health services.** Improve effective deployment of health workforce adjusted for workload and population movement to improve quality of health services. Prioritize rapid replacement and reinforcement of staffing policies in rural locations where poor seek services.
- 3. Reorganize the services by building care clusters to improve access to a range of standard healthcare.** The existing practice of clustering of the specialist and subspecialty in limited locations hinder equitable delivery of health care. Establish additional specialized care clusters services (approximately five centres) in strategic locations to minimize distance for tertiary services to complement the Mongar, Gelephu and JDWNRH referral hospitals. Concurrently, strengthen referrals, management and proactive interaction of specialists and primary health care teams by introducing systematic infrastructure of mentoring and supportive supervision to ensure adequate gatekeeping and delivery of people-centred care.
- 4. Explore options for a well-regulated private healthcare without privatizing public healthcare services.** Existing public healthcare should be protected to serve the poor and the general population. At the same time, explore liberalizing well-regulated private healthcare beginning with certain services. Potential services include setting up dual practice (after office hours) through organized care teams in densely populated areas. General practice, dental care services and diagnostic and laboratory may be potential services. As a precondition to the private healthcare, introduce strong policy for provider payment mechanism to minimize out-of-pocket payment.
- 5. Neglect of professionalism in health management affects agility of a health system. Balance the bureaucracy with technocracy at all levels starting with the Ministry of Health to prepare a 21st century health care in Bhutan.** Health sector globally is a technocratic organization. Fundamental competencies for management of a health organization requires competencies in healthcare services for preventive, promotive, curative and rehabilitative services. Bhutan's health system cannot be an exception. Build the pool of managers with public health and clinical professionals with a core competency in epidemiology, in disease surveillance, in data analytics and disease control program management at the Ministry of Health and at district levels.

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