SUMMER INTERNSHIP REPORT

At

IQVIA

(April 21st to June 21st, 2023)

Analysis of fundamentals of the health systems in Bhutan, India, Nepal, and Sri Lanka.

A Report

By

Aditi Nasa

PG/23/005

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH,

New Delhi

ACKNOWLEDGEMENT

After giving some thought to the extremely intense and event-filled previous two months, I would like to thank everyone who helped me get to this day of results. The following individuals were essential to making this internship happen. This Internship was a golden opportunity for learning and self-development. I consider myself fortunate for have been provided with this opportunity to learn and grow in Public Health Sector.

I would like to take this opportunity to express my deepest gratitude and appreciation to all those who have supported me throughout my internship journey.

I would like to express my gratitude towards **IIHMR DELHI** for providing me with the opportunity to work with IQVIA and my mentor **Dr. Pankaj Talreja** for incessantly guiding me.

I am grateful to **Mr. Kapil Dev and Mrs. Manjari Sharma** for their desire to involve me in relevant tasks, patience, and collaborative spirit that has all made a significant difference in my learning process. I am grateful for the confidence they had on me and the chances they gave me to help the team achieve its goals.

I am immensely grateful to **Dr. Nadeem**, my mentor, whose unwavering guidance and support throughout the internship has been instrumental in shaping my understanding of the Public Health landscape. His expertise and encouragement not only facilitated my learning but also helped me contribute meaningfully to the ongoing projects and have been instrumental in my development as a budding professional. I am grateful for my metors' willingness to share his time, knowledge, and experiences, that has contributed significantly to the quality and depth of this study.

The pleasant workplace culture made each day pleasurable and fruitful. Their invaluable advice, insightful feedback, and encouragement have been instrumental in shaping this internship

Furthermore, I am grateful for the opportunity to explore Public Health that has been enlightening and has broadened my horizons, making me more aware health systems in SEA counties and the potential of strengthened health systems.

I would also like to extend my appreciation to my fellow interns, with whom I had the pleasure of collaborating. Their enthusiasm and dedication made the internship experience even more enjoyable, and I am thankful for the knowledge exchange we had.

I look forward to utilizing this experience as a foundation for my future endeavors in the field of digital health and public health.

Thankyou

LIST OF ABBREVATIONS

HSS	Health System Strengthening
WHO	World Health Organization
MDGs	Millennium Development Goals
TB	Tuberculosis
USAID	U.S. Agency for International Development
SHA	System of Health Accounts
MoH	Ministry of Health
MCH	Maternal and Child Health
IMR	Infant Mortality Rate
NMR	Neonatal Mortality Rate
EPI	Expanded Programme on Immunization
HAQI	Healthcare Access and Quality Index
SEA	South – East Asian
CHE	Current Health Expenditure
THE	Total Health Expenditure
OOPE	Out Of Pocket Expenditure
DCS	Department of Census and Statistics
HIS	Health Information System
DHIS	Digital Health Information System
GDP	Gross Domestic Product
NCDs	Non-communicable Disease
PHC	Primary Healthcare
SNG	subnational governments
HRH	Human Resource for Health
ANMs	Auxiliary Nurse Midwife
FY	Financial Year
UHC	Universal Health Coverage
NPR	Nepalese Rupee
CHC	Community Health Center

Approval from mentor

Sir I have attached my internship report that I prepared during my summer internship at IQVIA.
Kindly check.

Thankyou.
Aditi

Sent from Outlook for Android

DT

Dr. Pankaj Talreja

To: Aditi Nasa

Sat 22/06/2024 13:38

Approved.

Best,
Dr. Pankaj Talreja

Sent from Outlook for Android

...

Certificate of Approval

The Summer Internship Project of titled “TITLE OF YOUR PROJECT” at “YOUR ORGANIZATION is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.

Name of the Mentor

Designation IIHMR, Delhi

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: Aditi Nasa

Summer Internship Institution: IQVIA

Area of Summer Internship: HSS & Primary health Care

Attendance: 100%.

Objectives met: 1) Developed understanding of health systems of different countries and related building blocks. 2) Developed understanding on proposal writing, contents & structure. 3) Developed analytical skills related to qualitative research.

Deliverables:
1) completed assigned description & analysis work
2) supported in revision of DHSS reports.
3) Supported in revision of Zero dose catch up reports
4) Drafted background for proposal. 5) Drafted health system

Strengths: Strengthening internship report.

- Disciplined
- positive attitude
- communication and fast learner

Suggestions for Improvement:

Need to focus on analytical part.

Signature of the Officer-in-Charge (Internship)

(MANJARI SHARMA)
IQVIA - PH

Date: 14/06/24
Place: Delhi.

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21st June 2024

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Aditi Nasa** was associated with **IQVIA Consulting and Information Services India Private Limited ("IQVIA")** To **analyze fundamentals of health system in Sri Lanka, Bhutan, India and Nepal** as a part of the curriculum during the period from **22nd April 2024** till **21st June 2024**

This certificate is being issued to recognize successful completion of her internship.

For IQVIA Consulting and Information Services India Pvt. Ltd

VARINDRA Digitally signed by VARINDRA Date: 2024.06.21 21:35:59 +05'30'

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Varindra B

OBSERVATIONAL LEARNINGS

INTRODUCTION

IQVIA is a top global supplier of clinical research services, technology solutions, and sophisticated analytics to the life sciences sector. IQVIA uses its analytics, big data resources, transformational technologies, and domain experience to build intelligent linkages across all facets of healthcare. With the speed and agility with which IQVIA Connected Intelligence delivers potent insights, clients can expedite the clinical development and commercialization of cutting-edge medical treatments that enhance patient outcomes. IQVIA operates in more than 100 countries and employs about 86,000 people.

In terms of protecting patient privacy, IQVIA is a global leader. The company uses a variety of privacy-enhancing technologies and safeguards to protect individual privacy while generating and analysing data on a scale that assists healthcare stakeholders in identifying disease patterns and correlating with the exact treatment path and therapy required for better outcomes. Medical researchers, payers, biotech, pharmaceutical, medical device, and government organisations can use IQVIA's insights and execution capabilities to advance their search for cures by gaining a better understanding of diseases, human behaviour, and scientific advancements.

IQVIA MISSION

IQVIA envisions a future in which human inventiveness and data science breakthroughs combine to produce innovative ways to enhance human health. Our vision is this. where each obstacle is viewed as a chance to significantly influence patients, clients, and people. Find a fulfilling work and contribute to a healthy planet.
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IQVIA VALUES

- Creativity
- Teamwork
- Innovation

IQVIA possesses extensive proficiency in delivering advisory services to governments, international non-governmental organizations (NGOs), and multidimensional funding agencies in emerging markets. Their comprehensive capabilities encompass strategic guidance, program management, national health surveys, commodity assessment and mapping, procurement and supply chain evaluation, in-country development, monitoring and evaluation, assessment of pharmaceutical markets, engagement with the private sector, ensuring access to medicines, policy and regulatory analysis, and health data analytics across different geographies.

KEY ACTIVITIES

- In depth understanding and also worked on building blocks of health system given by WHO for Strengthening District Health System in Urban Poor and Rural Areas to Reach Every Child and Reduce Zero Dose Towards Integrated Primary Health Care in South Asia.

- Studied about district health system of Nepal which included
  - To understand local government planning framework
  - Structure of governance in the country
  - National Health programs running in the nation.

- Worked on national and sub-national health system of Bangladesh, where I learned:
  - About service delivery mechanism in the country
  - Decentralization of health system and powers that provincial government holds in policy formulation.
  - Levels of health system in the country.
  - And the importance that health holds in the constitution of Bangladesh.

- Got to learn transcript and analysis.

- Prepared a report on Maldives which included the:
  - HRH Strategy of the country.
  - Infrastructure guidelines
  - OOPE that the country faces.
  - Service standard quality guidelines
  - Referral pattern in the country

- Drafted background for proposal submission of a project dedicated to improve Post partum Hemorrhage.

- Supported with secondary research on drug procurement for NHM and essential drug list of India.

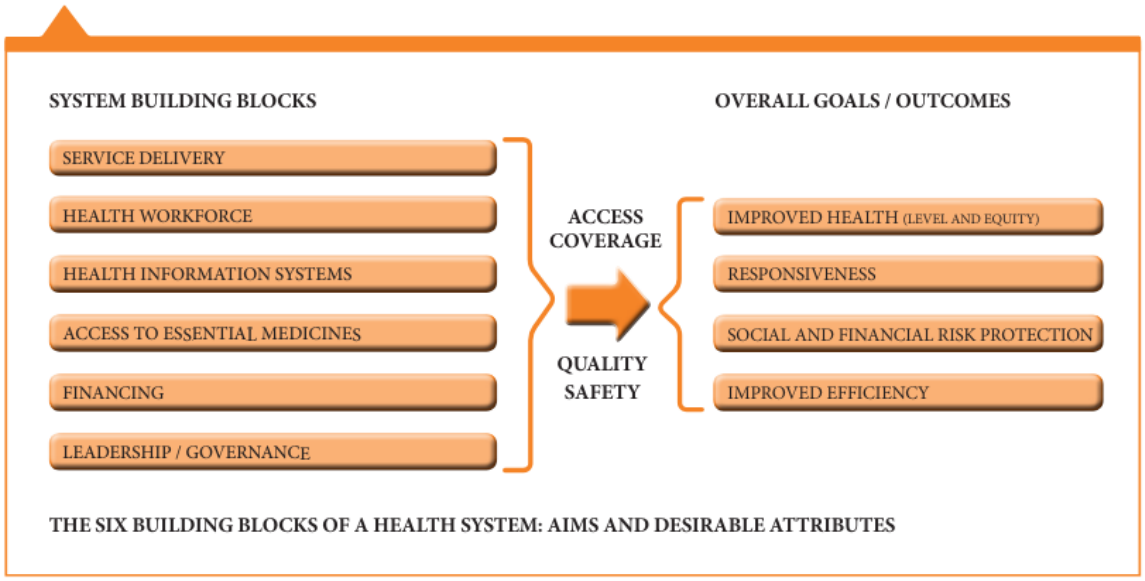
- Assisted in preparation of report to be submitted to UNICEF on strengthening of district health system in SEA countries.

HEALTH SYSTEM STRENGTHENING

A health system that functions harmoniously is built on a foundation of a well-trained and motivated workforce, a consistent supply of pharmaceuticals and technologies, well-maintained infrastructure, adequate funding, strong health plans, and evidence-based policies.
Health systems must be prepared to handle and react to risks to global public health, such as pandemic diseases and other extreme occurrences, given the interdependence of today's globalized globe.
Health system strengthening (HSS) is the process of improving the six parts of the health system and managing their interconnections to create more equitable and long-lasting benefits in health outcomes and services. HSS demands knowledge and action on the technological and political fronts. It can be seen as a programme or project, but it can also be seen as an implementation strategy, whereby programmes are implemented in a way that gives technological support to the existing healthcare system, so empowering it.

The WHO framework, which defines health systems in terms of six fundamental elements or "building blocks," serves as the foundation for this report's organization.

(i) Service delivery
(ii) Health workforce
(iii) Health information systems
(iv) Access to essential medicines
(v) Financing
(vi) Leadership/governance[1]



HEALTH SERVICE DELIVERY

The attainment of the health-related Millennium Development Goals (MDGs), which include delivering interventions to lower child and maternal mortality as well as the burden of HIV/AIDS, TB, and malaria, depends on strengthening service delivery.
An essential component of any health system is effective service delivery. In addition to other elements like the socioeconomic determinants of health, service delivery is a crucial contributor to the overall health of the population. The specific structure and nature of health services will vary from nation to nation, but the network of service delivery in any effective health system should have the following essential elements: -

[1] WHO health system strengthening framework

1. Comprehensiveness: To meet the needs of the target population, a broad range of health services are provided, including curative, palliative, rehabilitative, and preventative care as well as health promotion programs.
2. Accessibility: Services are directly and permanently available; there are no unwarranted financial, linguistic, cultural, or geographic barriers. The general people can obtain health services because primary care is a regular point of entry into the service network (instead of at the hospital or speciality level). Services may be provided in homes, communities, workplaces, or medical facilities, depending on the circumstances.
3. Coverage: The design of service delivery ensures that all members of a specified target population—that is, both the healthy and the ill, as well as all socioeconomic and income groups—are covered.
4. Continuity: People are intended to have access to ongoing care throughout their lifetimes, spanning a variety of services, medical conditions, and care levels, thanks to the way services are provided.
5. Quality: Medical services are the best available; they are timely, secure, effective, and patient-centered.
6. Person-centeredness: The individual, not the ailment or the financing source, is the main focus of services. Customers think health services are satisfactory and accommodating. The planning and assessment of service delivery involve the target population. People actively participate in their own medical care.
7. Coordination: The local region's health service networks, which cover provider types, treatment modalities, and service delivery levels, are actively coordinated for both routine and emergency preparation. The patient's primary care physician assists the patient in navigating the system and receiving the necessary treatments, in addition to working with other levels and types of providers. Coordination is also carried out with other sectors (such as social services) and partners (such as community organisations).
8. Efficiency and accountability: Health services are efficiently run to achieve the aforementioned core elements while wasting the fewest resources possible. Managers are in charge of overall performance and results and are empowered to carry out preset objectives. The assessment includes appropriate routes for civil society participation and the intended audience.

HEALTH WORKFORCE

The health workforce is defined as "all individuals involved in activities whose primary intent is to enhance health." These human resources include clinical professionals like physicians, nurses, chemists, and dentists as well as management and support professionals, or those who are essential to the functioning of health systems but do not directly offer services, like managers, ambulance drivers, and accountants.

The education, training, drive, and experience of persons responsible for organising and carrying out the delivery of healthcare services largely determine a country's ability to meet its health goals. The number of health workers and population health outcomes are clearly and favourably correlated, according to numerous research. However, for a number of reasons, including a lack of a diverse skill set, limited production capacity, the mobility of health workers both within and across countries, and demographic imbalances, many countries lack the human resources required to deliver essential health interventions. Training employees to strive towards reaching the country's health objectives is one of the most important challenges facing its health system. Regarding technique, there are no predetermined rules for figuring out whether the health workforce

However, the World Health Report of 2006 estimated that nations with less than 23 doctors, nurses, and midwives per 10,000 people typically do not reach the appropriate coverage rates for certain primary health care interventions that are prioritized by the framework of the Millennium Development Goals.[2]

[2] WHO Health system strengthening framework

HEALTH INFORMATION SYSTEM

Every element of the health system's decision-making process is based on reliable and accurate data. The development and execution of health system policies, governance and regulation, health research, human resource development, health education and training, service delivery, and finance all depend on it. Data creation, compilation, analysis and synthesis, and communication and utilisation are the four primary functions of the health information system. It also provides the basis for making decisions. The health information system collects data from the health and other relevant fields, assesses it to ensure its general quality, relevance, and timeliness, and then turns it into knowledge that can be applied to health-related decision-making.

IT HAS TWO COMPONENTS: -

Birth registration coverage: - It emphasizes that timely, accurate, and comprehensive civil registration is necessary for high-quality vital statistics.

Death registration coverage: - It includes the approximate coverage of deaths that are reported together with the reason of death.

HEALTH SYSTEM FINANCING

An essential component of health systems' capacity to preserve and enhance human welfare is health financing. In the worst-case scenario, there wouldn't be any jobs for health professionals, no medications would be accessible, and no health promotion or prevention would occur without the required funding. But financing entails much more than just creating money. It is necessary to explicitly examine the intended outcomes in order to comprehend the nature of indicators that can be used to track and assess the funding of health systems.

The National Health Accounts (NHA) is the most reliable source of information about health spending since it compiles data from all sources and financial agents. Despite the fact that some country analysts choose to employ variations on this topic, such as a method known as "national account sub-accounts," the System of Health Accounts (SHA), which was designed by the OECD for its member nations, has become the international classification standard. Generally speaking, the numbers that result from one approach can be changed to match the results of the other. In response to the demands of low-income countries, the World Bank, USAID, and WHO recently collaborated to establish a guide for conducting non-healthy adoption (NHA) in these nations. The guidance was based on SHA.8 When the techniques are used in different contexts, it has led to collaboration between.[3]

LEADERSHIP AND GOVERNANCE

An increasingly important topic on the development agenda is health governance. Effective oversight, coalition building, regulation, system design considerations, accountability, and strategic policy frameworks are all essential components of leadership and governance when developing a health system. The desire for more accountability is being driven by increased funding as well as a growing need to demonstrate results. The management of relationships between various health stakeholders, including individuals, families, communities,

[3] WHO Health system strengthening framework

businesses, governments, nongovernmental organisations, and other organisations entrusted with financing, overseeing, delivering, and utilising health services, makes accountability a crucial part of governance.
In particular, accountability involves financing to ensure that there are enough resources available to deliver basic services, as well as delegation or awareness (implicit or explicit) of the means by which services are given. accomplishment in connection with the actual delivery of services. acquiring relevant data for monitoring or performance evaluation. putting policies into place, such charging fines or providing rewards for hard work. Concerns about accountability are directly tied to the multidisciplinary subject of health governance. When it comes to creating health systems, it is an essential part of the components discussed in previous sections of this guidebook. Despite the general consensus that leadership and governance are essential to improving health outcomes, they are not sufficiently examined and evaluated.

ASSESS TO ESSENTIAL MEDECINES

Equal access to essential medications, vaccines, and technologies that are certain to be of the highest calibre, safe, efficient, and cost-effective, as well as their application in a manner that is both cost-effective and in line with scientific principles, are all guaranteed by a robust health system. The WHO framework for health systems is followed here. To achieve these objectives, the following are necessary:

- Details regarding costs, the state of trade agreements worldwide, and the ability to establish and bargain for rates;
- The evaluation of priority items' quality and the use of trustworthy manufacturing techniques where available domestically;
- Methods for distribution, supply, and storage that reduce leakage and other waste; and
- Support for the judicious use of drugs, supplies, and equipment through policies and plans that ensure compliance, lower resistance, increase patient safety, and improve patient education.

RATIONALE

By guaranteeing that everyone gets access to necessary healthcare services regardless of their socioeconomic level, place of residence, or other health determinants, health system strengthening can help eliminate health inequities. My goal is to investigate how improving the health system might lessen inequalities in health outcomes.

Metrics and indicators for evaluating the performance of the health system can be developed and improved with the help of research on strengthening the health system. This comprises metrics for the equity, sustainability, quality, accessibility, and economy of healthcare services.

Strengthening the health system is a top objective for both funders and international development organizations. Research may determine best practices, inform future funding priorities, and assess the efficacy of expenditures in health system improvement programmes and development aid.

My objective in doing this evaluation is to assess strategies that maximize resource allocation, minimize resource waste, and enhance the effectiveness of service delivery in health systems.

JUSTIFICATION

Improving Access to Healthcare: My research aims to uncover ways to improve everyone's access to healthcare services, especially underprivileged and marginalized groups, by analyzing the flaws and inadequacies in a health system.

Improving Quality of care: My research identifies opportunities to raise the standard of care provided by health systems. This involves making certain that healthcare services are patient-centered, timely, efficient, safe, and grounded in evidence.

Optimizing Resource Allocation: Research on bolstering the health system can help lawmakers make more informed decisions on how best to distribute resources within the healthcare system. This covers factors including workforce distribution, infrastructure development, and budget allocation.

By identifying the weaknesses of health systems, solutions to strengthen their resilience can be developed, making it possible for these systems to endure and successfully respond to crises like pandemics, natural disasters, or infectious disease outbreaks.

RESEARCH QUESTION

To analyze the fundamentals of the health systems in Bhutan, India, Nepal, and Sri Lanka.

METHODOLOGY

A variety of secondary data collection methods were employed, such as desktop analysis, information from credible government websites, research papers, publications, and current reports that are in the public domain,

as well as information from other relevant platforms. This methodology facilitates a thorough examination and integration of relevant information within the specified framework. To get a deep understanding of the topic, a variety of sources were thoroughly explored. By making use of the wealth of information that is easily accessible, the study makes sure that analysis and interpretation have a strong basis, enabling the generation of knowledgeable insights and conclusions.

SRI LANKA

COUNTRY PROFILE

In Sri Lanka, a healthcare facility is a place that offers excellent, conveniently located healthcare. The effectiveness of a healthcare system is influenced by numerous factors, as everyone is aware. The public sector provides around 95% of inpatient treatment and about 50% of outpatient care. Stewardship operations, including creating health policies and laws, monitoring programs, offering technical supervision, and overseeing health technologies, human resources, and tertiary and other speciality institutions, fall within the purview of the Ministry of Health (MoH). The primary and secondary levels of curative and preventative care are supervised by the nine provincial ministries. As of mid-2022, there were approximately 1500 healthcare institutions overall, with 588 of those being hospitals and 517 being primary care centres.

There are 354 physically designated regions (MOH) across the island of Sri Lanka where preventive healthcare is provided. Each area is served by a medical officer of health (MOH) and a team of community-based specialists who provide a particular set of preventative services. All state-provided services, including lab space and drugs, are provided free of charge at the delivery site. There are also separate service facilities for the military, police, and prisons.

Sri Lanka had achieved a relatively high level of health. An effective mother and child health (MCH)-care system has led to a large increase in the infant mortality rate (IMR), newborn mortality rate (NMR), under-5 mortality rate (U5MR), and maternal mortality ratio (MMR); nevertheless, the rate of decline has slowed.

Majority of hospitalized health is provided by the state sector (95%) and half of the outpatient care is provided by the private sector.[4]

LEADERSHIP AND GOVERNANCE

In Sri Lanka, the Ministry of Health is in charge of directing the whole health industry. addressing both the present and the issues of the future. by using open procedures, national health policies, plans, strategies, higher level steering committees, and task forces that provide the health sector with a clear direction. Enforcing regulations effectively by combining guidance with legal support. Increasing non-health sector agencies' participation, coordination, and multi-stakeholder engagement in order to meet health aims.

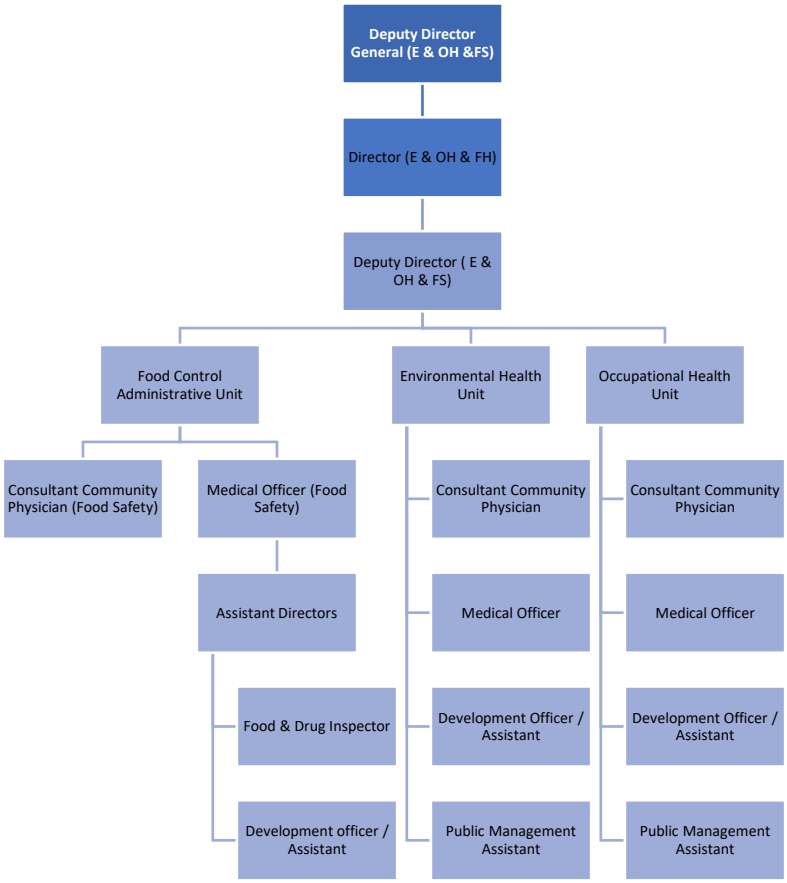
[4] https://www.health.gov.lk/top-officials/

The majority of health managers in the nation are physicians. The majority of them had their training in the UK, Australia, and the USA and hold an MSc or MD in medical management from PGIM, University of Colombo. While guaranteeing patient safety, they established and upheld high standards of productivity and high-quality medical care at their institutions. Public health experts oversee the preventative health industry.

HIERARCHIAL LEADERSHIP STRUCTURE FOR MINISTRY OF HEALTH, SRI LANKA

The Secretary of Health is the highest-ranking position in the Ministry of Health (MOH) in Sri Lanka. Dr. P. G. Mahipala holds this position and leads and directs all departments and divisions within the ministry. **Additional secretaries** assist in managing the day-to-day administrative operations of the ministry, such as budgeting, procurement, human resources management, and general office management. Next in line is the **Director General of Health Services**, whose duties include collaborating closely with the Ministry of Health to develop healthcare policies and strategies targeted at enhancing population health outcomes as well[5]

as plans and programmes for the delivery of healthcare services nationwide, guaranteeing that every citizen



has equitable access to high-quality healthcare. The **Deputy Director General of Health Services** is the person who comes next. They are in charge of overseeing the management of public hospitals and healthcare facilities, making sure that they run smoothly, provide high-quality care, and follow all rules and regulations. They also design and carry out plans for emergency medical services, disaster preparedness, and responding to public health emergencies and outbreaks.

[5] https://www.health.gov.lk/health-institutions-in-sri-lanka/

SERVICE DELIVERY

Lanka's health system has been recognized as a high impact, low-cost model on a global scale (Perera et al., 2019). The implementation of primary care and preventive care systems since 1926, the development of a vast network of easily accessible primary health care facilities, and the provision of free care at the point of delivery since 1951 were the main contributors to this accomplishment.

There are two facets to service delivery: preventative and curative. The overall efficacy of the healthcare system is measured by the Healthcare Access and Quality Index (HAQI), which is based on 37 of the 50 Sustainable Development Goals. With a score of 73 out of 100, Sri Lanka scored higher than all of the comparator nations in the WHO's South-East Asia and Western Pacific areas (Indonesia, Malaysia, Thailand, Philippines, and Vietnam). According to some comparable metrics, Sri Lanka's inpatient clinical care quality is on par with that of upper middle-class Asian nations, and in other cases, it even exceeds that of developed nations.

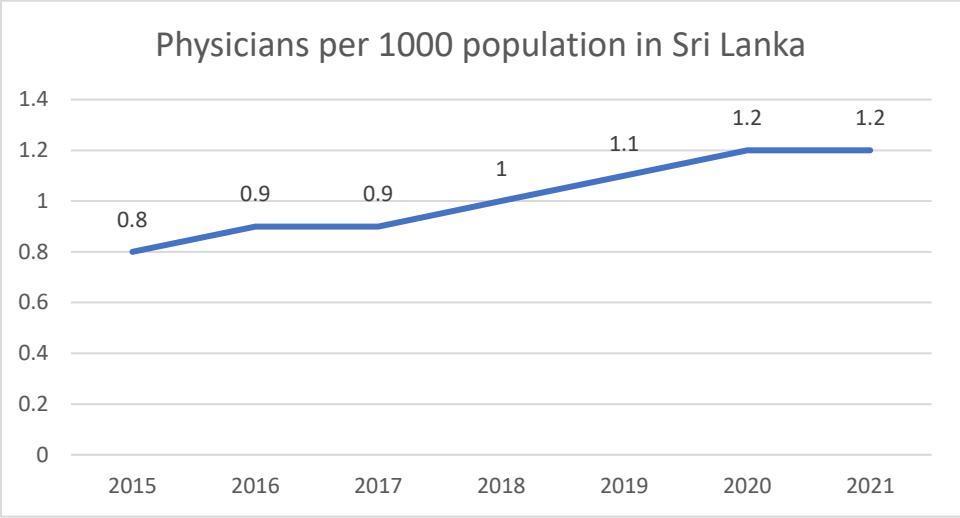
Among Southeast Asian nations, Sri Lanka has the highest hospital bed penetration rate (4 beds per 1000 people) (Ministry of Health, 2021). Both public and commercial hospitals offer inpatient care, with state-run institutions offering the majority of services. According to the Department of Census and Statistics (2016), 628 public hospitals made up 73% of all hospitals and 93% of all bed capacity in the nation at the time of the survey of healthcare facilities.

Sri Lanka boasts exceptional statistics in the fields of primary care and preventative health. With 30 maternal deaths per 100,000 live births in 2015, Sri Lanka had the lowest rate of any country in South Asia, lower than Bangladesh's 173, India's 113, the Maldives' 53, Nepal's 186, and Pakistan's 140. Maternal, newborn, under-5, and neonatal mortality have all seen notable improvements. Both sexes now have higher birth weights and women live an average of 6.7 years longer than males. Additionally, poliomyelitis, malaria, and measles have all been successfully eradicated in Sri Lanka.[6]

[6] https://www.health.gov.lk/health-institutions-in-sri-lanka/

HEALTH WORKFORCE

The MoH employs a little over 140,000 individuals in both the line and provincial ministries. In 2015, there were 3.7 doctors, nurses, and midwives for every 1000 people (World Health Organization, 2018b). This shows that during the past ten years, Sri Lanka's health worker-to-population ratio has increased by 70%. Sri Lanka has achieved the World Health Organization's (2014a) minimum density level of 34.5 qualified health workers per 10,000 persons in the context of universal health coverage. However, the growth in the number of employees has not been uniform across all categories (World Health Organization, 2018b).



HEALTH INFORMATION SYSTEM

All components of the health system are founded on sound and dependable information management systems, which are the foundation of evidence-based decision-making. Health research, human resource development, health education and training, governance and regulation, service delivery, finance, and the formulation and implementation of health policies all depend on it. The Sri Lankan health information system (HIS) is divided into two subsystems: population-based and facility/institutional-based.

- The Department of Census and Statistics (DCS) frequently conducts household surveys as part of population-based HIS, while the Department of Registrar General (RGD) is responsible for civil registration.
- Information from institutions in the curative and preventative sectors, such as clinical, health, and management information systems, is included in facility-based HIS.[7]

AVAILABLITY OF ESSENTIAL MEDECIES

In addition to their scientifically sound and cost-effective use, a robust health system ensures that everyone has fair access to necessary medical supplies, vaccinations, and technology that are assured to be of high quality, safety, efficacy, and cost-effectiveness.

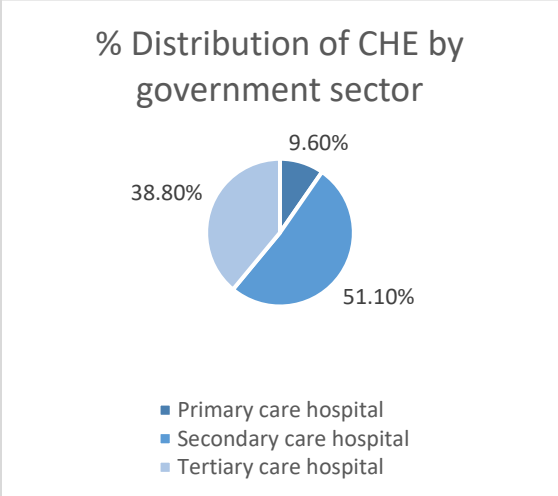
[7] https://www.health.gov.lk/

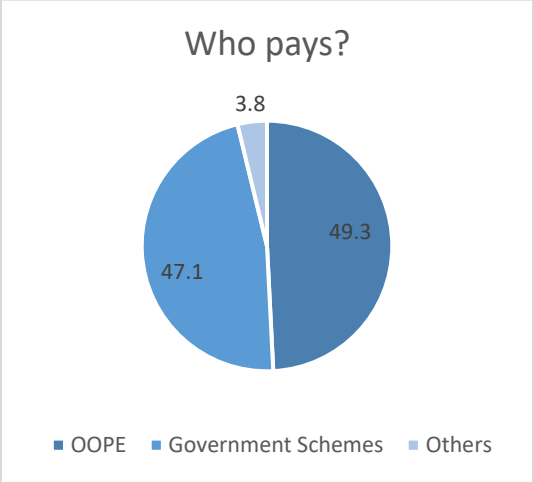
- The State Pharmaceutical Corporation is in charge of acquiring pharmaceuticals, and the Ministry of Health's medical supplier division is in charge of managing the networks for supply, storage, and distribution.
- National drug policy standards, guidelines, and regulations (NMRA) and how they support policy.

HEALTH FINANCING

In Sri Lanka, the Ministry of Health is in charge of directing the whole health industry. addressing both the present and the issues of the future. by using open procedures, national health policies, plans, strategies, higher level steering committees, and task forces that provide the health sector with a clear direction. Enforcing regulations effectively by combining guidance with legal support. Increasing non-health sector agencies' participation, coordination, and multi-stakeholder engagement in order to meet health aims. People can get essential healthcare services without facing financial difficulty or destitution because of the expense of those services thanks to the health finance system, which provides adequate funding for healthcare. The entire amount spent in Sri Lanka on public and private healthcare is 3.4% of

In terms of public health spending as a percentage of GDP, Sri Lanka's expenditures (1.6%) are comparable to those of its regional counterparts in South Asia (0.9%) and lower middle-





income nations (1.3%). Spending, however, is only half that of upper middle-income nations (3.2 percent). From 2.3 percent of GDP in 2000 to 1.6 percent of GDP in 2016, Sri Lanka's health spending has decreased over time.[8]

KEY CHALLANGES

- COVID-19 had a significant negative impact on tourism, one of Sri Lanka's primary revenue streams. This resulted in budgetary constraints and limited capital development, which raised personal expenses.
- Only 15% of medical supplies are made in Sri Lanka. As a result, Sri Lanka depends heavily on neighbouring countries. Antibiotics are also being used excessively.
- The entire population of the country has not yet been assigned a health identification number (HIN). Therefore, retrieving patient information when needed is very difficult.
- In Sri Lanka, the issue of medical professional migration has long been recognised.
- Secondary and tertiary care facilities in Sri Lanka are overloaded, and there is no suitable referral mechanism in place.

[8] https://www.health.gov.lk/wp-content/uploads/2023/11/Digital-Health-Blue-Print-Full-Book-01.11.2023-Final.pdf

- It's challenging to oversee a healthcare system with little funding while keeping standards high. Pressure from trade unions to fill health care administration positions with unfit candidates.[9]

SRI LANKA – PRIMARY HEALTHCARE STRENGTHENING PROJECT (THE WORLD BANK)

The Primary Health Care System Strengthening Project for Sri Lanka aims to improve the quality and uptake of primary health care services in specific regions of the nation, with a focus on the identification and treatment of non-communicable diseases in high-risk groups. There are three components to it. The provinces and the Ministry of Health, Nutrition, and Indigenous Medicine (MoH) will be assisted in restructuring the Primary Health Care (PHC) system and strengthening strategies through the application of standard health sector planning and budget execution techniques. This is the first component of the program. The three thematic areas were further translated into five results areas that the project will support after stakeholder interaction throughout project preparation. This plan will boost the industry's capacity to

- PHC policy and standards defined to support implementation.
- Strengthened services and capabilities for Primary Medical Care Institutions (PMCIs) to provide more thorough and high-quality care.
- Systems of support created to enable better PHC delivery, with an emphasis on non-communicable diseases (NCDs).
- The health system empowers people and improves its ability to meet public expectations.
- The second element consists of innovation awards and project implementation support, which would directly assist the Ministry of Health and, via the MoH, provinces for projects that would be difficult to implement using the country's conventional public financial management procedures. Increasing the use of PHC services with a focus on NCD identification and proactive follow-up is the first component.
- The component would provide essential support to enhance and facilitate the implementation of strengthening initiatives and the reorganization of the PHC system.
- Third element, after an emergency, the nation can quickly reallocate any unspent funds from other traditional investment project components to meet its immediate financial needs for mitigating, responding to, and recovering from any potentially harmful effects. This is made possible by the contingent emergency response component. In order to (a) assist the client in the initial response, (b) facilitate the early recovery phase, and (c) bridge the transition to the longer-term phases of recovery and reconstruction, the availability of quick finance is vital.[10]

SRI LANKA HEALTH SYSTEM ENHANCEMENT PROJECT (ASIAN DEVELOPMENT BANK)

The initiative aims to foster the establishment of a more responsive and comprehensive primary health care (PHC) system in Sri Lanka, thereby contributing to the government's development objective of ensuring a healthier nation. The initiative improved the planning and provision of critical PHC to the economically and

[9] https://www.health.gov.lk/wp-content/uploads/2023/11/Digital-Health-Blue-Print-Full-Book-01.11.2023-Final.pdf

[10] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/306851530329751047/sri-lanka-primary-health-care-system-strengthening-project

geographically disadvantaged communities in the provinces of Uva, Central, North Central, and Sabaragamuwa. The undertaking will

- Inform and operationalize government PHC reform initiatives.
- Improve underserved communities' access to primary healthcare services.
- Address selected gaps in core public health capacities in line with the International Health Regulations (IHR).

The planned effort will improve the efficiency, equity, and responsiveness of the primary health care (PHC) system. It is based on the principle of providing universal health coverage and a continuum of care to quality essential health services.
The project aims for parity in the planning and delivery of essential basic health care. In order to better inform and operationalize government PHC reform initiatives to decrease PHC facility bypassing, it aims to offer more complete services, especially for NCDs, establish a referral system, and functionally integrate preventive and curative treatment. The program will also target PHC access to disadvantaged people and address specific shortcomings in basic public health monitoring (IHR) in accordance with international health regulations.

IMPACT AND OUTCOME

The initiative is anticipated to have a positive impact on the government's development objective1, which is to ensure a healthier country with a more extensive PHC system. The PHC system will be more responsive, equitable, and efficient as a result of the project.

KEY INDICATORS FOR MONITORING

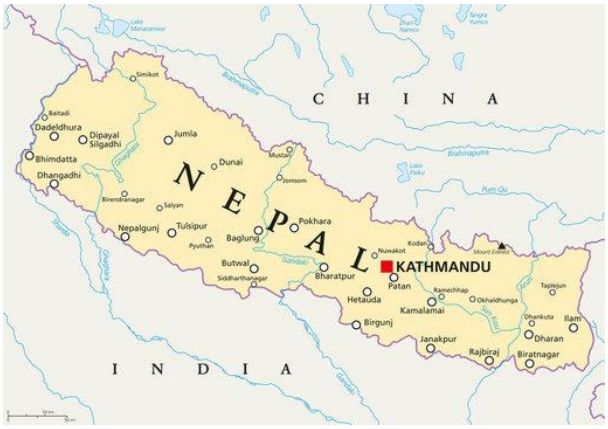
- 20% more people are using PHC's outpatient services.
- Patient satisfaction, knowledge, and attitudes towards utilization all increased by 20%.
- 90% of reported notifiable diseases were looked into by the medical officer of health areas in the target provinces within the allotted period.
- All nine clusters have implemented and evaluated the reform of the cluster system.[11]

11

NEPAL

COUNTRY PROFILE

The World Bank has classified Nepal, which has a population of more than 29 million, as a lower-middle-income nation. In 2022, its gross national income per person was $1340 USD. With a global ranking of 143, Nepal's human development index (HDI) value in 2021 was 0.602, third poorest in South Asia behind Afghanistan and Pakistan. At USD 58.3, Nepal's per capita health expenditure now stands well below the average of USD 174 across South Asia. In 2021, Nepal's Universal Health Coverage (UHC) Index has 54 points.



Every Nepali person is entitled to free basic and emergency medical care under the country's constitution. The main objective of the National Health Policy 2019 (NHP) is to guarantee access to and use of high-quality health services while also building and growing the federal health system for all people, grounded in social fairness and sound governance. It pledges to provide all citizens with free basic health services as well as access to emergency and specialized care.

LEADERSHIP AND GOVERNANCE

Devolution, also known as decentralization, of Nepal's national governance structure has occurred recently, giving subnational governments (SNG)—which are made up of states, provinces, and local civic bodies—more power and responsibility. SNG autonomy is focused on revenue collection, community development, and about 28 other areas of work, including health. The National Health Policy (2019)'s general guidelines are followed by the health sector's operations. The 2015 Nepalese Constitution's Schedules 5-8 grant the national, state, and municipal governments jurisdiction over the health system. Additionally, it states that the federal and state governments have concurrent authority over the health sector.

The Government of Nepal's Fifteenth Plan has set up a system for providing basic health care by federal, provincial, and municipal governments with ambitious aims in compliance with these significant changes in governance.[12]

SCHEDULE OF CONSTITUTION	LEVEL	FUNCTIONAL AUTHORITY
Schedule 5	Federal	Control of communicable illnesses, national or specialised services, health policies, health standards, quality, and monitoring.
Schedule 6	State	Health Services
Schedule 7	Federal and State: Concurrent	Pesticides and Drugs Being ready for rescue,

[12] Health System in Nepal in Context of WHO Building Blocks (gavinpublishers.com)

		relief, and recovery in advance.
Schedule 8	Local	Basic health and sanitation

CHALLENGES AND OPPORTUNITIES DUE TO DEVOLUTION

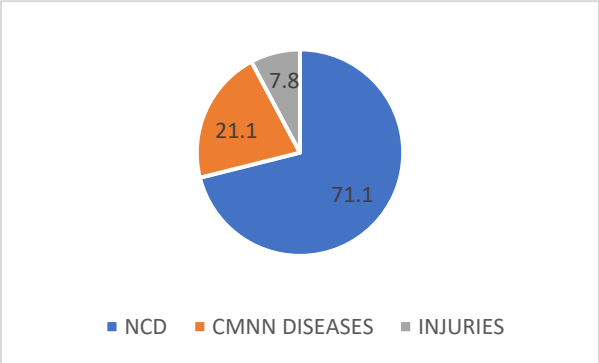
Local governments now have both new opportunities and problems in addressing health inequalities and needs locally as a result of federalism and the decentralization that followed. Lack of health-related human resources hinders the implementation of national health policies, plans, programs, and guidelines at all levels. Wider disparities in the use of health services, particularly among vulnerable and impoverished people, the unequal allocation of health-related human resources, and high out-of-pocket costs for medical care are further obstacles.

ACCESS TO ESSENTIAL MEDECINES

With the assistance of foreign development partners, the Nepali government launched the vital Medicines Programme (EMP) in 2012 to supply reasonably priced and high-quality vital medications. For the simple and widespread delivery of these medications, a variety of public and private distribution channels have been used. Pharmacy purchases are handled centrally by the Ministry of Population and Health. The nation is home to a number of warehouses that can accommodate cold storage when needed. The public health centres provide these medications for free. However, there are a number of logistical obstacles to the smooth distribution and ongoing availability of medications throughout the nation.

HEALTH INFORMATION SYSTEM

The country has made strides in strengthening its health information system by establishing monitoring, establishing National Health Accounts, and putting in place an integrated health information management system across the country. Using digital architecture to strengthen the health information system and provide high-quality data for decision-making is the aim of Nepal's Integrated Health Information Management Roadmap 2022–2030. The broad objectives for a digital health ecosystem are outlined in Nepal's 2017 National e-Health Strategy. The Ministry of Health and Population approved the eHealth Roadmap in 2019 for implementation, emphasizing the use of digital interventions to improve the efficiency of the health system and bring health services closer to people.



HUMAN RESOURCE FOR HEALTH

The Ministry of Health and Population created the National Human Resources for Health (HRH) Strategy (2021–2030) to address issues with the health workforce within the federal framework. The plan aims to ensure the equitable distribution and availability of a top-tier medical workforce in the federal health systems in order to attain UHC and promote health equity. Subnational governments have not done enough to support the expansion of the health workforce (SNGs).

HEALTH WORKERS IN NEPAL (2022-2023)

CATEGORY	NUMBER	PER 10,000 POPULATION
Medical Officer	28477	9.774

Registered Nurses	69429	29.08
ANMs	35009	12.015
Midwife	14	0.005
Pharmacist	14720	5.052
Ayurvedic Physician	790	0.271
Ayurvedic Health Workers	4281	1.439
Health Assistant	17363	5.959
Medical Lab Technician	29928	10.272
Homeopathic and Unani Physicians	228	0.0076
Clinic Phycologist	24	0.008

Due in part to the fact that salaries are now managed by SNGs, the percentage of health expenditures related to wages and salaries has dropped throughout federalization, from 24.3% in 2017–18 to 13.8% in 2021/22. Similarly, in fiscal year 2021–2022, federal financing remained the main source of initiatives to increase personnel availability (almost 100% federal) and training (61%/39%/0%, federal/provincial/local). These mistakes lead to severe labor shortages, where it might be difficult to locate skilled healthcare workers and important positions remain empty.

HEALTH FINANCING

Nepalese Rupees (NPR) has grown by almost three times from NPR 40.6 billion in FY 2016–17 to NPR 123.3 billion in FY 2022–2023 (1$=133 NPR). These increases may be linked to COVID-19 prevention and control initiatives. FY 2022–2023's health budget was NPR 103 billion, which was less than the budget for the year before. The Nepali government recently authorised a new ten-year health finance plan to provide equitable financial management and achieve universal health coverage (UHC). Targeted actions to expand fiscal flexibility in the federal context are part of the National Health Financing Strategy 2023–2033, which aims to close resource shortfalls in the health sector.

Since federalization, the share of health care spending borne by subnational governments has been rising steadily. Additionally, the share of internal SNG funding sources, such as taxes collected by provincial governments, has increased significantly, rising from almost 0% in the immediate post-federalization period (2017–2018) to nearly 64% in 2021–2022. In addition, the federal government has been working broadly to promote health care affordability through insurance programmes like the National Health Insurance Programme[13] (NHIP), which aims to stop residents from becoming impoverished due to medical costs—a vital first step towards universal health coverage. When taken as a whole, these show the significant resources the federal government has provided to help accomplish UHC and the shift to federalism.

Despite the fact that the burden of NCDs is increasing, not enough money is allocated to control them. In Nepal, the proportion of mortality from noncommunicable diseases (71.1%) has more than doubled since 1990 (31.3%). During the fiscal year 2021–2022, less than 4% and 1% of the budgets of the provincial and local governments, respectively, were allocated to NCD management. As a result, individuals are now responsible for covering the cost of treating NCDs. In Kathmandu, for instance, the majority of diabetes patients (97.4%) paid for their care out of pocket; the average monthly cost for private hospitals was NPR 10,125.31, while the average monthly cost for public hospitals was NPR 7312.17. Considering that NPR 103,335 was Nepal's per capita income during the same fiscal year.

[13] Health System in Nepal in Context of WHO Building Blocks (gavinpublishers.com)

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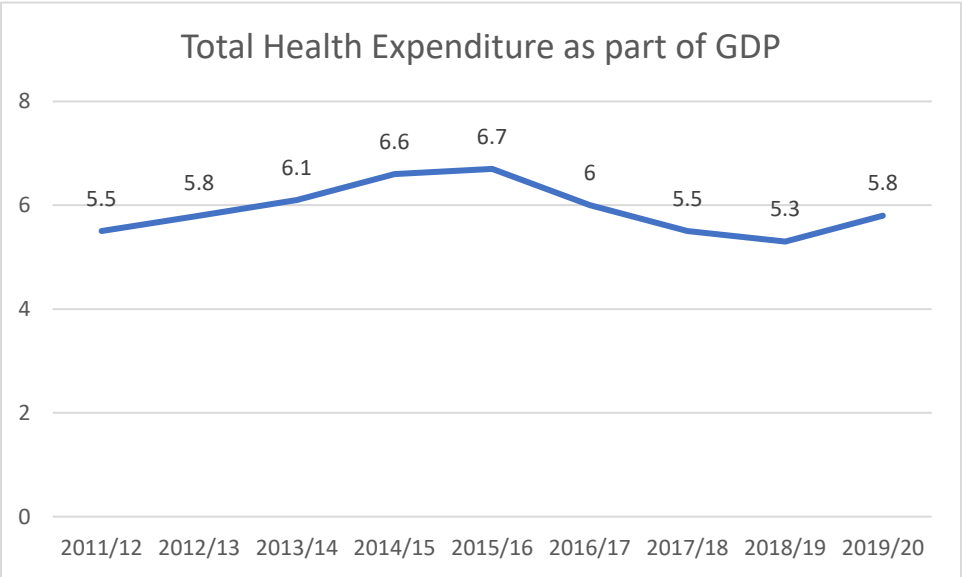


SERVICE DELIVERY

- Palikas are taking initiation to establish UHC and CHC in underreached settlements.
- Municipalities have given priority to implement social health insurance for all to increase access to BLS.
- Targeted interventions being implemented.
- Birthing centers are functional
- Difficult to serve equitably and conduct outreach clinics with limited resources and infrastructure.
- Same level of enthusiasm among mother's group and FCHVs.

CHALLENGES AND BOTTLENECKS IN SERVICE DELIVERY

1.There isn't a noticeable improvement initiative.
2. Low enrolment and limited health insurance coverage.
3. Timely service, medication availability, and human resource retention.
4. There isn't a noticeable improvement initiative.
5. Low enrolment and limited health insurance coverage.
6. Timely service, medication availability, and human resource retention.

[14] NHA Nepal

KEY CHALLENGES

- The absence of a clear health policy, insufficient funding for healthcare, and inadequate collaboration across various governmental levels impede the efficient operation of the healthcare system.
- The lack of qualified and experienced workers in the health system, especially in rural areas, has an impact on the standard of care provided.
- The inability to obtain health insurance restricts the health system's capacity to deliver high-quality services.
- Because of the shortcomings in the health information system, it is challenging to properly plan healthcare services, track health trends, and monitor health outcomes.
- Inadequate health infrastructure, especially in rural regions, makes it difficult for people to get healthcare services.

INDIA

COUNTRY PROFILE

India's population, economy, and epidemiology are all undergoing major shifts at the moment, which offers the nation both opportunity and challenges as it attempts to modernize its healthcare system. It became an upper-middle-class country in 2009 after three decades of attaining consistent real per capita GDP growth rates exceeding 5%.

A significant and increasing percentage of the working-age population is placed against an ageing population, and the nation's demographics are changing, with a demographic dividend anticipated. Naturally, its concerns over communicable illnesses and reproductive health outcomes are made worse by the rising burden of noncommunicable diseases. From its peak IMR of 88, India's infant mortality rate (IMR) has dramatically dropped.

In contrast, between 2016 and 2018, the maternal mortality ratio (MMR) decreased from 556 per 100,000 live births in 1990 to 113 per 100,000 live births. However, because states with lower economic standing continue to record greater rates, the improvement was not constant. According to the mixed findings for communicable diseases, tuberculosis continues to be a major cause of illness and is becoming more resistant to treatment, even though polio has been eradicated and the epidemic of HIV/AIDS and related disorders has been contained.

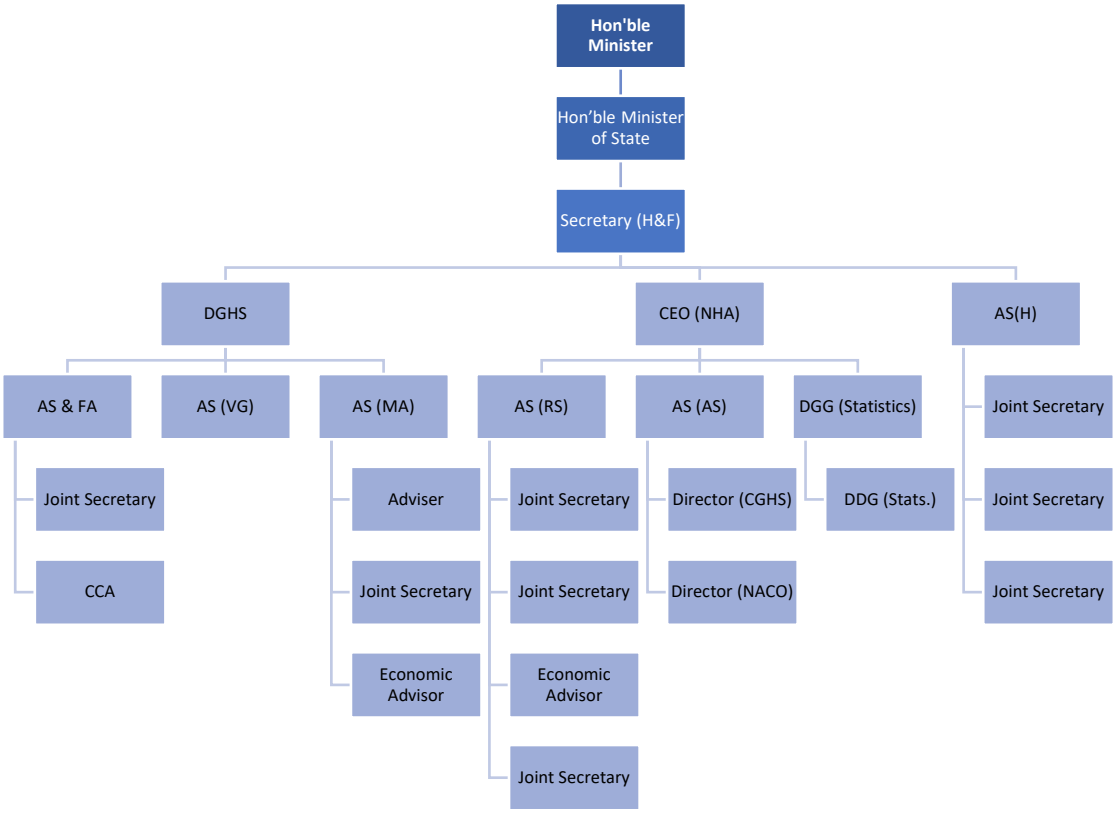
The threat of dengue and chikungunya has often been a concern for urban health planners. Since noncommunicable diseases (NCDs) and injuries together account for over half of the disease burden, NCDs are becoming a greater issue.

LEADERSHIP AND GOVERNANCE

India's federal system of government gives both the federal and state governments authority over policy. This indicates that the federal, state, and local governments have an impact on health-related decision-making, planning, and delivery systems.

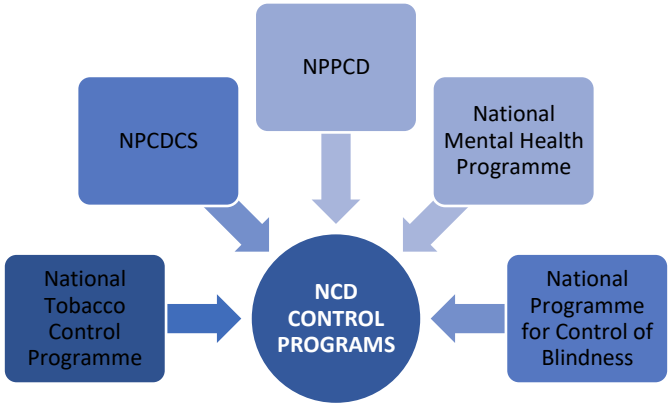
The Indian Constitution states that health is a state matter and that state governments are responsible for carrying out health policies. The national government oversees policies and programmes generally and provides funding and direction for them. State governments take on a bigger role when it comes to providing financing, regulation, leadership, vision, and health care delivery. Numerous public and private providers offer health care services. Health care providers in the public sector are subject to local administrative authorities and operate at various levels within states. The Right to Information Act may also allow for their examination. Private healthcare providers come in a wide range, from solo practitioners to hospitals, and they all follow different rules to differing degrees. Due to the constitutional division of powers, state governments have traditionally been in charge of enacting laws, setting policies, financing, and providing health care, with sporadic involvement from the federal government.

ORGANOGRAM MOH&FW

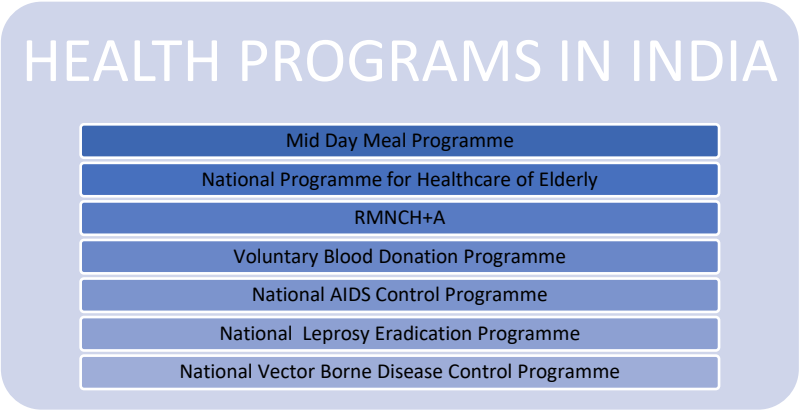


SERVICE DELIVERY

In India, a wide range of governmental, for-profit, and nonprofit private providers provide healthcare services. The ownership and organizational patterns of these providers differ. Complementing allopathic healthcare providers are alternative medical systems, generally referred to as Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH). The public health system offers both preventative and therapeutic treatments. Public health services that are under the jurisdiction of state and federal health agencies and ministries are paid for with general revenues from the government. These services are provided by public sector health facilities. At the primary level, these consist of community health centres, primary health centres (PHCs) with 20,000–30,000 residents, and sub-centers (SCs) with 3,000–5,000 residents.



India's healthcare system has both advantages and disadvantages due to its hybrid delivery structure. Personal curative health treatments are mostly the responsibility of private providers. Currently, in India, for-profit or not-for-profit private sector providers deliver 90% of all drugs, over 70% of all outpatient visits, and over 58% of all inpatient sessions. Nonetheless, there are noticeable differences across providers in terms of service effectiveness, pricing, and quality. Government health services provide around 30% of outpatient and 42% of inpatient treatment, as well as a significant proportion of medical education and health promotion and prevention.



The health system has historically received insufficient money, and lax regulations, particularly with regard to the private sector, demonstrate the low priority.

HUMAN RESOURCE FOR HEALTH

India is thought to have 5.7 million health workers. The National Health Workforce Accounts (NHWA) indicated that there were 26.5 physicians, nurses, and midwives for every 10,000 people. Physicians accounted for 8.6 persons per 10,000 people, while nurses and midwives made up 17.7 people per 10,000 people. In 2018, there were 8.9 chemists for every 10,000 people. There were 2.0 dentists for every 10,000 people in 2011–2012. Only 36% of India's health personnel is based in rural areas, despite the country's 71% rural population. This indicates that the majority of the country's health workforce is centered in metropolitan areas. A large portion of India's medical personnel works for private companies: 70% of nurses and midwives and 80% of doctors.
Practitioners of traditional Indian medical systems, including AYUSH, work in 120 private and public health sectors. In private health institutions, the proportion of AYUSH and dentists is much higher, at 90%. The distribution of health workers in India's states is uneven. Compared to Delhi, Kerala, Punjab, and Haryana, the health workforce density in central and eastern states like Bihar, Assam, and Jharkhand was significantly lower. Less than one nurse to doctor ratio was observed in several states.

NUMBERS OF DOCTORS IN INDIA, 2020

MEDICAL DOCTORE (PER 10000 POPULATION)	MEDICAL DOCTORS (IN NUMBER)	MEDICAL DOCTORS NOT FURTHER DEFINED
7.265	1014538	1014538

HEALTH INFORMATION SYSTEM

Understanding the population's changing health needs, creating and carrying out programs, and assessing the results of policy or programmatic efforts in public health all depend on having well-developed health information systems and data. Both the fragmented nature of the available data and the absence of systematic and scientific population health statistics were highlighted in the NHP 2002. These worries reflect India's disjointed and haphazard health information system, which has expanded over time as a result of administrative, financial, and regulatory problems. For instance, gathering health data is a shared responsibility among several ministries or organizations, and administrative and financial limitations have made cooperation difficult.

Periodic reports from the Sample Registration System (SRS), Civil Registration System (CRS), and population census conducted by the Ministry of Home Affairs' Office of the Registrar General of India and Census Commissioner (ORGI) are used to distribute data on live births and deaths (MHA). Additionally, the ORGI distributes "Medical Certification of Cause of Death" (MCCD) data on a quarterly basis. Every ten years, a census is conducted. The Directorate General of Health Services (DGHS) oversees the Central Bureau of Health Intelligence (CBHI), which collects and disseminates health statistics.

It maintains a database and releases an annual National Health Profile with comprehensive state & district level NCD and communicable disease morbidity statistics for every state and Union territory.

HEALTH FINANCING

India's health financing system is now characterized by passive purchasing, little risk sharing, and severe fragmentation. Despite numerous policy announcements that prioritize health, the public health sector in India has historically received inadequate funding from the federal and state governments. Poor health outcomes and widening gaps in access to healthcare have resulted from this. Public and private health spending in India is now estimated to be 3.8% of GDP, which is less than the 5.2% average for LMIC nations. Most of India's health system is financed by household out of pocket expenses, which make up over 63% of all medical expenditures. Approximately one-third of all health spending is currently covered by government financing, which originates from both the federal and state governments.

Sl. No.	Indicator	NHA 2013–14	NHA 2014–15	NHA 2015–16	NHA 2016–17	NHA 2017–18	NHA 2018–19	NHA 2019–20
1	Total Health Expenditure (THE) as percent of GDP	4.0	3.9	3.8	3.8	3.3	3.2	3.3
2	Total Health Expenditure (THE) Per capita (Rs.) at current prices	3,638	3,826	4,116	4,381	4,297	4,470	4,863
3	Total Health Expenditure (THE) Per capita (Rs.) at constant prices[2]	3,174	3,231	3,405	3,503	3,333	3,314	3,516
4	Current Health Expenditures (CHE) as percent of THE	93.0	93.4	93.7	92.8	88.5	90.6	90.5
5	Government Health Expenditure (GHE) as percent THE	28.6	29.0	30.6	32.4	40.8	40.6	41.4
6	Out of Pocket Expenditures (OOPE) as percent of THE	64.2	62.6	60.6	58.7	48.8	48.2	47.1
7	Social Security Expenditure on health as percent of THE	6.0	5.7	6.3	7.3	9.0	9.6	9.3
8	Private Health Insurance Expenditures as percent of THE	3.4	3.7	4.2	4.7	5.8	6.6	7.0
9	External/ Donor Funding for health as percent of THE	0.3	0.7	0.7	0.6	0.5	0.4	0.5

The majority of funding for public health services and other government-funded health sector initiatives comes from general revenue allotments made on a "historical" basis at the federal and state levels, with salaries making up the majority of these allocations. Apart from the direct financing flows to public facilities, another source of funding for inpatient treatments in the public sector has emerged with the introduction of publicly supported health insurance schemes acting as third-party payers. Moreover, there is another way

to push public monies towards private care because enrollees in public insurance can also select private hospital care.

ACCESS TO ESSENTIAL MEDECINES

Through advancements in pharmaceutical supply chain and procurement procedures, several Indian states have been instrumental in expanding public access to medications. Established in 1994, the Tamil Nadu Medical Services Corporation (TNMSC) has created a novel decentralized distribution system in addition to a centralized procurement system. All district headquarters now have warehouses where goods are transferred to facilities owned by the public. All public institutions receive a passbook containing monetary entitlements, allowing them to purchase medications from an approved list. These public hospitals provide patients with free access to all necessary medications. There is evidence to support the scheme's effectiveness in reducing out-of-pocket medical expenses. In Tamil Nadu, around 94% of those using public facilities receive free medication. This only covers a small number of medications, though, and consumers continue to pay high out-of-pocket costs for drugs that are not available through the public system. This suggests that the range of medications should be expanded to include treatments for NCDs and other chronic illnesses. Other states, like Kerala and Rajasthan, have adopted Tamil Nadu's model and made some comparable advancements.

KEY CHALLANGES

- India faces Inadequate financing for research, inadequate health spending, and inadequate access to fundamental healthcare services.
- India’s financial spending on healthcare for FY 2024-25 is 819000 cr. Whereas, it should have been 90181 cr. India is spending quite low on health.
- In India, preventive care is not given enough credit, even though it can help with a number of health problems.

BHUTAN

COUNTRY PROFILE

Over the past fifty-five years, Bhutan's health system—which is primarily funded and governed by the public—has changed and expanded dramatically. There are three tiers to the health service delivery system: primary, secondary & tertiary. Services for allopathic and traditional medicine are combined and provided under one roof. In order to promote health, village health workers are crucial as a link between the community and medical services. There are initiatives in place to handle the nation's public health problems.

According to Bhutan's Constitution, health services are provided without charge. Therefore, the main source of funding for health care is government money. The total health expenditure (THE) as a percentage of GDP was 3.6% recently.

Even with the challenging topography and dispersed population settlements, there has been a notable improvement in access to health care. Bhutan has improved its life expectancy during the last 40 years, ranking among the top countries in the world. MDGs 4 and 5 targets have been met, and since 2010, vaccination rates have remained above 95%. On the other hand, the nation has three distinct health-related burdens. Noncommunicable diseases (NCDs) are on the rise, but communicable diseases continue to pose a significant burden. Crime, drug abuse, and mental health disorders such as suicide are some other new and difficult difficulties.

In addition to differences in access to and use of health services, there are differences in health outcomes across urban and rural areas, income levels, districts, and the western, central, and eastern regions. For these reasons, attention must be devoted to health equality. The differences in effectiveness between various geographical areas and medical facilities draw attention to the areas where overall efficiency needs to be raised. In order to close current equity gaps and accomplish the Sustainable Development Goals, more needs to be done to encourage intersectoral action, despite the strong evidence supporting it.

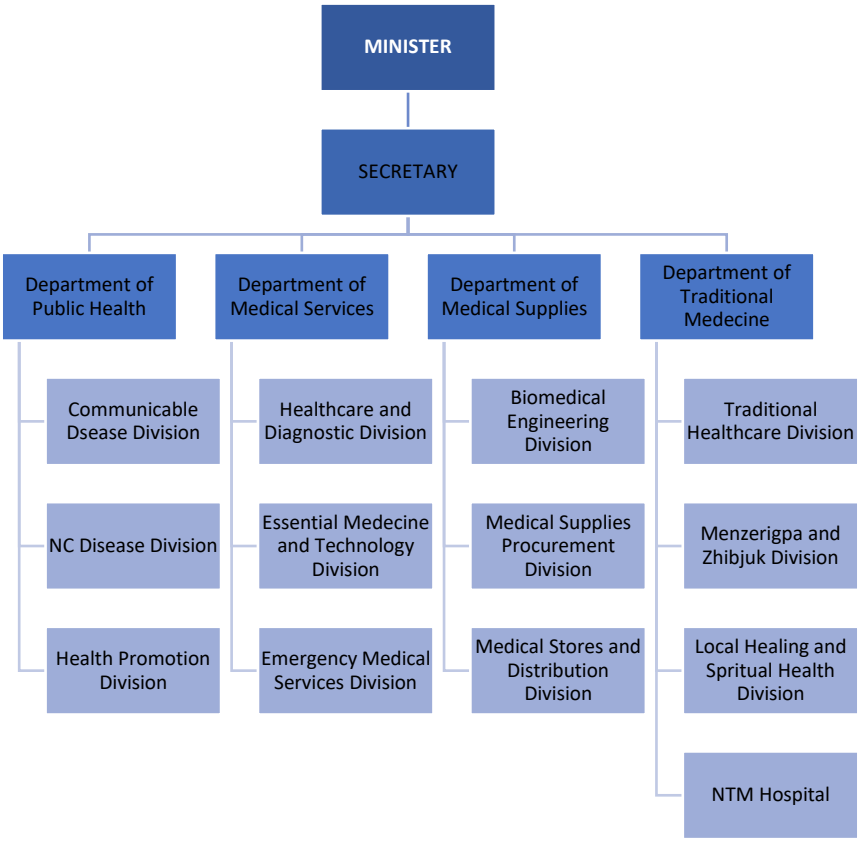
LEADERSHIP AND GOVERNANCE

In Bhutan, health leadership plays a critical role in the efficient administration and provision of healthcare services. Although the nation's healthcare services and infrastructure have advanced significantly, there are still issues that need to be resolved. Three competency domains and seven critical sub-domain competencies were found to be necessary for primary health care (PHC) managers in Bhutan. The execution and transformation domains were regarded as the next most important competencies, after the people domain. The most important sub-domain talents were leadership, analytical thinking, relationship development, professionalism, communication, managing change, and inventive thinking. The Ministry of Health (MoH) is in charge of developing policies, organizing health programmes, carrying them out, and overseeing the provision of services linked to preventative, promotional, curative, and rehabilitative care using both conventional and modern medical methods. It also guarantees the continuous availability of human resources, non-medical goods, and medical supplies, as well as technical advice to the district health management.

The RGoB's decentralization effort has given districts increased control over the management and administration of healthcare during the last few decades. Decentralizing health care planning and administration at the district level is thus the responsibility of district health management teams, which function under the auspices of local government. Thus, the district health office is in charge of allocating human resources for

health (HRH) throughout the districts, even if district hospitals and basic health units (BHUs) are under the direct supervision of the district health authority. Public sector entities include 184 BHUs grade II (BHU-IIs), including satellite clinics; 28 sub-posts; 54 indigenous units; 3 referral hospitals; 28 hospitals; and 494 outreach clinics (ORCs) with sheds.

ORGANOGRAM MINISTRY OF HEALTH, BHUTAN



HEALTH INFORMATION MANAGEMNT SYSTEM

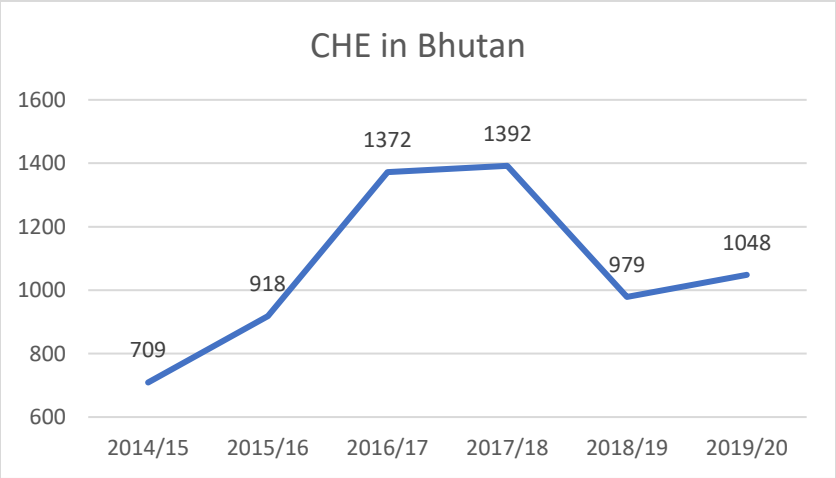
Bhutan's Health Information Unit was established in 1984 by the Ministry of Health. The platform for collecting disease morbidity and mortality data from all healthcare facilities has evolved over time, starting with a handwritten data collection and compilation platform in 1984 and ending with a stand-alone electronic Microsoft Access platform in 2003. These developments led to the current web-based DHIS2. DHIS2 was originally presented in 2014 and consists of three key components: data items, organizational units, and periods. All 20 district health offices, hospitals, and BHU-Is with internet connectivity have adopted it. The Annual Household Data, gathered from various healthcare facilities across the country, is entered into this web-based information system by district health offices.

Every district, with the exception of the two municipalities of Phuentsholing and Thimphu, has access to the annual household statistics. Monthly reports on morbidity, mortality, and public health activities are also entered into a web-based information system by the district health office. Every district health officer and data assistant has received training on how to enter and evaluate local data. A specialized officer in the BHMIS Unit gathers the data once a month. He or she guarantees the accuracy and timeliness of the data provided by the district health offices. By alerting users to any outliers and enabling quick action, validations are updated to guarantee data quality. Districts enter data using distinct logins and passwords. They could use the information from any health care facility to develop their yearly work plans.

HEALTH FINACING

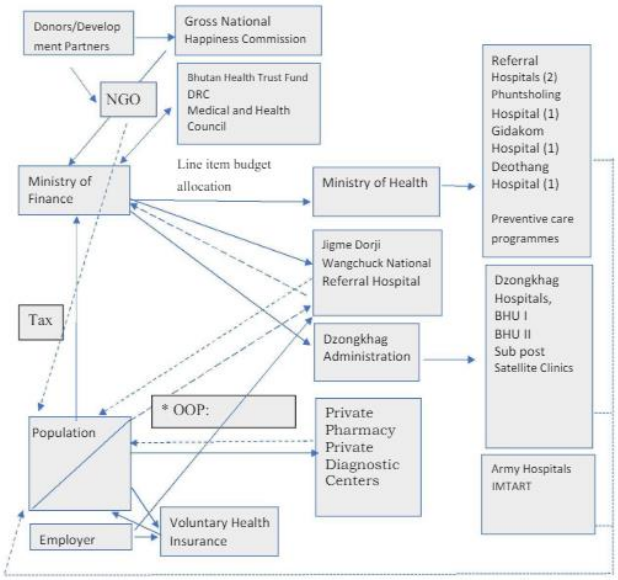
As a percentage of GDP, total health expenditure (THE) rose from 4.0% in 1995 to 6.9% in 2000 before dropping to 3.6% in 2014. However, the budget allocation has grown in absolute terms throughout the course of the five-year planned period, rising from Nu 3.1 million in the first FYP (1961–1966) to 13 952.96 million in the 11th FYP. Between 1995 and 2010, health-related out-of-pocket (OOP) costs fell from 33% of THE to 11% and then to 12%.

The State is primarily responsible for funding and overseeing healthcare in Bhutan. It is provided via a nationwide network of healthcare facilities that are ranked according to three tiers based on service standards



and care levels.

The Kingdom of Bhutan's Constitution, Article 9, Section 21, which declares that "The state shall provide free access to basic public health services in both modern and traditional medicines," is in line with this. At the primary level, there are currently 49 sub posts, 185 Basic Health Units (BHU) II, 25 BHU I, 30 hospitals, and 3 referral hospitals for tertiary care. The combined health expenditures for the FY 2018–19 and FY 2019–20, or roughly Nu. 7212 million and Nu. 8705 million, respectively, represented 4% and 4.5% of the GDP in those respective fiscal years. For the fiscal years 2018–19 and 2019–20, the total Current Health Expenditures (CHE) were approximately Nu. 6233 million (mn) and Nu. 7656 million, respectively. These sums cover all of the



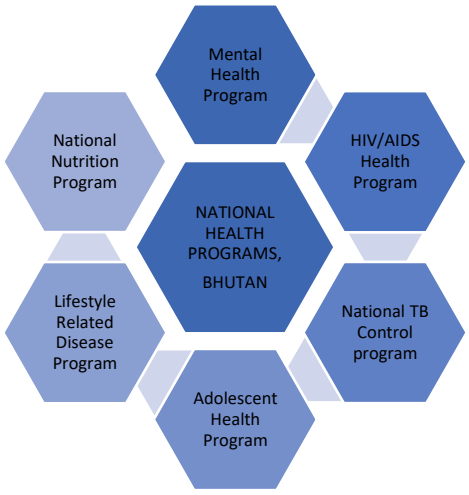
expenses incurred by the government, businesses, and households in their corresponding fiscal years, including the price of capital asset consumption in the public health system. The Royal Government of Bhutan (RGoB) was responsible for paying 3% of the GDP for CHE.[15]

BHUTAN HEALTH FINANCING SYSTEM

HEALTH SERVICE DELIVERY

The utilization of VHWs is a significant component in the delivery of health services in Bhutan. In the mid-1980s, VHWs were implemented countrywide after being tested in the dzongkhags of Wangdue Phodrang and Trashigang in 1978. The major goals were to forge a connection between the health system and community, to offer first aid, treat minor illnesses, raise community awareness, and organize support for promoting health and enhancing cleanliness. Bhutan's healthcare system is organized into three tiers: district hospitals serve at the secondary level, BHUs at the primary level, and regional and national referral hospitals at the tertiary level. At least 90% of the population was expected to live three hours' walk from an ORC, BHU, or district hospital in order for the coverage to continue. Through ORCs and VHWs, primary healthcare providers engage with the communities.

Additionally, district hospitals act as nodal referral centers for neighboring BHUs in other districts as well as for BHUs under their authority. According to the Constitution, all health services, from primary to tertiary, are rendered free of charge at the point of service delivery, including referrals abroad in cases when domestic treatments are unavailable. The health industry faces many obstacles that will require adjustments to the way health services are now delivered. Although slowly, the administration has begun to implement reforms after seeing that some of the fundamental issues need attention. In addition to the government health services, a number of other routes have already been formed for the delivery of healthcare.[16]



[15] https://www.moh.gov.bt/wp-content/uploads/ict-files/2021/07/NHA-Report-2021.pdf

[16] https://iris.who.int/bitstream/handle/10665/255701/9789290225843-eng.pdf

HUMAN RESOURCE FOR HEALTH

When growing human resources, the HRH Master Plan is adhered to, which is founded on the epidemiology of illness burden, technological advancements, and both short- and long-term requirements. In the nation, postgraduate medical education in a few chosen specializations, traditional medicine physicians, technicians, nurses, and paramedical professionals are all trained. Bhutan continues to rely on other nations for major postgraduate, super specialty, and undergraduate medical education. There is a balanced distribution of physicians and nurses throughout the three areas. The national referral hospital in Thimphu contributes to the slightly greater physician to population ratios in the western area. The aggregate average is also impacted by Gasa's extremely small population. Regarding each of the 20 dzongkhags separately, the population distribution shows no appreciable variation. The distribution of physicians and nurses throughout the eastern and central regions will also be better if the two RRHs are fully staffed. It is difficult to restrict the mobility of health professionals, especially physicians and specialists, both domestically and abroad. Mostly in pursuit of greater pay, medical professionals depart the health system to work for other national or international organizations.[17]

NUMBER OF DOCTORS PRESENT IN BHUTAN, 2021

Medical Doctors (per 10,000 population)	Medical Doctors (numbers)	Generalist Medical Practitioners (number)	Specialist Medical Practitioner(number)
5.595	435	266	169

AVAILABLITY OF ESSENTIAL MEDECINES

The Bhutan Essential Medicine List (EML) is a comprehensive list of medicines that are considered essential for the health care system in Bhutan. The EML includes medicines used in ICU, hemodialysis, and chemotherapy units, which were added in the latest edition. Bhutan's essential medicine includes 94 traditional medicines. For the MoH, all medication and medical supply procurement and delivery are overseen by the Department of Medical Supplies and Health Infrastructure (DoMSHI). A few possible explanations for the observed rational prescription include the availability and usage of Standard Treatment Guidelines (STGs), formularies, the lack of a private sector, and the National Essential Medicines List (NEML), which is regularly updated and used. Additionally, an efficient supply chain management system has prevented drug expiration and stock-outs. The National Drug Committee analyses and updates the National Essential Medicines List (NEML) every year to maintain standards and promote responsible drug usage.

KEY CHALLENGES

- Geographically speaking, there is a greater concentration of hospitals in the western region than in the eastern and central regions.

[17] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS

- Bhutan has a committed medical workforce that includes 1039 nurses and 269 doctors working there. Nonetheless, there are continuous initiatives to raise the caliber and accessibility of medical specialists, particularly in isolated places.

COMAPRITIVE ANALYSIS

INDICATOR	SRI LANKA	NEPAL	INDIA	BHUTAN
Country has a legislature on UHC	Yes	Yes	Yes	Yes
When was the National Health Policy last updated?	2022	2019	2017	2016
Are strategic health plans present?	Yes	Yes	Yes	Yes
As per the constitution is health a basic human right in the country?	No	Yes Article 35	Yes Article 21	Yes Article 9
Medical Doctors per 10,000 population (2021)	11.924	8.674	7.265	5.595
Nurses and midwife per 1000 population (2021)	2.4	3.5	1.7	2.2
Medical Doctors in number (2021)	25926	26052	927447	435
Hospital beds per 10000 population	42	3	5	17
Software for health information management	DHIS 2	RMNCAH Dashboard QI Dashboard MPDSR Immunization Dashboard DHIS 2	HMIS AB HWC NCD app RCH portal MCH tracker Ayushman Bhav	DHIS 2 EPIS
When was the essential drug list last updated?	2017	2021	2022	2011
When was the National drug policy last updated?	2015	1995	2013	2007
THE as percentage of GDP (2018-19)	559,100 million	5.8%	3.2%	3.2%

CHE (2021)	4.07%	5.42%	3.28%	3.85%
OOPE as percentage of THE	46%	57.9%	64.2%	15.40%
Domestic General Per Capita, PPP	283.00	76.00	81.00	253.74
Spending on preventive Healthcare	122,222,000		6,025,000,000	1,090,966,352
Current Health Expenditure as per capita (2021)	166	65	74	120.43
Service Standards for Quality	National Health policy on healthcare quality and safety.	Minimum service standards, National Healthcare Quality Assurance	Indian Public Health standards NQAS NABH NABL KAYAKALP	Bhutan Healthcare standards for Quality Assurance
National Standards for Health Infrastructure	National Strategic Framework for development of Health services	Nepal Health Infrastructure Development Standards	Indian Public Health standards	Bhutan Healthcare standards for Quality Assurance
Is National Ambulance Service available?	Yes	Yes	Yes	Yes
Is there a policy present on HRH?	Yes	Yes	Yes	No
Levels of Health system	• Primary *Divisional Hospital* • Secondary *Base Hospital* • Tertiary *District General Hospital & Teaching Hospital* • Quaternary *National Hospital*	• Primary *Health post & sub health post* • Secondary *District Hospitals & CHCs* • Tertiary *Central & Regional Hospitals*	• Primary *PHCs & HSCs* • Secondary *Sub – district hospitals & CHCs* • Tertiary *District hospitals & medicals colleges*	• Primary BHUs • Secondary District Hospital • Tertiary *National Referral Hospital*

CONCLUSION

This report provides a detailed comparative analysis of the six building blocks of health system, i.e., Leadership & Governance, Health Service Delivery, Health Workforce, Health Financing, Availability of Essential Medicines and Health Information system as suggested by WHO for SEA Region (2 best performing & 2 worst performing countries) Sri Lanka, India, Nepal and Bhutan.

Through this report, we can conclude that Sri Lanka has the best health system with all the building block performing well in the country which supports the fact that it has the lowest IMR, MMR, NMR AND U5MR in

SEA Region, with Nepal performing the worst as it has a number of challenges and bottlenecks, that the country needs to overcome to strengthen its health system and deliver better services to its citizens.

Aditi Nasa ST report

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