PERSONAL VIEW:

I think it all started with a man called Rudra Man. Now everybody, with any interest in the National Health Planning are thinking and talking about Integrated Basic Health care. I don't proclaim to understand it all, and much less so the term they use—the horizontal and vertical projects, cost-effective studies, development of model, and the planning-programming and the budgeting system, and terms like that. But as I understand it from the medical economy pundits, the aim of the national health service is to provide the economically-feasible basic medical or what they call the health maintenance service as opposed to the sophisticated, specialised and costly medical care. This may in a crude language be translated as minimum service to maximum people as against the maximum care to minimum people. Dr. Bart and Dr. Rudraman has elaborated and elucidated on this aspect in their articles in the JNMA published in June 73. I think there should be little quarrel about the points they have made. We are a poor country. And we know no country can afford to meet all health needs or to give each citizen the full advantage of all the modern medicine believe itself capable of achieving. Thus choices are already being made about the allocation of resources. It would however seem better to have priorities which are explicit and consciously chosen. And so it would be realistic, understanding our underdeveloped economy, and limited and disproportionate medical manpower to consciously choose to provide only the basic health care to all the people. This is what I call, to borrow the phrase from the public health people—the Horizontal Profile of our national health system. The aim of the horizontal profile thus is to provide much of the public health service like FP, MCH, maintenance of malaria control and some basic curative medical aid mostly through the network of health posts and health centres, staffed by the Auxillary Health Workers. This is the base of our pyramid of health system. Above this we have district hospitals who share and directs these function beside providing a referral medical service to the area. The district hospitals should be staffed with the medical graduates.

Now let me come to what I like to call the 'Vertical' profile of our health system to borrow the phrase again from the public health chaps. Let us once look beyond the pages of the books of economy, and be more realistic. There is no doubt that the specialised medical care is more costly and gives poor return in terms of cost-effectiveness. But nevertheless it is essential and essential to provide such service at least in one centre in the country. We cannot tell the man in the street or rather the man in agony how economical it is to try to control the disease by public health measures than to cure him. We have to do both. Emphasise on the public health measures—the best health investment the country can think of and at the same time provide some essential specialised medical service, so that people don't have to con-

tinue to go out of country for this service, thus causing much more financial drain and a national dependence on other country. I think we should develop ONE institution in the country— as a specialised hospital, a referral centre for the whole nation. This is the vertical profile of the national health system. And the national health planning should consider both—the horizontal and vertical profile. Currently there is a joke, often repeated in Kathmandu that All India Institute of Medicine at Delhi has become our chief, specialised referral hospital, and should be mentioned as such in our national health planning. There is some truth in it. And this will be more obvious and painfully more evident as the public consciousness for health increases, and we fail to read the lines in the wall and fail to plan and develop the Bir Hospital as a specialised hospital. This institution has so far suffered from no planning to bad planning and the lack of vision about its future role in the society.

And talking of priorities as it applies to the nations' health service let me hasten to add a word of caution from the expert, Prof. Able-Smith of London School of Economics and Political Science writing on the 'Health Priorities in Developing Countries' mentions that 'what would be wrong would be to base our priorities on economic considerations alone. If health programme were to be geared solely to serve crude economic objectives, they would need to be concentrated heavily on the younger worker. Infant and maternal mortality would be fought only to the extent necessary to ensure that the next generation of human capital was of right number to fit expected job opportunities, and the health planners would do nothing to prevent deaths among the permanently disabled or unproductive aged.' We want a health service, of all the thing with a human face; and an application of science with conscience. And to quote Prof. Able-Smith again 'it would be wrong to conclude that more rational health planning is impossible, but it is important to appreciate that none of the new techniques of analysis have any magic which can provide answers to the fundamental values problems which stand out so conspicuously in the health sector. Economist should not be allowed to determine health priorities nor should most of them wish to do so.'

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The significant constraint of a developing country like Nepal is that we have limited trained man power. Not only it is limited but it is also disproportionate with a significant deficiency of the lower and middle grade technicians. Our skilled manpower structure is like that of a unstable inverted pyramid—with more of highly skilled people at the top and much less middle or lower grade technicians as base. It is hoped that the Institute of Medicine will be guided solely at present to correct or remedy this unstable balance.

The greater tragedy of the underdeveloped countries however is that of the misutilisation or the underutilisation of its available manpower. And one does not need to be a politician or an economist that the misutilisation or underutilisation of a skilled manpower lead to poor or even the lack of job satisfaction and will lead to brain drain. Underutilisation and mis-

utilisation of a skilled manpower, however by itself is a brain drain which very few seems to have realised.

In the context of the utilisation of medical manpower, it may interest to mention a study undertaken by WHO recently in Malaysia which showed that it is the waste of talent and economically poor investment to send doctors to remote health posts and health centres where we cannot provide facilities for clinical investigation. In such conditions the service provided by a doctor and an auxiliary health worker is not different significantly. Doctors' utility or efficiency increases by virtue of his training if you can provide him facilities for investigation. So to send doctors to remote areas with no laboratory or X Ray facilities is a misutilisation of medical manpower. Medical assistants or AHW as we call them here is cheaper to produce than a medical graduate. It is estimated that "doctors cost about \$6,000 to train, medical assistant about \$600, and health assistants only about \$200". The auxiliary fits well into a economic structure of a developing country and the job that a health service can provide. Their salaries are within the means of a health service. So "it is difficult to justify the employment of a doctor for a few hundred scattered inhabitants in remote areas without communicational facilities when thousands of others are deprived of his service. Moreover, does it really make sense to bury a doctor in some remote spot where we could not have the minimum facilities needed for the proper utilisation of his skill on X Ray machine, an adequate and regular supply of drugs and laboratory facilities — a hospital" (D. Flabault, WHO). I feel our health posts and health centres should be manned by auxiliary health workers and health assistants; whereas the district hospitals should utilise the service of the medical graduates. It may be an advantage to have the people with Public Health training as the chief of the district hospitals so that he may not be bogged down in the private practice in the locality, and may effectively supervise the basic health care delivery system of the region. This is important and will be a more effective administrative arrangement as the most important component of the basic health care is the public health aspect.

Government has spend lot of money, and the individual has put lot of effort and time in acquiring specialisation and postgraduate training, and it would be short sighted policy not to get the best out of it by fully utilising their talent in the specialised hospital. As any economist will tell poor jobsatisfaction in this grade of people is the main cause of frustration and brain drain from the underdeveloped countries.

Future training of medical graduates, auxiliaries, other technicians like pharmacists, lab technicians; and specially postgraduate medical specialist should be guided by these basic facts, and the need of the country and capacity of our health service to utilise them, otherwise we will be faced with the problem of educated unemployment and misutilisation of skilled manpower.

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Now let us look back at the Bir Hospital again, — the chief hospital of the country. **Bir**

Hospital is a general hospital and at present provides inpatient, and emergency service for general medical, surgical, obstetric--gyne, eye, ENT, dental and skin diseases. It also has an attached infectious disease unit. Some time back I wrote about the need of turning IDU into a separate Hospital for Tropical and Communicable diseases (1st JNMA, April 1972), and the Bir Hospital Board (Editorial, JNMA, July 1972). I still hold these views. And I would like to take this opportunity to elaborate some of the points I made then. Modern hospital have now a days grown into an elaborate organisation. It is not merely the patients and doctors, but it has several other aspects. Smooth running of hospitals also require arrangements for proper and adequate and regular supply of drugs, Oxygen, X Ray films, properly run kitchen, laundry, efficient maintenance section, good record keeping etc. Thus hospital administration has become a speciality by itself. And the Medical Superintendents have now become an extinct species in Britain. To have a doctor as superintendent a waste of a medical talent but handing out of the responsibility to a person not trained for the job. The idea of the hospital secretaries or the non-medical superintendent has caught up with our neighbour India also. Now All India Institute of Medical Sciences at Delhi has a non-medical superintendent.

The usual cry of the consultants working in Bir Hospital is for more beds. They think the hospital has become smaller for the need of the city. They may be right. But only increasing the bed, I don't think we are going to solve our problem. Further increase in bed with the present set up and the budget is only going to cause further deterioration or breakdown of the service. Moreover the problem of the shortage of beds will remain as such, however we may increase the bed unless we change our certain policies fundamentally. Let me explain what I mean. At present the hospital provides a completely free service, including drug, and diet to inpatients in the general wards. This include special investigations. So there is a great demand for the hospital bed not only by the needy patients but those ambulatory patients requiring special investigations like special X rays which could otherwise be done as an outpatient except for that if done as outpatient they need to pay for it. Most of these patients one way or other get admission into the hospital thus not only availing the benefit of free X ray but blocking the scarce bed for longer period thus causing the hospital to spend more on him than would be needed otherwise. The attendance to outpatient has increased considerably recently. Not only have the patients to wait longer and longer to see a doctor, but the doctor has less time to devote to the patient. Not only the outpatient service has to be made more efficient, but more attractive to the patient. By only doing so we will be giving real service to the community and at the same time cause less strain on our bed situation. Hospital should provide more doctors in out patient especially in medical and surgical side, so that patient don't have to wait more than half-an hour at the maximum to see a doctor and each consultant sees not more than 20 patients in a session, so each patients get good care. Drugs at the OP should be provided at cost price and investigations should be either free or at some small charge. Whereas in the ward the drugs and the investigation should be charged depending upon the income of the patient. This will not only make OP service more efficient and attractive but hospital bed-available for the needy only. In the same way most of the surgical patients should be

investigated freely as outpatient and are admitted only just a day or two before operation. This will make more bed available from the present number.

Coming back to the consultants, the consultants in the Bir Hospital I think should be encouraged, and has the responsibility to develop specialities like renal, gastroenterology, orthopedics, chest surgery etc. Bir Hospital in future will necessarily have to be developed as a central referral hospital.

[S, M. SHRESTHA]