INTRODUCTION

There is virtually no limit to the amount of medical care an individual is capable of absorbing (1). Nepal is a poor country, one that has been put in the group of those that are least developed. In this context, therefore, we have nothing to boast about. Leaders who rule us keep on telling that things will be going to be better by the end of this century viz. by the year 2000 in reference to Primary Health Care. We have been hearing this since the Alma-Ata declaration. More recently there has been talk of liberalization and privatization. The talk is of public and private mix in the delivery of health care services. Though the writing is not quite clear on the wall, the intention seems to be to hand over the curative services to the private sector and for the government to restrict itself to just promotive health care. Whilst this is an easier option this seems tantamount to washing ones hands from having to do the difficult task of providing reasonable health services to the people at large. Nearly half of Nepal population is living below the poverty line. Its per capita GDP is US $110 (2), and official spending on health care by the public sector is a mere US $ 3.10 per person (including donor funding) (3). The fertility, infant mortality and population growth rates are very high. In the World Development Report 2000, Nepal is ranked 144 from the top (4). Nepal is one of the poorest and least developed countries in the world with extremely limited resources. The World Bank in 1998-99 (3) carried out a comprehensive analysis of health care delivery in Nepal. Following an analysis with WHO guidelines and support of experts from Nepal and outside, Government formulated a National Health Policy, with the following commitments: to improve the health status of the people particularly those whose health needs are not often met, are underprivileged, specially women, children and the rural population, by strengthening promotive, preventive, curative and
rehabilitative health care services; to manage technically competent and socially responsible health personnel in order to provide quality of health care services; to improve the management and implementation capacity of the public health sector; to develop appropriate roles for public, private and NGO sectors in financing health services & work for alternative Health Financing Schemes; to implement health programs with full community participation following the norms of decentralization and local government concept in an integrated approach. Hence, the capacity of people's access to the labour market by creating a healthy labour force, income generation activities, to assist the poverty alleviation (5).

Full acceptance and understanding of primary health care has been achieved at all levels of the health system. At the policy level it is realized that only an integrated approach is a viable alternative to manage the present crisis in delivery of primary level health care. However it is felt that the primary health care (PHC) concept should be clarified and explained to health workers associated with the referral system particularly at the hospital end (6). Whilst the government stated that Nepal is committed to HFA 2000, it also claimed that the National Health Policy of 1993 is radically different from anything in the past. In this policy document a commitment for providing health care at grass root level is spelled out very clearly. Manpower management was planned to make them more efficient and responsible to local leaders. The concept of reaching all the villages by way of Sub Health Post at the Village Development Committee (VDC: smallest administrative unit and a unique example of local governance) level was accepted and became official. The stress was on the integration of all health related activities in the District Unit with the intention of upgrading the health status of population, 93% of which is rural (7). Despite its commitment to acute care and other aspects of health care, hospitals have the opportunity to provide leadership in resolving the epidemic of social ailments. It is a major community concern. In its role as a major community agency, systems must recognize that the results of the majority of the illness lies in the lifestyles and social conditions people lives. Doctors alone can not tackle the situations, promotion of health needs an integrated effort by all agencies of Civic Governance, working together for promotion of health and healthy living, preventing diseases, treating cases, controlling transmission and rehabilitating those in need.
The hospital industry is still in the highly technological phase of its life and evolution. In this situation, that means getting involved with other social agencies in the region, each of which is frustrated by the burdens it is carrying. The challenge is to help their agencies, not to replace them. The challenge is to organize facilities, services, people, finances, and special knowledge in a community based operation. This action would entail a close relationship between the new Community Services Corporations and Public Health Agencies with Academic Institutions. Integrated health care systems were developed with the cooperation of government, physicians, citizens and local businesses and industry; and today are financially, medically, and organisationally successful. Tomorrow’s health care system is challenged to establish a new organisational entity with a mission that will control the epidemic and create a healthier community. Integrated systems are an unusual combination of a social enterprise, education, and an economic and/or business enterprise. Each of these has its’ own life. As a social enterprise, every person in the region is affected by the system’s social commitment. As an educational enterprise, quality of care is assured. As an economic enterprise, the system is assuring itself and the community that the best care, services, facilities and personnel will be available to care for those who are sick and injured. Each of these major aspects of community life must be rallied to the support of a proposal for a service organisation to respond to the problems and to plan for the next 5 to 10 years. In the mean time, we are in the midst of an epidemic. It must be attacked. Community interest, pride and well-being are our tomorrow are and will be tough. On the one hand, we must deal with an epidemic. There must be an organized and well-financed community corporation to lead this effort. On the other hand we must move into the future with a vision of greatness. We must also be willing to share our financial strength, medical care, research capabilities, creativity, vitality, and dreams for all our children with our concerned leaders. A Quote from Abraham Lincoln: “The dogmas of the quiet past are inadequate to the stormy present, we must think a new and act anew”. The success of the future depends upon the dynamism of work, rather than repeating the mistakes of past. This goes for in any management process including health care.
INTEGRATION OF PROVISION

As organisational units like hospitals or clinics become more autonomous, the service delivery system runs the risk of becoming fragmented. Fragmentation may occur among similar provider configurations (hospitals, ambulatory clinics, or public health programs) or between different levels of care. Such fragmentation has negative consequences for both the efficiency and the equity of the referral system unless explicit policies are introduced to ensure some sort of integration among the resulting semi-autonomous service delivery units (8).

When health services become fragmented, allocating efficiency suffers. For example, non-clinical health facilities designed to provide public health services in Poland and Hungary often engage in secondary prevention and a wide range of basic care because they are not adequately linked to ambulatory care networks. The university hospitals that have been made autonomous in Malaysia provide a wide range of inpatient and outpatient care for conditions that could have been treated effectively at lower levels in a community setting. The newly autonomous general practitioners in the Czech Republic have been quick to buy a large quantity of expensive equipment that is rarely used (9). When organisational changes among providers cause fragmentation, disillusionment with a market-oriented system can lead to some vertical and horizontal reintegration, with more hierarchical control. One way to preserve the virtues of autonomy for providers without fragmentation is via “virtual integration” instead of traditional vertical integration. Under vertical integration, a clinic takes orders from a hospital or a government department, limiting its responses to local needs. Virtual integration means using modern communication systems to share information quickly and without cumbersome controls.

This is particularly valuable for referrals, and can include non-governmental providers hard to incorporate under hierarchical schemes. Efforts at virtual integration face three common problems, related to decentralization, separating purchasers from providers, and user charges. In many countries, there has recently been an increased enthusiasm for decentralization as a means of attaining a wide variety of policy and political goals in health as in other areas. The explicit objective of decentralization is often to improve responsiveness and incentive structures
by transferring ownership, responsibility and accountability to lower levels of the public sector. This is usually done through a shift in ownership from the central government to local levels of the public sector-provinces, regions, districts, and local communities’ individual publicly owned facilities (9).

HUMAN RESOURCES MANAGEMENT FOR HEALTH

Most countries share this view of the importance of human resources for health development. Evans (10) suggests that “survival, let alone growth and development, of all organisations depends on the availability of human resources, time, effort and skills to carry out activities”. Within health sector the importance of human resources is recognized “both because the workforce has the ability to make health services effective, and because of the high proportion of health expenditure dedicated to salaries, incentives, and the payment of health workers” (11). Estimates place the health workforce’s use of the country’s recurrent budget at about 70-75% (12). In the past decade the workforce has become a focus for civil service reform, cost containment and health sector reform initiatives in many countries. Fiscal responsibility is a predominant concern of virtually all governments today. The world health report 1997 chronicles the fact that ministries of health are faced with chronic problems of imbalances.

There are three common imbalances in the health workforce. Numerical imbalances in countries that are either producing more health workers than they can afford, or not enough. Qualitative the type and level of education and training and the job that needs to be done are not consistent. Distributions mismatches between the geographical, occupational, institutional and specialty mix or between the public and private sector. A fourth type of imbalance often observed is the lack of synchrony between HRH policies and the national health policy. For example, national health policy may emphasize PHC while the HRH policies are designed to facilitate growth only in medical personnel (and specialization), often at the expenses of the education and training of health workers who are more oriented towards the delivery of PHC services.

Comparisons of the numbers, levels and categories of health workers across countries are subject to significant difficulties owing to differences in the organisation and management of health systems, differing
roles and responsibilities, varied standards of education, and nomenclature. The comparisons, nonetheless, can indicate a magnitude of differences, which require investigation. For example, the World Health Record 1997 states that the number of nurses and midwives varies substantially between countries at different levels of development (crudely measured in terms of their macroeconomic indicators). Economies in transition report an estimate 800 nurses and midwives per 100000 population; developed market economies report around 750, whereas Low Developed Countries have around 20 per 100000. It is clear that regardless of the overall organisation of a country’s health services delivery, these figures point to different capacities to deliver services and to meet health system objectives such as equity and access to health services. Nepal is one of the countries in SEARO region whose planning in Health Manpower was not reached up to the fairness. Table 1 shows a contrast of its success with neighboring countries. Of course, things are improving now, but needs a well-planned agenda to balance the ratio in different levels of health care services, its manpower as providers’ and public as consumers.

### Table 1. Medical and Nursing Personnel in SEAR Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Physicians</th>
<th>Nurses/Nurse-Midwives</th>
<th>Midwives &amp; Auxiliary Nurses/Nurse-Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>1994</td>
<td>18.1</td>
<td>7.7</td>
<td>Not available</td>
</tr>
<tr>
<td>India</td>
<td>1991</td>
<td>48</td>
<td>40.2</td>
<td>19.8</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1993</td>
<td>11.6</td>
<td>64.6</td>
<td>Not available</td>
</tr>
<tr>
<td>Maldives</td>
<td>1993</td>
<td>18.9</td>
<td>13.0</td>
<td>51.2</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1994/1995</td>
<td>28.4</td>
<td>22.4</td>
<td>23.7</td>
</tr>
<tr>
<td>Nepal</td>
<td>1995</td>
<td>5.3</td>
<td>5.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1994</td>
<td>22.7</td>
<td>73.8</td>
<td>37.0</td>
</tr>
<tr>
<td>Thailand</td>
<td>1993</td>
<td>23.5</td>
<td>80.4</td>
<td>87.6</td>
</tr>
</tbody>
</table>

**Source**: Regional Health Report 1996, WHO SEAR, New Delhi (13).

**Background Information of Integration of Health Services in Nepal**

By the late sixties both USAID and WHO had come around to the thinking that the Nepalese health services needed to be integrated (14).
This naturally led on to the proposal of trying the process in two districts viz. Kaski and Bara, which were dissimilar in terms of location, living styles etc. The administrative aspects were first handled by Community Health and Integration Division (CHID). A Central Integration Board (CIB) was also formed. As time went on, four more districts were added. In 1980 however, both the CHID and CIB were disbanded and a new Integrated Community Health Services Development Project (ICHSDP) was formed as per the Development Boards Act of 1956 (15).

Several WHO initiatives starting from the Basic Minimum Health Needs culminated ultimately in the Health For All by 2000 (HFA 2000) strategy of 1978. This in course of time, following acceptance by the world at the Alma Ata Conference of 1978, became the “Health Call of the World”. By 1987 the Ministry of Health, Government of Nepal, decided to integrate all vertically run programs. The District Public Health Offices were established. By this time the ICHSDP had a total of 37 integrated districts under it. All these now came under the newly established District Health Offices, which also became the central focal point for the district Health system. During this integration a large number of programs were merged into basic health system. Malaria Tuberculosis and Leprosy Control Programs, MCH & Family Planning, ARI, Diarrhea & Dehydration management Divisions started to work together from a single platform (16).

An important landmark in the Health Ministry took place with an act of parliament on 18th Jan. 1993 that started the process for the setting of autonomous Health Sciences University, in the eastern region of Nepal, catering for 35% of the population of the country (17). The University took its distinct position in medical education, declaring whole eastern region as a Teaching Districts. Initially 3 Districts Hospitals, 16 Primary Health Centers, 24 Health Posts and 136 Sub Health Posts were incorporated for field practice area. This provided an alternative way for Health Manpower Planning. Chronic scarcities of trained doctors are not a new problem in rural areas (18). Those working are either from a poorly equipped private sector not pace of advanced knowledge or traditional healers of different background. So, integrating health work force from public, private and academic institutions resulted in many unseen problems. The Health Sciences University is doing its best by creating partnership with many other organisations (health and social service related) in the eastern region.
of Nepal. It aims to obtain support for the total human development approach based on equity and social justice. Partners in this endeavor are District Health Offices, Village Development Bank, Britain Nepal Medical Trust (BNMT), UNICEF, Plan International, Family Planning Association of Nepal (FPAN) and UNFPA, SOS Balgram, AMDA Hospital, Rotary Club Dharan, Itahari, Inarwa, Dharan, Biratnagar Municipalities and active NGO working in Health Development. Under the leadership of BP Koirala Institute of Health Sciences many other social organisations, industrial groups, private groups are interested to take part in this endeavor.

The B.P. Koirala Institute of Health Sciences is trying to bridge the gap between educational institutions, where health manpower is produced, and health centers where service is provided. It believes that “this linkage between education and service should be at all levels of health professionals’ education from students’ selection, training and continuing professional education to health service delivery and from primary through tertiary care. And finally, such a linkage should address the priority health care needs of society.”

Active participation by medical faculties in ongoing major health activities will prove valuable in many ways. It will be highly rewarding learning experience for the faculties themselves. It will impart greater relevance and realism to undergraduate and post-graduate training programs being undertaken by the faculties. It will augment the technical content and standard of our integrated approach of health care delivery at the grass-roots level. Such participation, if imaginatively undertaken, far from detracting the faculties from their primary obligation towards education and training of the students under their charge, it will greatly facilitate their educational and training programs and make them more meaningful.

A state of the art hospital with 646 beds is functioning efficiently. It is an institution committed to providing the highest quality of health care services to the people of Nepal. Unlike most of the medical institutions and universities in the world it aims at providing comprehensive health care services from primary to tertiary level. It is committed to the development of replicable and sustainable models of integrated health systems, sensitive to the needs of both individual and community, living in both urban as well as rural areas (19). Being a community oriented and community based Health Sciences Institute, it emphasizes the need of delivering primary

health care services to the rural population at its doorsteps as well. At the same time it nurtures the goal of providing the highest degree of tertiary health care through the state of the art hospital manned by staff committed to the people of Nepal. Community based as well as basic research is an integral component of the Institute’s goals and objectives. The Institute is in the process of leading from the front towards improving the health status of people of eastern Nepal. The institute has a committed team of experts in various fields of medical and allied sciences, who are ready to take up newer challenges and tougher goals to prove their worth.

The doctor per population ratio is 1:15,800 of the population (20). However about 50% of the doctor population are in the capital. This is simply because of health institutions of larger bed capacity are located inside the Katmandu valley. On top of this, the central region of the country has 445 of the 874 government posts for doctors (21). A very rough estimate of hospital beds in Katmandu valley is put at about 2000 out of the total number of about 5000 beds in the whole country. A question that immediately arises in whether the Government supported hospitals and teaching institutions are so overstuffed, that under utilization of the technical personnel occurs? Considering the relatively smaller numbers of personnel that they employ, are the private and semi-private institutions providing substandard services? Have the nursing and paramedical staffs at such institutions been adequately trained in recognized institutions and are they registered in their respective Councils?

In the case of Nepal there are on average, 6 doctors per every 100,000 of the population. In rural areas the ratio is probably 1 per one hundred thousand population! This ratio will not be immediately changed. It will persist until such time as pay and facilities for living, lodging, and career development for those serving in rural areas are better than for those in the cities. As concessions on these matters are seen as “being soft” by the government authorities, it is likely that the manning of governmental posts will never be satisfactory. Proof of all this is evident in the fact that many of those selected for posting in government health institutions have not taken up this option. Even the passage of the newly enacted Health Act, is not helping much as there is no enthusiasm to join government services.

With the new medical schools and the new specialized institutes plus the nursing homes of the urban centers vying for the services of the doctors, there will not be very many left for service in the districts as per the
intention of the government. The numbers of middle level workers such as nurses, laboratory technicians required etc is not going to be available, as there are not enough for the present existing services. The private sector is more attractive than the government one and so the reality that will be faced soon is that there will be a gross shortage of middle level workers. In such a situation, the planned new institutions will not be able to function and the standards in existing ones will drop because of inadequate numbers of staff. To continue functioning, certain compromises will have to be made, leading thereby to undesirable functioning. Manning of the hospitals in the district is going to be more difficult. The district health services at the grassroots level will be functioning with lack of appropriate staff with absence of monitoring, and with a total lack of effective and supportive supervision. Alternative arrangements or options will have to be taken up. As the year 2000 approaches it seems that Health For All is perhaps just a mirage in the distant horizon.

The only solution to this problem is to share the responsibilities between academic health institutions and district health services. They should join hands following the example of the BP Koirala Institute of Health Sciences. Nepal has signed the Declaration of Alma Ata. Our commitment was to HFA 2000 with determination to provide Primary Health Care. The National Health Policy has been laid down with the stress on the rural areas. When the BPKIHS was established and the community based training course was started, the stress was on the concept of “health teams” providing care to the people. Now as developments in Nepal unfold, it seems that stress is being laid more on the training of physicians with more emphasis on tertiary care. What has happened to the concept of a health care team? It seems to have fallen by the wayside. So too have suffered the teachings of the seventies and eighties when it was said that the “high cost, big buildings, orientation to episodic illness and sophisticated technology” was not suited to developing countries such as ours (22). The stress was to have been on labour-intensive instead of capital oriented-policies, the new catchword “public/private mix in the delivery of health care”. The identification of the district as the unit of health care seems another gimmick to pronounce and keep the masses in the world of make believe health care.
One way however of looking at all this is with a philosophical outlook and saying that the process of decentralization and integration of health services is on the move. Instead of concentrating all the health institutions in the capital, the building of health institutions in Pokhara and Dharan is right direction. Now the Institute should be responsible to those populations residing in adjacent areas and support its poorly equipped peripheral health institutions. Developing countries like Nepal are facing increasing challenges, which in all probability will get worse. Health problems will be greater in magnitude and the interventions will be more complex and costly. Planning of manpower including in health sector is out of balance in any developing countries. If properly undertaken, integrated management especially in primary health with the help of sound academic health institutions, a ray of hope of successfully meeting the challenges of “Health For All” will enhance the wisdom needed, now more than ever (23).
REFERENCES