

GROSS NATIONAL HAPPINESS AS A REFORM PARADIGM FOR HEALTH CARE CHALLENGES IN THE 21ST CENTURY

1. Introduction

It is with the greatest privilege and humility that I have accepted on behalf of the Royal Government of Bhutan the invitation made by Dr. Samlee Plianbangchang, the Regional Director, WHO SEARO, to speak to this august gathering. I hope I will do the topic justice.

On behalf of the Government and people of Bhutan and on my own behalf I extend my heartiest greetings to all the participants gathered here to deliberate the issue of international importance: *Health Care Reforms for the 21st Century*.

The conference is timely for us in Bhutan as we are presently working on the National Health Policy, guided by the principles and philosophy of Gross National Happiness or GNH. The government is also working on the National Economic Development Policy.

My presentation will focus on four broad areas namely; lessons of the last century, paradoxes of the Region with regards to health care, challenges facing the health sector in the 21st Century, and some suggestions for health care reforms through the GNH approach.

2. Lessons of the last century

Mr. Chairperson, as we all know that the past, present and future are intrinsically intertwined. I would like us to briefly consider the greatest achievements made in the last millennium, particularly those towards the latter part of the nineteenth and twentieth centuries. In so doing I hope that we might be able to not only rejoice and acknowledge the unlimited strengths and capacities of human beings for innovation and development, but to also identify some of the many challenges and opportunities that will face us in the 21st century.

We are today proud beneficiaries of unprecedented development in the fields of science and technology. Of particular interest to this gathering should be the biomedical science developments of the latter part of the last millennium that have revolutionized the practice of medicine and healthcare throughout the world.

Great advances in the fields of epidemiology, bacteriology and immunology were made in the last half of the nineteenth century which, in tandem with rapid economic development, resulted in general improvement in living standards, nutrition, water supply, and education¹. By the turn of the twentieth century, the rapid expansion of scientific knowledge and advances in biomedical technologies led to the eradication of smallpox in the late 1970s, the development of vaccines to prevent many communicable diseases that were a major public health concern, the containment of leprosy, poliomyelitis and iodine deficiency disorders, significant

reductions in deaths from neonatal tetanus and measles, and the effective treatment for communicable and non-communicable diseases. Indeed, as highlighted by Feachem², human health has probably improved more over the past half century than over the previous three millennia.

Despite making tremendous achievements in health care in the last century - as reflected by increased expectancy of life at birth and reductions in infant and maternal mortality rates - the world is still besieged with problems. Many of which, if not most of which, are rooted in human actions. Central to these human actions is the greed of mankind! Permit me to quote the Prime Minister of Bhutan, Lyonchhen Jigme Y. Thinley, who said that, *“our greed for money and greed for power is destroying the very essence of human beings; this wanton greed is responsible for the destruction of the mother earth’s ecosystem, which sustains the very life on this planet.”* Today, as we recall the technological and scientific advances made in the last century, we should also honestly reflect on the past misdeeds stemming from political, religious and economic ideologies that have led to the unforgivable deaths of hundreds of millions of lives through war, civil strife, acts of terrorism, starvation and malnutrition, lack of basic health care services, and other man-made calamities.

The impact of the recent global economic recession is a grim reminder that the capitalist-driven market economy is failing. We all know that communism, too, has failed. It is worthwhile to recollect the statement made by the Czechoslovakian foreign minister at the UN in 1983, *“capitalism knows how to create wealth but does not know how to distribute wealth. Communism, on the other hand, knows how to distribute wealth but does not how to create wealth.”* Relevant to this context is the concept of Gross National Happiness (GNH) which is being increasingly acknowledged worldwide as an alternative development paradigm. Towards the latter part of my presentation I will delve a little further into the concept of GNH which was conceived and propounded as the goal and purpose of development, by the fourth King of Bhutan, Jigme Singye Wangchuck.

Perhaps the plethora of problems and the plight that the global community finds itself in stems partly from our relentless pursuit of scientific and technological developments at the cost of ‘human development’. According to Edward De Bono, our perceptions and actions are patterned or dictated by reasoning and logical thinking. This is impeding the advancement of human development. Therefore, we need to go beyond our perceptions formed out of reasoning and logical thinking to work on human development advancement. If we are to successfully address the health care challenges of the 21st century, we must all introspect on our strengths and weakness, seize upon opportunities that were either previously missed or left untapped, transcend parochial politics at all levels, and come up with new thoughts and ideas to develop comprehensive, needs-based and ‘people-centered’ health intervention framework strategies.

3. South East Asia: A Region of Paradoxes

Mr. Chairperson, may I now draw our attention to our immediate Region. The South East Asia Region is composed of a multi-ethnic, multi-lingual and multi-cultural conglomeration of

people living in both some of the most economically progressive and least developed countries in the world. The SEAR is home to over 25 % of the world's population, yet comprises just 11 countries out of 193 UN member states. The Region includes some of the world's fastest growing economies e.g. India, and yet South Asia was home to 41% of the world's poor in 2005³. The Region contributes to a sizeable proportion of the world's richest people while at the same time significant numbers of its people live under extreme poverty, eking out an existence on less than US \$ 1.75 per day. Some countries in the region have sophisticated world class tertiary healthcare facilities while many communities in the region have to make do without access to even the most basic health services. In Mount Everest and the Himalayan ranges, we have the highest elevations in the world yet many countries in the region have vast stretches of low-lands- both of which are subject to the adverse elements of nature. The region boasts the world's largest democracy and the burgeoning independence of the media, whilst other countries continue to be run by non-egalitarian systems of governance.

The governments and the people in the region are continually challenged by the widening disparity in income distribution and access to socio-economic opportunities, civil and political strife, and the forces of nature, such as floods, earthquakes, tsunamis, cyclones, landslides, etc. all of which bear considerable impact on the health and healthcare delivery systems. This year alone, Bhutan has borne the brunt of flash floods, landslides, windstorms, fires and earthquake all of which have caused the loss of lives and substantial damage to property.

Notwithstanding these paradoxes, the Region can draw on its numerous strengths and opportunities. The wheel of advancement in biomedical and health information technology is steadily spreading to towns and rural communities. There is a growing body of scientific literature at the regional and global levels. But the outcome will depend on how correctly and adequately we channel our shared desire for socio-economic development through increasingly inter-dependent and reciprocal engagements at the government and people-to-people levels. As so aptly put by Amartya Sen, *“much will depend on what use we make of the vast opportunities offered by the market economy, democratic politics, an independent media, social arrangements for equity and public provisions for human security.”*

4. Core health care challenges of the 21st century

Mr. Chairperson, the very fact that we are all gathered here today to hold consultations on health care reform is a testament that all is not well with our health care systems. Despite having evolved progressively through the most part of the last century, being guided supported and in partnership with the WHO since its inception in 1948 and following 30 years of the primary health care initiative for universal healthcare coverage, the health care system worldwide is facing serious challenges. Highlighting the main healthcare challenges, the world health report 2008⁵ calls for renewed commitment of all the States to consolidate and step-up the primary health care model as the means to surmount these challenges.

I believe that these challenges basically center around three main health system inputs, namely, human resources, physical capital, and consumables (in addition to the other important determinants of a health system like poverty, the political and social environment, and the

availability and appropriate use of scientific and biomedical technology). These challenges must be deliberated within the local and regional context before we formulate and advocate for a set of context-sensitive reforms to address them appropriately.

a. Human Resource Shortage in Health

Appropriately trained health manpower is a critical component of health system inputs and without it, others, such as financial resources, health infrastructure and health technology, are worth nothing⁶. The shortage of health professionals is a global challenge, both in developed and the developing countries⁽⁷⁻¹¹⁾. In 2006 the WHO reported an estimated global shortage of about 2.3 million physicians, nurses and midwives, and over 4 million health workers over all¹². We all know that acute shortages of health manpower is partly aggravated by the increasing brain-drain of health professionals, particularly nursing and medical doctors, from developing countries including the SEA region to more industrialized countries. The unregulated migration of health workers is causing a deficit between health care needs and available health workers to fulfill those needs. The disproportionate concentration of health professionals leading to geographical imbalance, both between and within countries, is a serious challenge. For example, the United States and Canada carry only 10% of the global burden of disease yet these countries have 37% of the world's health workers in contrast to Africa, which is home to only 3% of the world's health workforce yet carries 24% of the global burden of disease⁷.

The health worker crisis relates not only to the total number available but also to the geographical imbalance in 'distribution, quality of training of service delivery staff, health systems operational efficiency, productivity, process improvement and sustainability'¹³. We must all strive to implement the Tokyo Declaration calling for a fundamental reorientation of health manpower planning, production and management.

Even Bhutan, with a population of just 700,000, is not spared from the adverse impacts of shortages in human resources in health. A few of our doctors and nurses have already left the system. We are compelled to explore from beyond our borders to recruit doctors, particularly from Myanmar and India, to address the doctor shortage by paying these overseas doctors at almost three times the salary paid to local doctors. Though compared to packages paid to doctors in private clinics in developed countries, the amount is insignificant. In Nepal, private specialist-doctors are paid three times higher salaries than their counterparts in the Civil Service but still the turn-over rate remains high.

b. Inequality and inequity of healthcare access

Despite remarkable gains in primary health care coverage as manifested by the reduction in maternal and under-5 child mortality rates, increased life expectancy, increased coverage of sanitation and access to safe drinking water, inequitable and unequal access to health care remains a major challenge in many of the SEAR countries. People in several communities in the region still live more than five kilometers from the nearest health center. Although health

care is provided free of cost in Bhutan, people in rural areas do not have the level of access to health that is enjoyed by people in urban areas.

Globally speaking, huge gaps exist between health care needs and health care spending. High income countries spend almost 100 times more on health per capita than low-income countries. Worse still, is that more than 50% of the spending on health in poor countries is out of pocket payment. Developing countries account for 80% of the global population and 90% of the global disease burden, yet these countries generate just 20% of the global GDP, out of which only 12% is spent on healthcare financing. Health care financing reforms must look at mechanisms to institute equitable access to health care, including efficient and sustainable financing in low and middle income countries.

Globalization and commercialization of health care has further widened the gap between the rich and the poor, between one population group and another, between ages and between sexes. Indeed, for most people in the world today and particularly in some SEAR countries, 'every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequality and under the double burden of suffering and disease'¹⁴. What Robert McNamara, President of the World Bank, said in 1980 rings true: "the pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilizing."

c. Wastage and Fragmentation of healthcare

The wastage of resources in terms of under and over-utilization of health services including those of the health workforce is tremendous. For example, in the United States, about 25% of the roughly one trillion dollars spent on health care in 1998 was attributable to unnecessary or avoidable care, redundant tests, and excessive administrative costs¹⁵. Poor countries cannot afford to be wasteful. But I understand that such wastage is occurring in our region, including Bhutan. Some of the reasons I can conceive include the practice of 'defensive' medicine, motives of profit, patient ignorance, irrational care, the unconsciousness of cost, a laissez-faire attitude and so on.

The fragmentation of medical care is fuelled by an increasing trend by health professionals towards specialization in vertical disciplines, disregarding the importance of horizontal specialization such as General Practitioners and Poly-Clinicians. Even public health programmes, many, if not all, of which are donor-driven, are basically oriented towards addressing specific disease or health conditions. Our indiscriminate drift towards the highly curative and disease-centered care has caused the 'dehumanization of care' and the growing neglect of the disease prevention and health promotion approaches.

Addressing the problems of the wastage and fragmentation is a serious challenge. Not being willing to consider the issues would be tantamount to reversing whatever health gains we have achieved so far.

d. Poverty and healthcare

Extreme poverty has been identified as the world's biggest killer and the greatest cause of ill-health and suffering¹⁴. Despite having some of the fastest growing economies in the world within the Region, as exemplified by India, and other progressive countries like Thailand and Indonesia, 41% of the world's poor are to be found in South Asia alone. Is it not a travesty of social justice that 'some developing countries barely have US \$ 4.0 to spend per person on health care over an entire year, which is less than the amount of small change carried in the pockets and purses of many people in developed world?'¹⁴

Poverty adversely impacts on the distribution of health system inputs and outputs through scarce resource allocation, weak infrastructure development, limited management capabilities, and inequitable and unequal access to healthcare. Indeed poverty and poor health are inextricably linked, with one leading to the other and vice versa. And the hardest hit by the world economic recession and climate changes are always the poor.

e. Changing demographic profile

Asia is home to 60% of the world population, out of which 25% of the global population reside in SEAR countries. The effects of demographic transition which the developed world has already experienced are now also being felt in the developing world. More and more people now live longer. The increase in the number of old people leading to higher economic dependency and geriatric problems will be one of the pertinent forces affecting health care and social services in the 21st century. The negative population growth in Japan and other developed countries poses a newer threat to the global workforce including the health sector.

The growth rate in SEAR is alarmingly high and uncontrolled population growth will weigh heavily on the distribution of land and social support networks in addition to influencing the migration of people both within and between nations, and adding to political and economic instability. Urbanization poses additional challenges for health systems. Today 50% of the global population lives in urban areas and this is expected to grow to 70% in the next four decades. We need to tackle the health problems of the urban poor, of adolescents and youth, and of the homeless – the majority of which are related to the diseases of society, such as poverty, unemployment, exploitation, ignorance and risky behavior. We will have to meet the challenges posed by rising levels of accidents, violence, and suicides involving young people in our Region. Meeting the health care needs of youth and women will be a vital investment for securing the world's future.

f. Negative Health Impacts of Globalization and Global Warming

Notwithstanding the immense benefits associated with the global liberalization of trade and the movement of peoples and goods, the negative impact of globalization and liberalization is increasingly felt on healthcare. Such negative impacts include spurious drugs and medical equipment, contaminated food stuffs, the indiscriminate transfer of costly technology¹⁶ that is driven by commercial interests, unlimited access to unauthenticated information, inconsistent safety standards, the brain-drain, the easy availability of junk foods, etc.

People living near or crossing international borders have to contend with specific health problems related to the freer movement of people, goods and disease vectors. Therefore, diseases like malaria, tuberculosis, HIV/AIDS, drug abuse-related conditions will continue to be a major public health problem along borders. A global initiative on health and safety at international borders is needed¹⁷. Our fight against the containment of these diseases and emerging pandemics will be futile without coordinated interventions on both sides of borders.

The impact of continuing ecological degradation, the loss of biodiversity, environmental pollution, diminishing natural resources, depletion of the ozone layer and predicted global climate changes on health and health care systems will be enormous and unlimited. The 21st century will have to handle food and water scarcity challenges caused directly by uncontrolled climate change.

g. Emerging and Re-emerging Burden of Diseases

The epidemiological transition of diseases taking place in the region poses a growing challenge to health care. Despite having some effective preventive and curative service programmes, traditional diseases like tuberculosis, malaria and HIV/AIDS continue to plague the population which is compounded further by the evolution of drug resistant malaria, multi-drug resistant tuberculosis, and Chikungunya. The South East Asia Region has the second highest burden of HIV infection, and one third of the global tuberculosis burden.

Of the 14 million deaths that occur annually in the Region, 40% are attributable to communicable diseases. This is substantially higher than the global average of 28%. Large proportions of people in the region continue to live without access to safe drinking water and sanitation. Even before the battle with communicable diseases is won, the Region must grapple with the new and emerging public health problems, such as, life-style related and ill-health conditions, pandemics, and natural and man-made disasters. The recent years have seen the escalation of lifestyle related diseases in Bhutan, incurring substantive expenditure from the government exchequer.

h. Sustainable Health Care

Meeting the increasing demands for health care in the face of limited resources and rising costs is a universal challenge. The problem is more intense in poor countries due to disparities in social determinants of health. Ensuring continuous availability of essential drugs and access to basic health care by all segments of society is indeed a serious challenge.

5. Harmonizing Health Care Reforms with GNH

It may have been evident from the foregoing brief discourse on problems challenging us in this century that the underlying cause of these problems is rooted in our lopsided views on development and progress, being fuelled by our insatiable greed for material comfort. But it is crystal clear that development and economic prosperity are not necessarily synonymous with happiness. Development policies, when driven by unregulated cut-throat competition and profit-driven forces of the free market economy, give rise to numerous social ills ailing the global community today. In this context, the concept of GNH offers an alternative paradigm for development based on the principles of balance and harmony in our endeavor for socio-economic progress with 'happiness' as its ultimate goal.

GNH is centered on 9 domains consisting of time use, living standards, good governance, psychological well-being, community vitality, culture, health, education, and ecology¹⁸. Holistic, people-centered, participatory and balanced development (including a balance between material and spiritual development) is the very essence of the GNH philosophy. As may be evident from the nine GNH domains, the concept is indeed in line with the holistic definition of health, which was defined by the WHO as encompassing physical, mental, social and spiritual well-being. Let me quote Karma Ura, an author on GNH, who said that we can successfully transition from 'a century of population explosion to a century of graying and browning; from a century of Gross Domestic Product fetishism to a century of holistic and non-materialistic well-being; from a century of technocratic utopia to a century of harnessing appropriate technology; and from a century of treatment to a century of fundamentally happy and healthy lifestyles,'¹⁹

I would like to now briefly touch upon some of the areas that this august forum might consider worthwhile to deliberate upon in the next three days.

a. Stepping up Primary Health Care Initiatives

Many of us can recount the immense health gains achieved since the adoption of the principles of the primary health care initiative 30 years ago. Bhutan has particularly received international commendation for the progress made under the PHC initiative although there remains a lot to be achieved.

Increasing volumes of studies have highlighted that many of the current problems challenging the health sector relate to the diversion of focus away from primary, preventive and promotive aspects of care towards curative care. The World Health Report 2008²⁰ calls for a renewed

commitment by all to step-up the PHC model as the health service delivery approach to address the challenges of the current century.

While I pledge my full support to the PHC model, I do feel that it is critical not to neglect the curative care component. In this context, Mr. Chairperson, let me use a bird metaphor to describe how I perceive the health care system or service. The health care can be likened to a bird with one wing representing curative care and the other wing representing the preventive and promotive component. For the bird to maintain a steady flight and fly ever higher, both wings must work in tandem with perfect harmony. Similarly, both the curative and preventive aspects of health care must be pursued to maintain equilibrium.

b. Management and Development of Human Resources

Developing and managing human resource in health is critical to health care systems. Several studies^(10, 11, 21, 22), have highlighted the impact of financial and non-financial incentives as a measure for attracting potential workforce into the health sector, for motivating and retaining those who are already in active service, and as strategies to address the problem of migration and brain drain. Human resource initiatives for health sector reforms should include strategies to increase 'health equity, quality of services and patient satisfaction'²³. Critical to fulfilling these goals is the information and knowledge management by health workers as a basis for evidence-based practice.

We must design policies and strategies including better pay packages and perks and other incentives to recruit and retain health workers that are based on local needs. We can draw on lessons from initiatives such as, 'exchange programmes' and 'bilateral hospital twinning schemes' implemented by South Africa and the United Kingdom that allow for time-bound exchanges of health care workers from two countries to facilitate sharing of best practices^(7,8). Similarly, both the employing and the supplying countries must implement the Global Health Worker Migration Initiative (HWMI) in addressing the inequitable health care access due to the migration of health workers.

c. Reforms in Medical Education and Health Worker Training

The health sector may be likened to a ship with the health workers as the engine, and the managers as the captain of the ship. Just as the ship is propelled by the engine, and guided and steered through the rough seas by its captain – the health sector is run by the health workers who in turn must be led and managed by their managers or leaders. For smooth sailing, the engine must be oiled and maintained regularly and updated in line with technological advances whereas the captain must always be fit, innovative and dynamic to deal with the unexpected. Clearly, it is imperative that health workers and leaders are appropriately trained to deal with prevailing and foreseeable challenges.

Despite the initiative of the World Federation for Medical Education²⁴ for reorientation of medical education to train health workers for holistic health care delivery, medical education today continues to be 'disease-centered'²⁵, and medical practice based on 'limited evidence in

the form of textbook information and obsolete premises'¹⁵, curative-oriented and hospital-based²⁶, and increasingly driven by technological sophistication and commercialization 'so to push aside the more personal and humanly sensitive side of medical care'.

I see an urgent need to critically review and reorient the missions of training institutions and medical education and training policies to respond to the rapidly changing health care needs of today. Production of health workers in sufficient numbers alone is clearly not the only objective. Medical education reforms should be geared towards producing not human 'robots' that are directed by automation of diagnostic and therapeutic procedures but fellow 'humans' who are adequately trained in the art and power of healing through compassion, integrated team work, patient-centeredness and holistic approaches in partnership with the community. If trained holistically, compartmentalized walls within which our doctors enjoy working will be brought down. And they must be broken down. I could not agree more with Sir Cyril Chantler, who said, "if modern medicine is to be humane, then compassion and wisdom on the part of clinicians are attributes that are needed perhaps as never before"²⁷. Indeed the medical universities and teaching institutions must form an integral component of health-service innovations and health sector reforms.

For developing countries like Bhutan, we need to draw on the lessons from Switzerland and Cuba to train more doctors as General Practitioners or Poly-clinicians. It is not economically viable to have a large team of specialists, whose services will be under-utilized, in a small district hospital but to have one or two GPs. Similarly, other health workers can be trained in multi-skills.

d. Effective Leadership Health care

Several studies have highlighted 'poor leadership' in health as being responsible for many of the problems ailing the system including poor quality of service delivery, low levels of patient satisfaction, and decreasing morale and motivation of health workers. Bhutan, too, according to the reports of Royal Audit Authority and Anti-Corruption Commission, suffers from poor leadership at all levels of health care facilities. Bureaucratic and administrative measures alone are not sufficient to improve the appropriateness of care; a better solution is to develop clinical leadership. After all, in matters of health care, the health workers must 'lead and not follow'²⁸.

In leading and managing health reforms effectively, we may draw lessons from best practices of effective leadership models in Afghanistan, Sudan and South Africa²⁹, in leading and managing human resources in health through development of a nationwide HR information system, development of HR policy, establishment of a dedicated HR unit, multi-sectoral approaches and comprehensive planning, expanded recruitment and training, revision of pre-service training curriculums, and testing and certification of health workers.

e. Sound Health Care Financing and Sustainability

The rationing of health care has assumed critical importance against the backdrop of an ever-growing demand for health services, rising costs and dwindling resources. At the broader level,

political strategy is required to adopt technologies and practices that will ensure availability of health services, the supply of drugs and vaccines, and other health care on a sustainable basis.

There are various financing health systems or models such as private-based insurance systems (example, USA), social health insurance systems (first introduced in Germany), state-funded systems, community health insurance systems and voluntary health insurance systems.³⁰ A system that works in one country does not necessarily work in another. For example, the social health insurance system is working fairly well in Germany but a similar system has not worked nearly so well in Kazakhstan.

Although studies by the World Bank, IMF and others suggest that state-funded financing based on the principles of equity and justice seem to be a better option for poor countries, many developing countries' economies are heavily 'donor-driven', making sustainability an issue. As there is no 'one-size-fits-all' model, we must customize health care financing based on local needs and relevance to local social, economic and cultural backgrounds of respective countries.

f. Harnessing Appropriate Health Care Technology

Technology is a double-edged sword. Biomedical and technological advances have huge potential to contribute to the development of even the poorest countries. However, inappropriate use of science can be very costly when measured in terms of 'money, programme distortions, and positive harm'²⁶.

The introduction and use of newer technologies, as encompassed in the WHO definition of 'appropriate technology', requires that such technologies afford technical advantages, have positive health impacts, are cost effective, acceptable, and easily maintained by the end-users within the available resources and skill.³¹ We are all witness to the tremendous benefits of relatively simple and practical technologies like cold chain, Oral Rehydration Solution, various types of field testing kits, battery-powered X-ray machines, microcomputers, and methods for determining haemoglobin and blood glucose levels.

The indiscriminate transfer of technology is not only undesirable but can be counter-productive. In fact, 'advanced technology has attracted resources away from priority needs'²⁶, which can prove devastating in poor and developing countries. A growing body of evidence identifies a number of so-called "advances" that do not work at all, and benefit no one.³² We must balance what is really essential and practicable for healthcare delivery against increasingly sophisticated and seemingly marvelous technologies and procedures that actually may be less beneficial. Therefore, every country must draw a strategic plan for the assimilation of health technology.

g. Forging a Regional Global Partnership

In this globalized world of ours, where we are faced with common challenges of survival and security, there is a greater need than ever to forge a 'global solidarity'²⁰, and to develop bilateral and multilateral partnerships within the regional and global contexts. We must

acknowledge the need to provide a wider role for international institutions like the WHO and other UN bodies, WB, IMF, GFATM, GAVI, GAIN, etc. As a matter of fact, I see these institutions playing a leading role in much the same way that governments must be held accountable for health governance. We simply cannot sustain at the exclusion of other development partners. In this context, ‘it is a paradox of our time that effective governance requires control being simultaneously passed down to local communities and up to international institutions.’³³

CONCLUSION

We are all aware that health care systems across the globe are plagued by inequitable and unequal access to health services, the double burden of diseases imposed by communicable diseases and life-style-related conditions, and the emergence of newer public health problems, the stemming of changing socio-demographic profiles, the increasing globalization of trade and health care, and the negative consequences of environmental degradation and global warming. The first decade of the new millennium has brought with it a multitude of problems, be they economic, energy, food crises, and/or natural calamities of a magnitude and frequency never before seen. All these should serve as wake up calls that our way of living needs to change course. Our very presence here today bears testament to our resolve and commitment to address our ailing health care systems.

All these health care challenges demand reorientation of our health policies, redirection of resources, total coverage of the population with emphasis on the disadvantaged groups, teamwork, a carefully designed intersectoral approach, application of appropriate technology, and full community involvement. This clearly calls for working together in mutual partnership with bilateral and multilateral agencies including the private sector, health care providers and the people themselves. We must acknowledge that no single piece of health care reform will be a panacea for addressing the health problems of all, and we must develop strategies and policies based on local context.

With the global community increasingly acknowledging the merit of GNH as an alternative development paradigm, the Region too may like to consider the harmonization of health care reforms within the concept of GNH. GNH places a larger focus on what all beings value, that is, happiness. Happiness, according to Lyonchhen Jigme Y. Thinley, the Prime Minister of Bhutan, “is about joyful birth and parenting, meaningful and satisfying labour, aging with contentment amid security, and dying in dignified serenity.”³⁴

Mr. Chairmen, Excellencies, distinguished delegates, ladies and gentlemen:

Over the next three days I am confident that the strategies and recommendations that emerge from this conference will address some, if not all, of the challenges that I have highlighted herein.

I, on behalf of my Government and on myself, offer my unstinted support and commitment to look at ways and means to take the health care reforms that we are going to promulgate at this conference to their desired goals and objectives.

I recognize that the task before us is daunting. But we shall have to act. And act now!

May the Triple Gem Bless us all!

Tashi Delek! Thank you!

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