

## **Launch of the Bachelor in Public Health Programme at RIHS**

**April 13, 2010**

**Address by Honourable Minister of Health Lyonpo Zangley Dukpa**

Honourable Regional Director of WHO SEARO Region Dr. Samlee Plianbangchang, the Guest of Honour, Your Excellency Lyonpo Dorji Wangdi, Minister of Labour and Human Resource, Honourable Members of Parliament, Honourable Vice Chancellor of the Royal University of Bhutan, Honourable Former Minister of Health Dr. Jigme Singye, Dr. Prakin Suchaxaya, Regional Adviser (nursing), Dr. Phitaya Charupoonphol, Dean, Faculty of Public Health, Mahidol University, Dr. Oraphin Singhadej, Secretary General, WHO Collaborating Centre, Thailand, Dr. Hasbullah Thanbrany, President, SEAPHEIN, Centre of Health Economic, Indonesia, Dashos, Aums, Ladies and Gentlemen.

Coming from education background and being part of creating this historical event in the field of medical and health education in Bhutan, the land of Gross National Happiness, I am thrilled and overwhelmed to address this august gathering at the historic launch of Bachelor in Public Health at the RIHS. You will agree with me that this much needed health education programme will make a big difference in the delivery of health care service, especially in the area of the primary health care, which has been fully decentralized to districts and also Gewogs.

I vividly remember what Dr. Samlee Plianbangchang told me during one of our meetings that we do not want people to come to hospitals. If they do so, there is something wrong with our public health system. Two weeks ago, the UNFPA Country Director Dr. Nesim Tumkaya averred that health is usually associated with doctors, hospitals and medicines, the aspect of which constitutes only 30 to 40

% of health care. **In other words, health is perceived by people mainly in terms of clinical care where as 60 to 70 % of health is, in fact, non-clinical and preventive.**

The launch of this BPH programme will enable our health workers to equip themselves with enhanced knowledge in public health and epidemiology so that they would adequately address the preventive aspect of health care, which constitutes two thirds of the overall health care services. Obviously, this programme will have immense impact on the development and quality delivery of health care service in the country. This will also promote professionalism of our health workers under the policy of CME (continuing medical education). If addressed the preventive aspect of health professionally and profoundly, we will be able to work on the financial sustainability as well. Against this backdrop of benefits this course will accrue, I would like to thank WHO in general, Dr. Samlee in particular and other development partners for making this dream come true. This is truly a moment of joy for me as the Minister of Health.

I always say and I must say it again that Dr. Samlee Plianbangchang is more cognizant or knowledgeable about the Bhutanese health care system, particularly primary health care, than what I know as the Health Minister as because he was involved in the 1980s in the development of primary health care system in the country. This morning, we have another expert in the Bhutanese health care in the person of Lyonpo Jigme Singye, former minister of health and now working as a consultant in WHO SEARO. I feel humbled by their presence and I also feel reluctant to speak about the Bhutan's health care service. Notwithstanding this scenario, I will not do justice to my responsibility if I do not share some of my views with you this morning. I may be forgiven if I deviate from the norms of

formal speeches. I do it because of my genuine concerns and emotions taking advantage of the presence of dignitaries, health professionals and development partners..

1. We all know that Bhutan has come a long way in the health sector as is evident from **the statistics of health facilities and health workers**. Prior to the launch of the first five year plan, there were two hospitals ( one in Thimphu and the other in Samtse) and 11 dispensaries scattered across the country manned by one Bhutanese qualified doctor, 11 compounders and few nurses. We now have over 207 doctors (including 36 drungtshos), 665 nurses, 512 technicians including pharmacy technicians, 506 ACOs, HAs etc working in 30 hospitals, 178 BHUs and over 519 ORCs. I do not wish to bore you with the statistics of achievements. You can access our health bulletin for such information.
2. The statistics are useful. But what is more important for all of us to know is that under the visionary and dynamic leadership of our Kings, especially the fourth King, our Government has wisely and **persistently focused on the development of sound primary health care ever since the introduction of modern health care system**. In other words, our health care system is founded on primary health care. The signing of the Alma Ata Declaration of Primary Health on September 12, 1978 has provided further impetus to our commitment to primary health care. Now, WHO has been advocating for revitalization of primary health care across the world.
3. If we have done fairly well in primary health care, we must acknowledge the **contributions of our all health workers**, especially the HAs, BHWs and others, who were and still are the backbone of PHC. Our Prime Minister

would always talk about health centres which have statistics pertaining to number of households, age-wise population, coverage of safe drinking water scheme, ten top diseases and so on. These are impressive. **What our health workers lack is the knowledge and skills that will enable them to analyze, interpret and translate these data for further improvement of delivery of health care service.** Thus, as I said earlier, the BPH is intended to equip them with such skills and knowledge.

4. Over the last three or four decades, we have developed **a good structure and system of health care service** starting from ORC at the grass root level through BHUs, to regional referral hospitals and the national referral hospital. A unique feature of our system is **the integration of the indigenous medicines and the modern medicine.** These services are now available in all district hospitals and selected BHUs, offering choice to the people. I would like to acknowledge the initiative taken recently by WHO to integrate traditional medicines with allopathic and modern medicines. More and more people even in America are now opting for traditional treatment.
5. We all know that we **provide all levels of health care from primary to secondary to tertiary level free of cost.** The Article 9, section 21 of the Constitution of Bhanu endows every Bhanu with constitutional right, “The State shall provide free access to basic public health services in both modern and traditional medicines.” Given the escalation of costs every year, we are faced with the **question of sustainability of health care financing.** This is compounded by the ever increasing expectations of people for better and faster services and the demand by health workers for higher pay and perks. Personally, I have no problem with the expectations of people and the

demand of health workers. The challenge my colleagues and I encounter in the Ministry is how to work towards the fulfillment of expectations and demands and, at the same time make our people and health workers more responsible so as to achieve cost efficiency and effectiveness. What I am going to share with you now is some of the strategies and measures we are adopting in some cases and are planning to do so in other cases. Still in few cases, we are at the stage of contextualization and conceptualization processes.

6. As I already alluded to, most health care systems in the world focus on care for those already ill or injured. We believe if we work aggressively on the prevention aspect of health care service, the demand for curative or medical services will decrease and thus, less costs. Besides the on-going activities for public health such as sanitation and hygiene, clean drinking water, comprehensive immunization programmes and many such others, we are thinking hard **to introduce the health card system**, especially for those Bhutanese who dwell in cities and towns. We may make mandatory for our people to do annual medical check-up. Our health workers could give necessary advice such as on healthy lifestyles and early detection and treatment of diseases would decrease costs. We hope our development partners, especially WHO, will not miss this opportunity to come forward and help us in this noble venture.
7. We are aware that our hospitals, like hospitals in other Asian countries, are facing three major challenges of catering to more patients, expectations of higher quality care and pressure to be more efficient. I have visited almost all hospitals. Notwithstanding the industry and integrity of our hospital staff,

the urgency of the need to improve the hospital management systems to face the challenges cannot be underestimated. This is why we are working on the **transformation of hospital operation** beginning from JDWNRH on pilot basis. This is aimed at providing better and faster service keeping in mind that the patient satisfaction is the overarching goal. It also aims to achieve cost effectiveness through efficient management of resources both men and materials. Hospitals in districts provide both prevention and curative aspects of health services. We hope to work with our development partners in this important area of improving the hospital management system to achieve health related MDGs. We will be introducing **“Off-hour Clinic” at JDWNRH along the line of practice in Thailand on pilot basis for one year in the afternoon from 4.00 pm to 7.00 pm.** This is to provide choice to people and decongest the crowd in the morning so that faster and quality service could be provided to the general public during the normal hours in the morning.

8. We are working on the prioritization and rationalization of human resource development as well as deployment, which will be reflected in the revised master plan. There has always been a gap between the supply and the demand in health care service even in developed countries. This is complicated by **the longer time it takes to train doctors and nurses.** For example, it takes six to seven years to complete the course for an MBBS student and another six to seven years to do his masters. Two of our doctors pursuing Master courses in Bangladesh are breaking records by taking more than seven years to complete their course. 13 years of schooling and fourteen years of professional studies at the Government exchequer's cost is something we need to be wary about. This is incredibly costly and

something is wrong with the system too. An average cost of an MBBS student works to be over 3.00 million and another 3.00 million for his Masters programme (four years master programme) if the course is completed in time. This is one of reasons why this government has accelerated the setting up of our own medical college. RISH will form part of the Bhutan Institute of Medical Sciences.

9. We hope to launch in June this year the **Health Help Centre**, taking advantage of Information Technology. This Centre, a kind of call centre run for 24X7, will have algorithm based intelligence software and provide three broad services namely, general health care or medical triage, emergency medical service and public health through the toll free number. This will be a revolutionary reform in the health care service. Through this centre, people even in rural areas will have access to health professionals within one hour. With the support from our development partners, we exude confidence in this adventurous journey of health care.
10. We are also working on **outsourcing non-clinical services** in a phased and cautious manner. We have already outsourced some of the services in JDWNRH. The problem is the lack of capacity and capability of private sector to take such tasks and responsibilities more efficiently.
11. As regards the health care financing, let me repeat some of the issues I highlighted in my address to the participants of workshop on health care financing in Paro on 25<sup>th</sup> January 2010. It was attended by experts on health economics from the World Bank, WHO, Mckenzy and Company and other countries such as South Korea and Thailand. **There are broadly three patterns or models of health care financing across the world.** The

National Health Service (NHS) in UK is a good example of state-run or publicly funded system. As in the case of Scandinavian countries, the UK uses tax finances to pay for 80% of its health care spending. In Germany and some European countries, social insurance schemes bear most of the financial burden. The US relies on private insurance, paid mostly by employers. Each of these systems has its own merits and demerits. A few days ago, a consultant of Mckenzy, who is a Swiss national, remarked that a Swiss citizen pays 80% of his health cost and demands quicker services. This is built in the genes of the Swiss people, he said. In UK, like Bhutan, people do not pay and they do not mind waiting for three to four months for any surgery. I told him that the dependency on the government is built in the genes of the Bhutanese people. Health care financing is a complex issue as is evident from the debates in America on healthcare reforms initiated by the President Obama. But, we cannot shy away and shun the problem facing the country in terms of increasing expenditure on health care service. In 2009, the cost of drugs and medical equipments and devices alone was around 300 million and the cost of referral of patients outside the country for one year was over 120 million. These are few examples I am giving. Some consultants project that the health care cost will increase by 60 to 70% in the next few years. This is why we are doing the feasibility study on the issue of sustenance of health care financing while we are already working on the measures to reduce costs through efficient management of resources.

12. The reason why I have highlighted some of the reforms we are implementing and plan to implement is to keep our development partners informed so that they will not, as I said, miss the wonderful opportunity to be part of the reforms.

13. In conclusion, I take this opportunity to thank again our development partners, WHO, UNFPA, UNICEF, UNDP and others for their support to the launch of BPH. **We have collectively conceived and given birth to the baby called BPH. It is our collective responsibility to nurture and nurse this baby till it becomes the centre of excellence in public health in the region and beyond.** Abandoning a baby is against the Buddhist and GNH philosophy. For example, we are gravely concerned about a dead baby body recently found in the Thimphu River abandoned by its mother. We are investigating into such incidences and working on how we could address this social problem. Under any circumstances, BPH should not be in a similar situation. I know, it will not happen as it has numerous foster mothers.
14. Lastly, let me share a few words with BPH students. Some of you are as old as me or as young as me. You are fortunate to be the first batch of BPH students. You have greater responsibility as well. You will set the trend and standard in every respect and sphere of the life of BPH. You are lucky because we have a wonderful government or country that provides you with such opportunities. You know and I know that in other countries, you have to pay for pursuing such further studies. Here, in the land of GNH, you are not only given free but you are paid stipend in addition to your salaries. This is truly the land of happiness. But, you are not here on holidays. I will personally keep in touch with your progress. I know you can do it. You want to fulfill your dream, your family dream and the dream of government. On the successful completion of your course, you will help us in achieving some of the aspirations I have highlighted above. With this I wish you all Tashi Delek.