Self-financing medical education in Nepal

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Developing countries face problems with special ethical implications. This paper will discuss one such problem, that of health care allocation.

The improvement in a society's health is attributed in part to modern medicine. However, such medicine tends to be expensive. All over the world, the availability of modern health services depends on the amount allocated for them out of a country's disposable income. The proportion of a country's gross national product allocated for health care has a bearing on the population's longevity and other indicators of its health.

One significant determinant of the availability and use of medical technology is money. Public investment in the sectors of education and health is becoming scarce as government policies divert funds to other areas seen as priorities (for example, expensive weapons in the name of defence activities). Moreover, inefficient tax collection procedures result in developing countries collecting less income tax from individuals and business. As a result of all these factors, health and education in these countries are given low priority, leading to poor health and high illiteracy in the community.

Costs of training

An essential aspect of establishing modern medicine in poor countries is training which enables the transfer of medical technology to the community. However, the cost of training in modern medicine is prohibitive, benefiting only a selected few from privileged and wealthier sections of society. Training these people has limited value because many of them look for entry into a wealthy country, and leave the country where they were trained at considerable cost. This is one reason why it is critical to extend medical education beyond the wealthy to reach poorer sections of society, whose people who are more likely to serve their own communities.

Limited public resources have prevented the subsidised training of people from less-advantaged groups in poor countries. Yet this is exactly where the training is most urgent. A compromise measure is to permit private investment in sectors like health and education.

However, private investors are interested only in the returns on their investments. There is also the problem of maintaining high standards of medical education and the associated health care facilities, in private institutions.

One country which is trying to solve this problem - training more medical personnel who will serve domestic needs - is Nepal, with a per capita health care allocation below $3, and one doctor for every 23,899 people.

The first medical institution in Nepal was set up by His Majesty's Government with aid from the Japanese government. A second autonomous medical school was established with the help of Indian government aid. Both medical colleges are staffed by Indian doctors at present. It is expected that trained Nepali doctors will gradually replace the Indian faculty.

Self-financing medical colleges

In order to speed up the process, and to tackle the future financial burden of running these institutions, His Majesty's Government took a decision to permit self-financing medical institutions. These medical colleges will receive no government aid. They are to build their own infrastructure, which includes a large, self-sufficient hospital, equipped with modern technology. Various government committees will monitor and enforce internationally developed standards for the facilities and education - space, faculty, syllabus and so on - offered by these medical colleges.

Government control

While the committees will not regulate the fee structure of these self-financing medical colleges, the government will control the selection of 20 per cent of the student body. These students, chosen on the basis of merit, will receive free medical education.

These self-financing medical colleges are required to have a well-equipped and staffed 700-bedded hospital attached. It is expected that these hospitals will benefit some 2,000 people at any given time, providing medical treatment, preventive health counseling, and jobs for the local population. Moreover, 30 per cent of the beds will be available free to local people who cannot afford to pay, and an additional 10 per cent of the beds will be provided at a concession to deserving patients. The set-up will benefit from other allied, self-financing educational institutions such as for dentistry, nursing and medical technology.

At present, there are six such colleges in Nepal, providing education which meets the high standards set and enforced by local regulatory bodies. They are also a source of income for the societies which run them.

The basic ethical issues here are: how does one make a profit without exploiting another? Further, will this education benefit only the socially and economically elite? The answer is that privately-financed medical colleges in Nepal make a profit while also making education available to resource-poor sections of society. Society as a whole benefits from the production of educated doctors.

How is this privately-financed system different from one which opens the doors to multinational investment? The basic difference is that here, key decisions are made by independent

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committees, with the involvement of academic bodies, professional and local organisations connected with health and education. The primary targetted benefit is not of an immediate nature. The immediate economic benefit is only an offshoot of the main development goal of improving health care.

Distributive justice

In the absence of resources to provide quality modern medical education, self-financing private entrepreneurial medical colleges in developing countries do not compromise on the principle of distributive justice. This type of establishment can enable a country with limited resources to do justice to its citizens, giving a modern medical education without spending valuable taxpayers' resources. This may be better than the traditional aid programme, since donors often dictate terms to recipients. In this aid programme, the recipient dictates terms, and receives aid in exchange for the entrepreneur's personal benefit. The success of such a programme depends on the strict enforcement of regulations.

The basic difference from a traditional aid programme is that here, the donor is a private agency and gets profits directly. However, the recipient is able to dictate the conditions of his/her benefit, thus avoiding exploitation.

In traditional aid programmes, the receiver is always controlled by donors' conditions. While most of these conditions may be ethical, they sometimes intrude into one's autonomy. This intrusion could be because of a lack of understanding of the culture or because the donor wants to foster dependence from the recipient. On the other hand, the recipient may be forced to accept this dependent status in order to obtain aid for development. Such serious ethical constraints will not occur in the case of self-financing education.

One objection that may be raised to self-financing education is that benefits or profits are given to individual entrepreneurs. In traditional aid programmes, too, profits are channeled, though indirectly, to entrepreneurs through a public agency, either government or non-governmental. The direct receipt of benefits in entrepreneurial aid programmes is more transparent. This transparency enables the recipient to see the aid not as charity but as an indirect economic stimulant to business enterprise in the host country. Furthermore, in the case of medical education, the long-term benefits go to local students, who could not otherwise have afforded medical education. These students are most likely to stay and serve the community. Further, the 30 per cent requirement of beds for the local poor will provide modern medical services free to the community.

Finally, how is this system to avoid the problem common in all developing countries, of corruption in the monitoring procedure? It is expected that the fact that many agencies are involved in the monitoring procedure, and can check one another, will increase public accountability. Reports of monitoring should be made available for public auditing. Most important, the monitoring committees must receive proper education on the monitoring procedure including the consequences of contravening it. As medical education directly affects the future health status of a nation, this monitoring should be considered a moral responsibility of the highest order by committee members.

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Report

Workshop on rational use of drugs

Institute of Health and Family Welfare, Calcutta,
April 9, 10, 1999

Irrationality of various kinds in the use of drugs has almost become the rule in India. In this context, a recent workshop on the subject was of particular value. The department of health and family welfare, West Bengal, discussed various aspects of the subject in a two-day workshop organised by the School for Tropical Medicine in collaboration with the Foundation for Health Action. The meeting was funded by WHO/India Essential Drugs Programme.

The workshop, held at the Institute for Health and Welfare, Salt Lake, Calcutta, on April 9 and 10, 1999, was attended by teachers of different medical colleges and specialist medical officers and administrators of several hospitals of the sate. The workshop took the following issues up for discussion with regard to government hospitals: a review of the use of drugs; identifying the factors responsible for irrational use of drugs; the role of a limited drug list; and the role of unbiased drug information in RUD in government hospitals including the state's medical colleges. An action plan was drawn up at the end of the workshop. Readers may write to the Bulletin on Drug and Health Information (254 Lake Town, Calcutta 700 089) for copies of the proceedings.

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