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18 May 1979
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1979 年 5 月 18 日

THIRTY-SECOND WORLD HEALTH ASSEMBLY
TRENTE-DEUXIEME ASSEMBLEE MONDIALE DE LA SANTE
ТРИДЦАТЬ ВТОРАЯ СЕССИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
32ª ASAMBLEA MUNDIAL DE LA SALUD
جمعية الصحة العالمية الثانية والثلاثون
第三十二届世界卫生大会

PROVISIONAL VERBATIM RECORD OF THE
ELEVENTH PLENARY MEETING
18 May 1979, at 14h30
Palais des Nations, Geneva

President: Professor P. TUCHINDA (Thailand)

COMPTE RENDU IN EXTENSO PROVISOIRE
DE LA ONZIEME SEANCE PLENIERE
18 mai 1979, à 14h.30
Palais des Nations, Genève

Président: Professeur P. TUCHINDA (Thaïlande)

ПРЕДВАРИТЕЛЬНАЯ СТЕНОГРАММА
ОДИННАДЦАТОГО ПЛЕНАРНОГО ЗАСЕДАНИЯ
18 мая 1979 г., 14 ч. 30 м.
Дворец Наций, Женева

Председатель: Профессор П.ТУЧИНДА (Таиланд)

ACTA TAQUIGRAFICA PROVISIONAL
DE LA UNDECIMA SESION PLENARIA
18 de mayo de 1979, a las 14,30 horas
Palais des Nations, Ginebra

Presidente: Profesor P. TUCHINDA (Tailandia)

محضر حرفي مؤقت
للجلسة العامة الحادية عشرة
١٨ مايو/أيار ١٩٧٩ ، الساعة ١٤٫٣٠
قصر الأمم ، جنيف

الرئيس : الأستاذ ب . توشينـــدا (تايـــلانـــد)

第十一次全体会议

发言全文临时记录

1979年5月18日下午2时30分

日内瓦·万国宫

主席：P·塔钦达教授(泰国)

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CONTENTS

SOMMAIRE

СОДЕРЖАНИЕ

INDICE

المحتويات

目　　录

1. SECOND REPORT OF COMMITTEE B
DEUXIEME RAPPORT DE LA COMMISSION B
ВТОРОЙ ДОКЛАД КОМИТЕТА B
SEGUNDO INFORME DE LA COMISION B
التقرير الثاني للجنة "ب"
乙委员会第2份报告

The PRESIDENT:

The Assembly is called to order. We shall consider the second report of Committee B, as contained in document A32/43. Please disregard the word "draft" which appears on this document, since the report was adopted by the Committee this morning, with an amendment which I shall read out to you now. The amendment concerns the decision appearing under item 3.9, on the first page of document A32/43, which should read as follows: "Committee B decided to recommend to the Health Assembly that it note the progress made by the Working Group of the Executive Board on the organizational study on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO" (interim report), and decided that the final report be submitted to the Thirty-third World Health Assembly. In other words, the words "the scope of the study be enlarged" have been deleted by the Committee. In accordance with Rule 53 of the Rules of Procedure, this report shall not be read aloud. Seven resolutions are contained in the report, which I shall invite the Assembly to adopt one by one.

Is the Assembly willing to adopt the first resolution entitled "Use of the Portuguese language at the Regional Office for Africa"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the second resolution entitled "Assessment of Djibouti"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the third resolution entitled "Assessment of Viet Nam"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the fourth resolution entitled "Scale of assessment for the financial period 1980-1981"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the fifth resolution entitled "Appointment of the External Auditor"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the sixth resolution entitled "Review of the Working Capital Fund"? In the absence of any objection, the resolution is adopted.

Is the Assembly willing to adopt the seventh resolution entitled "Collaboration with the United Nations system: General matters"? In the absence of any objection, the resolution is adopted.

Concerning agenda item 3.9, "Organizational study by the Executive Board on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO" (interim report), Committee B recommends to the Health Assembly that it note the progress made by the Working Group of the Executive Board on this organizational study, and decide that the report be submitted to the Thirty-third World Health Assembly. In the absence of any objection, this recommendation is accepted and we have thereby approved the second report of Committee B.

2. REPORT BY THE GENERAL CHAIRMAN OF THE TECHNICAL DISCUSSIONS
RAPPORT DU PRESIDENT GENERAL DES DISCUSSIONS TECHNIQUES
ДОКЛАД ГЕНЕРАЛЬНОГО ПРЕДСЕДАТЕЛЯ ТЕМАТИЧЕСКИХ ДИСКУССИЙ
INFORME DEL PRESIDENTE GENERAL DE LAS DISCUSIONES TECNICAS
تقرير الرئيس العام للمناقشات الفنية
技术讨论会总主席作报告

The PRESIDENT:

We shall now hear the report of the General Chairman of the Technical Discussions. We have had as our General Chairman of the Technical Discussions this year Dr Ivo Margan,

Vice-President of the Federal Executive Council, Yugoslavia, and we owe him much for the clear, decisive and capable manner in which he has led the debate, and for the substantial personal part he has played. I now have pleasure in calling on Dr Margan to present his report.

Dr MARGAN (General Chairman of the Technical Discussions):

Mr President, ladies and gentlemen, I have now the privilege of introducing the report of the Technical Discussions on "Technical cooperation among developing countries in the field of health" that is contained in document A32/Technical Discussions/5. The Discussions, which took place on 11 and 12 May this year, attracted a record number of 348 participants, which speaks by itself of the exceptional importance which countries attach to this subject. From the outset it was considered that these Discussions should be oriented towards practical, operational conclusions and recommendations which seem necessary for the purposeful thrust forward to translating the principles and objectives of technical cooperation among developing countries (TCDC) into effective action. The background document to my introductory address and the guidelines for discussions provided by the six group secretaries were conceived and prepared to that effect. Possible subjects of cooperation, mechanisms and procedures and information systems were outlined as the main operational components requiring conclusions and recommendations from the participants. The report is a brief record of the ideas expressed, approaches sought and suggestions made in that respect. Possible shortcomings in its presentation as well as omissions in its content are primarily due to the wealth of such ideas and suggestions, which ranged from original specifics to inherent repetitive generalities.

The general feeling of the participants was that if TCDC was rationally organized and managed in an effective manner it could become an extremely important tool in solving the burning health problems of the developing countries and in raising health standards the world over. Another common denominator which could be deduced from the Discussions was that, notwithstanding all the opportunities offered by this new concept of international health cooperation, TCDC should not be considered as a panacea for coping with all the health problems of individual countries, nor should it become a catch-phrase for the manifold constitutional responsibilities and tasks of WHO, as was explicitly stressed in the Discussions. The third general point made was that the developed countries had a major role to play in promoting and supporting TCDC activities. This role should consist, inter alia, in the transfer of technology, information exchange, strengthening of national health and teaching institutions through training, finance and other support, as well as in solving the problem of "brain drain".

Regarding the subjects which under the circumstances might best lend themselves to cooperative activities, the report lists the following: bulk purchasing of essential drugs, drug production, quality control, drug research and distribution; training of all categories of health personnel with emphasis on cooperation in teacher training, support of national training facilities, and strengthening of specialized training institutions which would contribute in the long run to reducing the brain drain; and cooperation in research, control and surveillance of communicable diseases.

The problem of mechanisms and procedures for carrying out TCDC at national, intercountry and global levels was approached primarily from the aspect of the obstacles and constraints, which were seen as financial, legislative, institutional, political, ideological, cultural, and linguistic, as well as administrative. An adequate information system was considered as forming the basis of TCDC. It was specifically recommended that a national information system with a built-in mechanism for information exchange with other developing countries, assisted by WHO and UNDP, was essential for the development of TCDC. In this context WHO should undertake a review to determine the need and the way to use existing information services and endeavour to provide information on individual countries' potential in health manpower training and research.

The problem of the brain drain from developing countries was also a major concern for all the discussion groups. The report stated that this problem was exacerbated in the developing countries by the unavailability of a suitable working place to apply skills and knowledge. Strong emphasis was laid on the need for forthright regulations in developed countries to prevent the brain drain by whatever means could be mustered.

Referring to the conclusions and recommendations, which are listed, as is traditional, at the end of the report, the following remarks would seem necessary. These recommendations in no way exhaust the structural and operational measures necessary to launch cooperation on

a quantitatively and qualitatively new basis. Secondly, the initiatives incumbent on the countries on the one hand, and on WHO on the other, are not delineated. The analysis and study made in the course of the preparation of these Technical Discussions left no doubt that administrative and operational limitations in the developing countries have been playing a major role in slowing down TCDC. To remove these limitations, substantial technical and organizational advice and practical help are required.

Against such a background it is clear that the initiative for initial action lies primarily with WHO. Related to the operational conditions prevailing in the developing countries is a specific recommendation to establish in each country a focal point to facilitate and coordinate TCDC activities and to act as the central point of TCDC in general. A recommendation that WHO should initiate and assist in organizing group meetings of interested countries to consider cooperative projects and joint ventures in the field of production, procurement and distribution of essential drugs, medical and laboratory equipment, also deserves special mention, as it is an example of an activity which could be immediately pursued.

I am deeply convinced that the concept of TCDC has been built on a sound basis. My conviction is based on the cooperation achieved so far among developing countries, the experience acquired, the high degree of awareness of the potential of TCDC, and the positive political attitude towards this concept. It is for these reasons that TCDC offers tremendous possibilities for further development, provided that cooperation is carried out through specific activities among respective groups of countries in all fields of common interest. A number of such fields and possible subjects for cooperation were mentioned in the course of our Technical Discussions. The successful tackling of many health problems in developing countries would in fact be possible if TCDC were approached as a method and instrument for pooling resources and knowledge for that purpose. Such an approach obviously will also permit the tapping of considerable resources for financing TCDC schemes. I therefore feel it is a commitment and a necessity for all of us immediately to take adequate cooperation measures to solve well known and clearly identified health problems and to develop appropriate mechanisms which would make the participation of all partners concerned possible.

An inherent component of such mechanisms is the establishment and development of TCDC centres or focal points at country, intercountry and global levels. The way in which these centres or focal points will be organized and function at country level should be left to be determined by the respective governments, it being understood that WHO should offer all possible assistance. As to the intercountry level, the establishment of such centres or focal points is a matter of urgency since they are inter alia indispensable for the collection, processing and distribution of information, which in turn are preconditions for operating TCDC.

Since TCDC already offers unlimited possibilities for immediate practical action, it would seem unwarranted to make such action subject to further studies, analogies and other theoretical exercises. The same applies to possible temptations to make such activities subject to the prior establishment of a sophisticated administrative structure. There are many simple and immediately applicable forms of operation in the fields which have been so consistently mentioned in the course of our Discussions. There are wide possibilities for cooperative projects and joint ventures in the production, procurement and distribution of essential drugs, medical and laboratory equipment as well as water supply and sanitation equipment. Such possibilities also exist as regards the development of health infrastructure, including the construction of health centres, laboratories and hospitals best adapted to the health status of populations and to the level of socioeconomic development of individual countries. In this connexion, I would like to mention in particular the building and expansion of board and lodging facilities situated close to teaching institutions, which would permit an increasing exchange of teachers and students. This kind of exchange is a well known form of cooperation which has already proved its usefulness.

Considering the health problems of developing countries with ravaging mass diseases, practically forgotten or unknown in the industrialized world, there is no hope for any solution of scientific breakthrough without the full cooperation of the countries concerned. It goes without saying that particularly in the field of tropical disease research, cooperation among developing countries must be intensively developed.

While there is a common consensus that WHO has to play a qualitatively and quantitatively new role in the world TCDC movement, I would not want to end this statement without reiterating my belief that WHO will stand up to this task. Undoubtedly there remain a number of

organizational problems and some questions of interpretation which the Organization will have to solve. In this connexion, may I say that at this juncture it is essential clearly to differentiate between what WHO should do under its technical cooperation programme budget policy and what are the responsibilities of the countries themselves under TCDC. In differentiating between these two concepts, the fact that they are closely linked should be constantly kept in mind. Thus, I would like to reiterate once again my basic belief about TCDC. This new dimension of international solidarity will make its full contribution to world health if the noble rhetoric of its objectives and principles is translated into deeds, even if those deed are initially limited in number and modest in scope.

To conclude, may I express my appreciation to all those who have contributed to the preparation and conduct of these Technical Discussions. To you, Mr President, ladies and gentlemen, I address my sincere thanks for the patience and attention you have shown in listening to me.

The PRESIDENT:

I am confident that I am expressing the feelings of each member of this Assembly, Dr Margan, in thanking you most sincerely for the outstanding way in which you have directed the Technical Discussions as General Chairman. In your opening address, stressing the importance of technical cooperation among developing countries in the context of health, you inspired the group with enthusiasm for the ensuing Discussions, and I hope that the conclusions of these debates, which you have just now summarized admirably, will not only be taken into consideration by the health authorities in each country, but will also give WHO the necessary impetus to play a key role in the development of technical cooperation in the field of health among developing countries.

The Technical Discussions which have been held under the auspices of the Thirty-second World Health Assembly do not form an integral part of its work. However, in view of their interest to Member States, I am sure the Director-General will study the possibility of placing the result of these Technical Discussions at the disposal of governments.

I suggest that, as in previous Assemblies, we take note of the report, and I would like again to thank all those who have contributed to the success of the Discussions, particularly the group chairmen and rapporteurs. Does this suggestion meet with your approval? In the absence of any objection I declare that the Assembly has taken note of the report. Once again, many thanks to you, Dr Margan, for your invaluable contribution to the success of the Technical Discussions.

3. AWARD OF THE JACQUES PARISOT FOUNDATION MEDAL
ATTRIBUTION DE LA MEDAILLE DE LA FONDATION JACQUES PARISOT
НАГРАЖДЕНИЕ МЕДАЛЬЮ ФОНДА ЖАКА ПАРИЗО
ADJUDICACION DE LA MEDALLA DE LA FUNDACION JACQUES PARISOT
منح ميدالية مؤسسة جاك باريزو
雅克·帕里索基金奖章的授予

The PRESIDENT:

We now move on to item 1.1.6 - Award of the Jacques Parisot Foundation Medal. I have pleasure in welcoming Dr Manuel Flores Bonifacio, to whom the Jacques Parisot Foundation Medal has been awarded. I invite Dr Bonifacio to come to the rostrum.

Dr Bonifacio took his place on the rostrum.
Le Dr Bonifacio prend place à la tribune.
Д-р Бонифацио занимает место на трибуне.
El Dr Bonifacio ocupa su puesto en el estrado.
أخذ الدكتور بونيفاشيو مكانه على المنصة

Bonifacio 博士到主席台就位

The PRESIDENT:

The Health Assembly will recall that the rules of the Jacques Parisot Foundation were revised in 1976, and it was decided that the Jacques Parisot annual lecture be replaced by a research fellowship in social medicine or public health. These fields were of particular interest to Dr Jacques Parisot, in whose memory the Foundation was created. As many of you

will recall, Dr Parisot presided over the Ninth World Health Assembly held in 1956.

The Jacques Parisot Fellowship this year has produced a study in a field of crucial interest to public health: the professional attitudes and opinions of physicians engaged in health care delivery.

The author, Dr Manuel Flores Bonifacio, is a sociologist, and has tried in this study to look at the medical profession in his country from a social science perspective. Drawing his sample of doctors from the urban as well as the rural sector, he has tried to determine and evaluate what practising doctors themselves have to say on the question of their training and education, their perception of the health resources and health problems of the Philippines, and the problem of continuing education, especially for doctors in remote rural areas.

I shall not go into further detail about the study, since Dr Bonifacio will shortly present a summary for our benefit. I can only add that with his wide background in several aspects of sociology, Dr Bonifacio is eminently qualified to undertake a study of this kind. He is at present Professor in the Department of Sociology in the College of Arts and Sciences, and Dean, Institute of Social Work and Community Development, both in Quezon City, Philippines.

I have great pleasure in awarding the Jacques Parisot Medal to Dr Bonifaco.

Amid applause, the President handed the Jacques Parisot Medal to Dr Bonifacio.
Le Président remet la Médaille de la Fondation Jacques Parisot au Dr Bonifacio. (Applaudissements)

Председатель вручает медаль Фонда Жака Паризо д-ру Бонифацио (Аплодисменты).

El Presidente hace entrega al Dr Bonifacio de la Medalla de la Fundación Jacques Parisot (Aplausos)

وبين التصفيق سلّم الرئيس ميدالية جاك باريزو الى الدكتور بونيفاشيو

在鼓掌声中，大会主席向 Bonifacio 博士赠授雅克·帕里索奖章。（鼓掌）

Dr BONIFACIO:

Mr President, Vice-Presidents, Members, Regional Directors, Members of the Committee of the Jacques Parisot Foundation Award, it is with a deep sense of pride and honour that I accept the award on behalf of my country, the Philippines.

The study, as was mentioned to you already, is concerned with a comparison of urban and rural doctors in the Philippines, from a sociopsychological point of view. The following are the objectives of the study - and in fact I consider it an opportunity and an honour for somebody who is not a physician to delve into the problems of the medical profession, especially in a country like the Philippines.

The first objective of this study is to find out the attitudes of selected physicians towards medical training.

The demand for health services in the countryside in the Third World, and in the Philippines in particular, is now so acute that new approaches to health services and training are being undertaken in order to meet the enormous health service demands of the people. It is indeed a known fact that medical education takes a total of nine years to complete. This, of course, assumes that the student passes the medical board examination once he takes it. However, if initially he fails, he has to take it again, and this means he has to wait before he finally becomes a medical practitioner. In other words, his usefulness to those who will need his professional services will have to wait. This is the tragic aspect of medical education - while we can prolong the training of a person until he has fully mastered the rudiments of his profession, the sick person simply cannot wait. As we know, there are illnesses that will not only lead to the death of the person but, in some cases, will affect other members of the family and the community as well. In view of this, there is a need to look into medical training as perceived by those who have gone through the medical school and are actually in practice. To us, trained medical practitioners are not only concenred with rehabilitative or restorative strategies, they are equally concerned with preventive approaches to health. In fact, since the medical profession is involved in many developmental activities, a development orientation is added to their concept of health services.

In order to confront this long and tedious medical education, the College of Medicine of the University of the Philippines, through the Institute of Health Sciences, has introduced a unique and innovative approach to medical education with the use of a "ladder approach".

This means that a student is exposed to a series of skills and for every set of skills he completes, he is awarded a corresponding diploma until he becomes a fully fledged physician. While this is a welcome approach to medical education, we are sure that there are other approaches that can be developed.

Given this situation in the Philippines today, it is very important to find out how those who passed through the long process of medical education, and who actually have to face the realities of inadequate health services to meet the health needs of the people, feel about medical training. For instance, we are going to find out whether they feel that the same long training in medicine should be continued and, if they do not agree to this, what is their alternative. How should prospective medical practitioners be trained in order to meet the health manpower needs of the country? What forms/types of training should be evolved? What can the Department of Health do? What can the Philippine Medical Association do?

A careful documentation of the physicians' attitudes toward medical training is now an imperative, since they will have policy implications for the existing government policy regarding medical education. To us, medical training needs to be reviewed not only because it is very long but also because it is expensive and in view of this, only children from the well-to-do families can really take up medicine. It should be pointed out that since they come from well-to-do families, our prospective physicians also come from the urban areas, and this is one of the major reasons why most medical graduates would like to serve the urban rather than the rural community. Of course, we know that it is also more lucrative to stay in the urban area.

Since most if not all medical students are urban-based, it will be very difficult to field them in the rural areas in spite of their commitment. It can be assumed that they are aware of the problems of the countryside, but because of their urban upbringing, it will be difficult for them to identify with the rural people, especially because most of the rural people are not capable of paying for their services in cash. Therefore, most of those who will help the people in the countryside must come from the rural areas, because they can readily identify with the people and they have a full grasp of their feelings and problems. This is our thinking regarding medical training. Do medical practitioners feel the same way? What are their feelings about the whole medical education? In short, therefore, whatever approaches we utilize in revising medical education, to meet the growing demands in the countryside require a careful assessment of the attitudes of those in the field of practice.

The second objective of the study is to find out the physicians' perception of health service. Considering the inadequacies of health services to meet the demands of the people, it is important to examine the perception of those who are actually involved in medical practice. The comparison between urban and rural practitioners is crucial in determining the extent of doctors' knowledge regarding the adequacy or inadequacy of health services. In addition to this is an attempt to capture their own solutions to meet the demand for health services. In fact, they will be able to tell us what they consider to be the major health problems as far as their experiences in practice are concerned. They will be able to point out what types of services are badly needed by the people and how such services can be organized for more effective delivery to those who need them. Also we shall try to find out from them how the people in the community can be utilized in extending health services. In other words, our study will attempt to find out how doctors feel about health resources, what new resources could be developed, and how the people in the grassroots can be involved in health care delivery system.

The third objective of the study is to find out the processes of professionalization and communication among physicians. It is our hypothesis that there is a wide gap between urban and rural doctors. We know for a fact that urban doctors have many opportunities to grow professionally. For one thing, most medical schools are located in the urban areas, and this being the case, they can be easily exposed to new trends in health care systems. In fact, they have greater access to new medical information coming from many other sources. They also have greater access to continuing education in health, and more contact with other physicians who have advanced training in various aspects of health.

In contrast, we feel that the rural physician is isolated from other physicians, and new trends in health care, and has less opportunity to attend continuing medical education. If this is substantiated by our data from the field, we will be able to establish that such conditions of isolation would explain the lack of attraction to rural medical practice. In fact, this would show why we cannot attract most physicians from the urban areas to serve in the rural areas.

On the basis of the above, we can derive at least one policy implication. Ways will have to be found in order to reduce the gap between urban and rural medical practice. It is clear that it will be difficult to bring urban doctors to the rural areas. The solution is not to bring the patients to the urban areas but to improve the rural medical capabilities by continuing medical education, organizing health teams, and providing them with more access to current medical information through an improved communication system among those directly and indirectly included in the health care delivery system.

The study was conducted on the basis of these objectives, and some of its major conclusions are the following.

1. The doctors in our sample belonged to families where there were members who also belonged to the health profession. Although there were no sex preference in terms of children pursuing a medical career, there is still evidence of an expressed preference for the male. The majority of the doctors, mostly rural doctors, are graduates of private schools. One out of every three rural doctors would go to another field if they had to go back to college. Most urban doctors have higher mobility than rural doctors in terms of local and foreign travel. While the majority would not want to change their location of practice, there were some in rural areas who would like to practise in urban areas, and urban doctors who would like to practise in rural areas.

2. There is a strong feeling among our sample that medical education should be reduced to seven years. In fact, rural doctors would like to divide medical education into two parts: Bachelor of Medicine (4 years) and Doctor of Medicine (4 years). What both groups like about the practice of medicine are their happiness and contentment in seeing patients improve, and the gratitude and generosity of patients. Rural doctors also like service and interaction with people, while the urban doctors mentioned income and authority. Both groups dislike the great responsibility of dealing with patients. Rural doctors dislike low income, and ungrateful and rude patients and relatives. This is also true for urban doctors in the reverse order.

3. There exist some negative feelings towards the underboard training, although on the whole the doctors have a favourable image of medical education in terms of meeting the current health needs of the country. There were some who found medical education inadequate because of the emphasis on cure, Western orientation, lack of faculty preparation, and because the facilities found in school are not found in the rural areas. More rural doctors consider medical education to be disease - and specialization-oriented. Urban doctors in a related manner mentioned that it is technique-oriented rather than people-oriented. Rural doctors feel that there is no need for advance training abroad and that medical education alienates doctors from the poor since the faculty are not familiar with the general health problems of the country. This is further supported by the urban doctors, who said that medical education is urban-oriented.

4. With reference to what should be expanded and included in the medical curriculum, the following were identified: public health, community medicine, preventive medicine, occupational medicine, medical economics, medical sociology, and related behavioural sciences, minor surgical procedures. In fact, the doctors feel they need additional training in these areas.

5. The changes that they want to see are the following: adaptation of the medical curriculum suited to the health needs of the country, improvement of facilities and teaching methods, and finally, designing of short medical courses. In general, both rural and urban doctors have a negative perception of the patient in terms of his unfamiliarity with the nature and sources of his illness and his lack of cooperation with the doctor in the process of treatment, which are all results of poverty and lack of health consciousness on the patient's part.

6. As far as our sample is concerned, the following are the major health problems in the country: malnutrition, improper nutrition, food production, communicable diseases, environmental sanitation, pollution, lack of health consciousness, facility imbalance, overpopulation, and congestion. In addition to these, they also mentioned that the present health care delivery system is inadequate due to lack of competent and motivated personnel, low salary, incentives, and support facilities.

7. They feel that the country badly needs an extensive primary health care system, that people's participation is needed to augment inadequate health manpower, and that an incentive system should be devised to attract more doctors to practise in the rural areas. There is also the feeling that the present health care delivery system is inapplicable to the Philippines because of inadequate resources at the same time that it is poorly organized and managed. Finally, they feel that there is a need to develop an interdisciplinary approach to health care.

8. Some major solutions to the problems they identified are: development of health consciousness, organization of health services, a health education campaign, improvement of facilities, systematic distribution of health manpower and, finally, collaboration and coordination of health services, organized planning and the greater use of incentives.
9. More urban doctors feel that the responsibility of primary health care services should be given to the Ministry of Health. They also feel that there is a need for paramedical staff to augment health manpower resources, and a need to develop herbal medicine. They disagreed that advance medical technology is not needed to meet the health problems in the rural areas. Finally, they are ambivalent about the effectiveness of the national health plan in confronting major health issues. The rural doctors, on the other hand, feel that many times the doctor is not aware of what community resources to tap to facilitate an effective health care delivery system.
10. On the problem of brain drain, two factors were identified. First, the push factor, characterized by poor incentives, inferior training, and inadequate facilities. The pull factor, meanwhile, is characterized by better incentives, the lure of adventure, and more opportunities for learning new things. Some of the solutions advanced are: more incentives, better facilities, improved training, lower school fees, construction of more hospitals, and instilling in students the desire to help their own people.
11. Some problems identified with rural medical practice are: lack of facilities and personnel, ignorance, superstition, and poverty. Some of the suggested solutions are: seeking of government help, a health education campaign, increased budget, provision for free medical consultation, medicine and facilities, and encouragement of more students to practice in the rural areas. Cited as major involvements of the medical profession in development programmes are: community development, nutrition, environmental protection, health, and food production.
12. Doctors are found to be closest to other health workers and farthest from non-health workers. Their sources of medical information are: medical journals and books, news pamphlets, seminars, and lectures. Urban doctors, more than rural doctors, are benefited by the latest medical information. Barriers to effective communication between doctors are: busy practice schedule, lack of communication, openness, and interests, and geographical distance. Suggested solutions are: more regular and interesting scientific meetings, the establishment of a communication system, and better social relations. The rural doctors specifically suggested the compulsory attendance of seminars.
13. Finally, both groups felt that professional collaboration is necessary in the following areas: specialization, referral, direct patient care, charity treatment, and community health services. As to who should initiate the collaboration, they feel that doctors and health officials in their personal capacities are the primary initiators; second only are medical associations and the Government.

On the basis of this study, we are advancing nine recommendations:

(1) In order to develop greater health consciousness in the people, there is a need for a more vigorous health education campaign.

(2) Medical education should be reviewed in terms of length, relevance and commitment to meet the needs and solve the health problems of the country.

(3) Professional collaboration in the delivery of health services should be strengthened and the involvement of related professions in the delivery should likewise be reviewed, since health services cannot be separated from other services.

(4) In order to improve medical services in the country today, there is a need to develop a service exchange programme between rural and urban doctors.

(5) The people's participation in the planning and programming of health services should be encouraged. One way of realizing this is by involving the local government in programmes such as the early detection system, where the local official records and monitors the incidence of diseases in the community for transmittal to the proper health authorities.

(6) There is a need to expand and develop new areas of concern in the study of medicine. Some of these areas are: public health, community medicine, family medicine, rural medical practice, preventive medicine, occupational medicine, medical economics, medical sociology, and related behavioural sciences.

(7) Since health problems are related to other problems which are social in nature, there is a need to develop an integrated information system.

(8) Similar to the concept of legal aid services, the Philippine Medical Association should study the possibility of medical aid services directed primarily to those who cannot afford these services due to poverty.

(9) There is a need for a more relevant continuing and integrated education in health and related fields in order to ensure the effective and integrated delivery of health and related services.

Mr President, distinguished delegates, on behalf of my country, the Philippines, this is the report that I have to present to you this afternoon. Thank you very much.
(Applause/Applaudissements/Аплодисменты/Aplausos/تصفيق/鼓掌)

The PRESIDENT:

I thank Dr Bonifacio for his impressive report and I give him my warmest congratulations.

Distinguished delegates, I recall that the main committees will meet immediately, Committee A in Room XVI and Committee B here in this Assembly Hall. Should Committee B be unable to adjourn in time for the meeting of the General Committee which is scheduled to be held at 17h30 this afternoon, this meeting of the General Committee will be postponed until tomorrow, Saturday, at 12h30. And the main committees will meet from 9h00 to 12h30 instead of 9h00 to 13h00 as previously fixed. The relevant announcements will be made in Committee A and Committee B during the course of this afternoon. The meeting is adjourned.

The meeting rose at 15h25.
La séance est levée à 15h.25.
Заседание заканчивается в 15 ч. 25 м.
Se levanta la sesión a las 15,25 horas.
رفعت الجلسة في الساعة ١٥ر٢٥
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