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Doctors for health

A WHO global strategy for changing medical education and medical practice for health for all

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Contents

1. Looking at the past and the future

In 1977 the World Health Assembly—the principal governing body of the World Health Organization—resolved that the main social target of governments and of the WHO should be the attainment by all the world's people of a level of health that would permit them to lead a socially and economically productive life. This goal has become commonly known as "health for all".

In 1979 the World Health Assembly reaffirmed that health is a powerful lever for socioeconomic development and peace and that the key to attaining the goal of health for all was the primary health care approach. WHO defines primary health care as essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable.

The Thirty-fourth World Health Assembly (1981) adopted the Global Strategy for Health for All by the Year 2000, but by 1988 it was widely recognized that most countries still had far to go to make health for all a reality, particularly the least-developed countries.[1] In 1992 WHO Executive Board established a Working Group on the WHO Response to Global Change and charged it, in part, with proposing the necessary changes in the Global Strategy for Health for All.

The resulting report, in 1995, urged that the Health-for-All Strategy be revised to incorporate concerns for reducing the burden of poverty and to create mechanisms to improve solidarity and equity.[2] In *The world health report 1995: bridging the gaps*, WHO identifies poverty as the world's deadliest disease and cited the growing inequities, both between countries and between the rich and poor within a country.[3]

In the same year the World Health Assembly, in adopting resolution WHA48.8, "Reorientation of medical education and medical practice for health for all", urged WHO and its Member States to

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قرار جمعية الصحة العالمية
RESOLUTION OF THE WORLD HEALTH ASSEMBLY
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

Forty-eighth World Health Assembly **WHA48.8**
Agenda item 18.2 12 May 1995

Reorientation of medical education and medical practice for health for all

The Forty-eighth World Health Assembly,

Considering the need to achieve relevance, quality, cost-effectiveness and equity in health care throughout the world;

Mindful of the importance of an adequate number and mix of health care providers to achieve optimal health care delivery, of the reorientation of the education and practice of all health care providers for health for all, and of the need to begin systematic consideration of each;

Recognizing that it is important to place medical education in the context of multidisciplinary education and to provide primary health care in a multidisciplinary way;

Recognizing the important influence of medical practitioners on health care expenditure and in decisions to change the manner of health care delivery;

Aware that medical practitioners can play a pivotal role in improving the relevance, quality and cost-effectiveness of health care delivery and in attaining health for all;

Concerned that current medical practices should be adapted in order to respond better to health care needs of both individuals and communities, using existing resources;

Acknowledging the need for medical schools to improve their contribution to changes in the manner of health care delivery through more appropriate education, research and service delivery, including preventive and promotional activities, in order to respond better to people's needs and improve health status;

Recognizing that reforms in medical practice and medical education must be coordinated, relevant and acceptable;

Recognizing the important contribution that women make to the medical workforce;

Considering WHO's privileged position in facilitating working relations between health authorities, professional associations and medical schools throughout the world,

1. URGES Member States:

(1) to review, within the context of their needs for human resources for health, the special contribution of medical practitioners and medical schools in attaining health for all;

(2) to collaborate with all bodies concerned, including professional associations, in defining the desired profile of the future medical practitioner and, where appropriate, the respective and complementary roles of generalists and specialists and their relations with other primary health care providers, in order to respond better to people's needs and improve health status;

(3) to promote and support health systems research to define optimal numbers, mix, deployment, infrastructure and working conditions in order to improve the medical practitioner's relevance and cost-effectiveness in health care delivery;

(4) to support efforts to improve the relevance of medical educational programmes and the contribution of medical schools to the implementation of changes in health care delivery, and to reform basic education to take account of the contribution made by general practitioners to primary health care-oriented services;

2. REQUESTS the Director-General:

(1) to promote coordinated efforts by health authorities, professional associations and medical schools to study and implement new patterns of practice and working conditions that would better enable general practitioners to identify, and to respond to, the health needs of the people they serve in order to enhance the quality, relevance, cost-effectiveness and equity of health care;

(2) to support the development of guidelines and models that enable medical schools and other educational institutions to enhance their capacity for initial and continuing training of the medical workforce and to reorient their research, clinical and community health activities in order to make an optimal contribution to changes in the manner of health care delivery;

(3) to respond to requests from Member States for technical cooperation in the implementation of reforms in medical education and medical practice by involving networks of WHO collaborating centres and nongovernmental organizations and by using available resources within WHO;

(4) to encourage and facilitate coordination of worldwide efforts to reform medical education and medical practice in line with the principles of health for all, by cosponsoring consultative meetings and regional initiatives to put forward appropriate policies, strategies and guidelines for undergraduates and postgraduates, by collecting and disseminating relevant information and monitoring progress in the reform process;

(5) to pay particular attention to the needs of many countries that do not have facilities to train their own medical practitioners;

(6) to present to the Executive Board at its ninety-seventh session a report on the reorientation of education and practice of nurses and midwives, and at its ninety-ninth session a similar report relating to other health care providers for health for all, complementary to the reorientation of medical education and practice in this resolution, and to request the Executive Board to present its recommendations on the reorientations of nurses and midwives and other health care providers to the Forty-ninth and Fiftieth World Health Assemblies, respectively.

(Twelfth plenary meeting, 12 May 1995—Committee A, second report)

Hlth Res., Vol III (3rd ed.). 1.8

undertake coordinated reform in health care and therefore necessarily in the practice and education of health care workers.[4]

The present strategy document is a response to this resolution. It also takes into account the General Programme of Work of WHO for the period 1996 2001 and its four policy orientations: integrating health and human development in public policies; ensuring equitable access to health services; promoting and protecting health; and preventing and controlling specific health problems.[5]

2. Health care reform and the health workforce

Health care systems worldwide face new challenges that call for new responses. The quest for relevance, quality, cost-effectiveness and equity in health care, which characterizes the health-for-all movement launched in 1977 and now reaffirmed by WHO, appears to be universal.

Health status and health care everywhere are influenced by prevailing social, political and economic realities. It is therefore important to understand these realities and to act accordingly, in the knowledge that health interventions are valid investments in social development.[6]

The interdependence of actions for health is so complex that reform of a health care system requires, if not a common vision, at least a convergence of views as to the fundamental values on which reform must be based, on the part of the main actors of the health sector—health care planners and funders, health care providers, health researchers and educators of the health workforce—and main actors of the other socioeconomic sectors—such as education, agriculture and the environment—as well as the community at large.

The fate of national strategies for health for all relies on political will and the availability of expertise and resources. Health care providers are among the most important resources, given their essential role in implementing these strategies and the significant portion of the health budget they require to function properly—some 70% in many countries—so appropriate measures to plan, train and deploy a cost-effective number and mix of health care providers are indispensable prerequisites for successful health reform.

One strategy to stimulate reform in the health care system is to reform the health workforce. Indeed, a comprehensive plan to reorient the health workforce is at the core of any successful reform in health, as it implies defining new roles for health care workers as well as planning new health care settings in which they will prac-

tise; determining optimal working conditions; and organizing appropriate programmes of basic and continuing education.

But because health care reform is multifaceted, acting on the health workforce must be seen as only one strategy for major change. Health care providers and their practice environment constitute only one of the subsystems of the total health system. Other important subsystems with which that of the health workforce is closely interrelated are those of health planning and management and of health professions education. Each of these three subsystems has its own purposes, dynamics, allegiances, rules and traditions. In many instances they remain relatively isolated from each other, as their goals and objectives may not always converge.

The challenge is to understand the inevitable level of interface that does exist among them—to point out the degree of their interdependence in order to identify and overcome barriers to their recognizing a commonality of interests—and to translate this understanding into programmes of action they all can accept.

3. Doctors of the future

Within the health workforce, physicians may traditionally have held key positions in shaping and operating health care systems, but they now realize they are not immune to public criticism; their decisions are challenged more and more, particularly with the increasingly widespread expectation of value for money. It is recognized, for example, that other categories of health care workers, such as nurses, may be able to provide certain services as effectively as physicians and at less cost. In these circumstances, what will be the role of the physician? In addition, more and more countries are now experiencing an oversupply of physicians.

In determining their future with regard to health as a state of physical, mental and social well-being and to the worldwide goal of health for all, all health care workers of the future—and doctors in particular—will have to consider striking a balance between individual and community health care and between curative and preventive care, choosing appropriate technology to provide cost-effective services and satisfying an increasingly demanding public.

World Health Assembly resolution WHA48.8 encourages all countries to undertake activities to reform medical education and medical practice with a view to increasing relevance, quality, cost effectiveness and equity in health care. Though the resolution focuses particularly on the physician and this strategy reflects this emphasis, it is clear that the impact on the rest of the health workforce will have to be addressed as well.

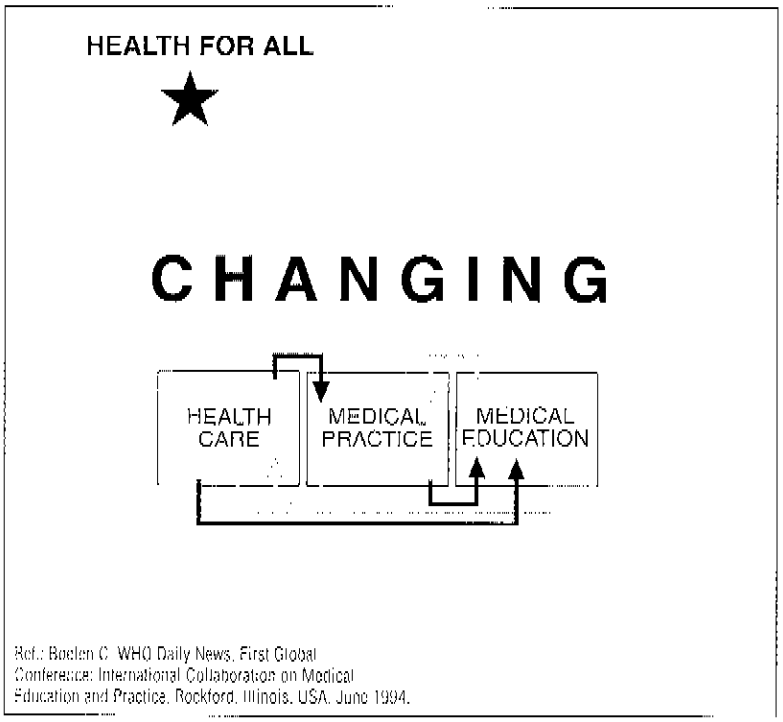
Tomorrow's doctors must be prepared to accept that decision making in health care is a multidisciplinary and multiprofessional exercise. Also, doctors of tomorrow may not be doctors of the day-after-tomorrow, as societies and health systems evolve and adaptation to current and anticipated needs continues. But we believe there are skills that will always be essential everywhere, as demonstrated by what we call the "five-star doctor".

The five-star doctor

- ★ **Care provider**, who considers the patient holistically as an individual and as an integral part of a family and the community and provides high-quality, comprehensive, continuous and personalized care within a long-term relationship based on trust.
- ★ **Decision-maker**, who chooses which technologies to apply ethically and cost-effectively while enhancing the care he or she provides.
- ★ **Communicator**, who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health.
- ★ **Community leader**, who, having won the trust of the people among whom he or she works, can reconcile individual and community health requirements and initiate action on behalf of the community.
- ★ **Manager**, who can work harmoniously with individuals and organizations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data.

4. Changing medical education and medical practice

Shaping the profile of the doctor of the future offers a pragmatic opportunity for health care, medical practice and medical education interests to work together with health for all as their common goal. Such a profile could develop as a point of convergence of these interests and the expression of a common denominator for their work.



Ref.: Boelen C. WHO Daily News, First Global Conference: International Collaboration on Medical Education and Practice, Rockford, Illinois, USA, June 1994.

Optimal practice patterns could then develop to enable the doctor of the future to respond efficiently to challenges in the health sector. Optimal educational approaches should be in place to prepare future graduates and to reorient doctors already in practice to assume the new roles and responsibilities expected of them.

In principle, health authorities, professional associations and medical schools should have ample opportunity to apply their specific strengths and potential in joint projects to examine the most appropriate ways for doctors to respond better to people's health needs. But to do so they will require creative minds, pragmatism, courage and determination to venture outside their usual habitats.

In thinking about the doctor of the future, special attention should be given to the role and education of general practitioners/family doctors, whose ability to provide comprehensiveness and continuity in health care and to contribute to cost effectiveness in the health care system is being increasingly acknowledged. However, the family doctor's potential to hold a central position in the health care system will depend on the capacity to adapt to new requirements in health care organization, an optimal relationship with medical specialists and other health care workers, and comparative contribution to improvement of health status.

WHO has long promoted coordinated health services and health personnel development.[8] The message of the global conference on international collaboration on medical education and practice, cosponsored by WHO and the University of Illinois College of Medicine at Rockford, Illinois, USA, in 1994, gives evidence of the widespread understanding and acceptance of the principles of integration and coordination.

■ **The conference urges that priority concern be focused on the interface of health care, medical practice and health professional education such that there is a ready and coordinated responsiveness to societal needs. That interface should be the foundation for a partnership between university, government, health care providers and community that serves as the focal point for their interactive strengthening of their respective areas of responsibility and interest. The recommended direction of action is towards community-based, policy-relevant, publicly accountable systems of health care and educational development that result in equitable, effective and compassionate care for patients, families and communities in keeping with the needs and values of each society. A united thrust by all collaborating organizations, institutions and individuals must be established and sustained worldwide for steady progress towards reform of medical education and medical practice to help achieve Health for All.**[9]

5. Components of a global strategy

We hereby propose a global strategy to help guide and support the design and implementation of appropriate approaches and methodologies for reorienting medical education and medical practice to serve the goal of health for all. The global strategy comprises political, technical, information and coordination components.

5.1 The political component

Rationale: Political leaders and policy-makers in the health sector in each country must provide their active support to realize the reform in health care, medical practice and medical education that is needed and compatible with the specific socioeconomic context of the country.

Activities: Political support will be enhanced through the following means:

- Wide dissemination of the World Health Assembly resolution to governments, responsible authorities in the health and education sectors, professional associations and educational institutions for health personnel to advocate reforms called for by the resolution.
- Encouraging concerned national and international organizations to pursue activities entailed by the resolution, with a view to developing a vision shared by health authorities, professional associations and academic centres on reform in health care, medical practice and medical education.
- Promotion of collaborative processes suitable to different national contexts to engage health authorities, professional associations and academic centres in joint research projects.

5.2 The technical component

Rationale: WHO must develop the required knowledge base and expertise to assist countries and national and international entities

to design, implement and evaluate strategies and methodologies suitable to various socioeconomic contexts and states of development, consistent with ensuring sustainable progress in reform.

Activities: Research will be conducted and case studies will be compiled with a view to facilitating the endeavours of countries and concerned organizations and institutions to organize and implement coordinated reform in health care and in the practice and education of health care workers for health for all. Issues related to the future of the medical profession will be considered closely with those related to the future of other health care providers.

5.2.1 *Health care reform*

- *Responses to critical issues in health care:* Expanded analysis of issues on which health care reform is expected to be based—such as health care financing, priority-setting, definition of quality, the quest for cost-effectiveness, appropriate use of technology, delegation and substitution, empowerment of clients and equity—will be promoted, as will analysis of the potential of the medical profession and the academic world to address them. Position papers will be formulated as a basis for policy development and programme implementation, from the perspective of both medical practice and medical education.

- *Contributing to new practice patterns:* Innovative models will be examined for planning and providing both individual and community health care in a unified and coherent manner towards increased relevance, quality, cost-effectiveness and equity in health care. As appropriate, the conception and testing of further models will be fostered.

In consonance with such models, which will be adapted to meet features of different health settings and specificities of different socioeconomic environments, implications will be identified for the planning, training and management of the health workforce. New practice patterns and new roles will likely emerge for health care workers, including physicians.

5.2.2 *Reform in medical practice*

- *Substitution and complementarity:* The relative contribution of the different health professions to improved relevance, quality, cost effectiveness and equity in health care will be examined by means of evidence-based approaches. Several modalities of health care will

be compared, with different combinations of health care workers. For instance, situations will be analysed wherein general practitioners and other primary health care providers, depending on local circumstances, serve as gatekeepers and coordinators of health affairs for a given population.

- *The changing role of doctors:* Profiles of the doctor of the future will be shaped by the same forces influencing the health care system of the future. The role of the doctor will be re-examined as part of the re-examination of the roles of all health care providers. Debate will be stimulated at the national level with a view to establishing the needs and expectations—and fostering a convergence of viewpoints—of health authorities, professional associations, medical schools and the community at large on the doctor's changing roles and profiles. It appears likely that within the range of skills doctors of the future will be required to acquire, those in health care management will be prominent. Particular attention will be paid to the profile of the future general practitioner or family doctor, who will increasingly play an important role as a gatekeeper to specialty services.

5.2.3 *Reform in medical education*

- *Fulfilment of the social mission:* Special emphasis will be put on assessing the responsiveness of medical schools to health needs of society through their activities in the domains of education, research and health service delivery. Measurement tools and guidelines will be developed to allow medical schools, as well as other educational institutions in the health sector, to assess their present responsiveness to social needs and their impact on professional practice and health care, and to monitor progress in these areas.

- *Quality in medical education:* Quality in medical education will be promoted, based on principles of relevance to health needs of individuals and communities, adequacy for optimal practice patterns and efficiency of the learning process. In training programmes, emphasis should be put on health care management, quality assurance and health economics. The comparative analysis of benefits, constraints and costs of various educational approaches will be encouraged. Tools and procedures for measuring quality in medical education will be designed and validated through field testing for use in internal evaluation, external evaluation or accreditation of medical schools.

5.3 The information component

A special effort will be made to disseminate both essential information and new knowledge in relation to strategies and methodologies for changing medical education and medical practice for health for all, in order to create solidarity among current reformers and encourage and inspire others to engage in reform.

5.3.1 Newsletter

Designed to fill a previously unoccupied space in the literature, the WHO newsletter *Changing medical education and medical practice* reports on ideas and action on reform at the interface of health care, medical practice and medical education the world over. Twice a year it is distributed worldwide to some 2500 health authorities, medical schools and other concerned organizations and groups. Each issue includes articles in French. A version in Portuguese is now available, and plans are under way for a Spanish-language version. In addition, the newsletter in English is available via the Internet.

5.3.2 Electronic messaging

An electronic messaging system has been set up to facilitate the exchange of information on activities relevant to reforms in health care, medical practice and medical education.* Efforts will be made to widen membership in this and other means of electronic messaging to accelerate the circulation of information, particularly in countries and organizations and institutions now outside the mainstream of information.

5.3.3 Data bank

WHO will participate in establishing a global data bank with essential information on the current situation in medical schools and the medical profession, on significant developments regarding strategies and methodologies for implementing the needed reforms, and on the existence of technical expertise and other resources worldwide. The *World directory of medical schools*, which is intended to describe and analyse trends in medical education worldwide, and a

* The Global Forum on Medical Education and Practice, GLB HLT, was established during the Globe. Conference on International Collaboration on Medical Education and Practice, 12–15 June 1994, Rockford, Illinois, USA. This forum — a listserver — is available worldwide to those with access to Internet and is intended to foster and facilitate exchange of information. To enroll, simply send e-mail to: LISTSERV@UICVM.UIC.EDU and in the body of the message, enter: SUBSCRIBE GLB-HLT and your name.

world survey of general practice, which is expected to draw a global picture of the general practitioner's contribution to the health field, will be important additions to the data bank.

5.3.4 *Publications*

Reports of international consultations, monographs on selected topics, progress reports on research and publication of research findings in the various domains of the technical component as outlined above will be encouraged and publicized.

5.4 The coordination component

Efforts will be made at WHO regional and headquarters levels to encourage international collaboration aimed at providing opportunities for national authorities, institutions and concerned groups to benefit from experience and expertise available worldwide and to monitor progress towards the implementation of needed reform. Because of its mandate to coordinate health at international level and its privileged relationship with health authorities, professional associations and medical schools in its Member States, WHO is prepared to facilitate this coordination.

5.4.1 *Setting up international working parties*

International working parties (IWPs) will be set up to include organizations and institutions from different regions of the world with the capacity to contribute to research in one of the technical domains outlined above. To the extent possible, collaboration will occur in the form of multi-centred research projects that employ a similar protocol to address a given topic. One institution in each IWP will serve as its coordinator, facilitating the exchange of information among all participating member institutions, organizing meetings of investigators, and publishing and disseminating research results and experiences. Several IWPs will be set up to cover the spectrum of reform.

5.4.2 *Developing a research agenda*

Agencies and groups interested in research relative to health care organization, medical practice and medical education will be encouraged to jointly address issues such as health workforce planning, new practice patterns, reallocation of tasks among several categories of health care workers, use of new technologies, man-

agement of health information, improvement of the decision-making process and impact on health care of the education of the health workforce.

A call will be made to set up an international research agenda with a view to defining priority research areas; stimulating institutions and individuals to develop protocols for carrying out research with the above-mentioned scope; identifying sources of funds locally, regionally and internationally; and stimulating policy-makers and programme developers to use research findings to improve health care and health status.

5.4.3 Getting advice from an international board

It is proposed that a small group of internationally renowned experts be constituted as an advisory board for changing medical education and medical practice (ABC) to promote the global strategy for changing medical education and medical practice from the perspective of health care reform. Members of this board will be drawn from concerned national and international organizations and foundations, with a view to instituting coordinated approaches, reducing overlapping, encouraging complementarity, developing joint ventures and raising funds to support priority projects. The ABC will also be brought together at regular intervals to develop policy guidelines and to monitor the progress of the global strategy.

6. Monitoring progress

Progress in implementing the WHO global strategy will be judged on the basis of principles and recommendations contained in Resolution WHA48.8 and the course of action suggested in the global strategy. It is hoped that regional, national and institutional strategies will be developed as well, and that specific and quantifiable indicators will be developed to allow appropriate monitoring of progress at these levels.

Initially, certain developments may be observed that may in themselves serve as general indicators of progress in reform. The following is a range of such developments, from which more specific indicators at country level could be derived:

- Policy guidelines are developed for coordinated reform in health care, medical practice and medical education with the resolution as a reference point.
- Research is conducted to identify the most appropriate ways to implement needed changes in health services, medical practice and medical education.
- Health care reform initiatives are taken and changes in health financing are made with consideration for integrated models of health care delivery and implications for the practice and education of health care workers.
- The health workforce is reviewed with consideration of new roles for health care workers in health services delivery.
- The optimal contribution of health care providers is planned and provided for, with a view to achieving relevance, quality, cost-effectiveness and equity in health care.
- The optimal response of educational, research and service institutions to society's health needs is assessed and acted on.
- Changes in medical education are made to improve its relevance

and efficiency at undergraduate, postgraduate and continuing education levels.

- National mechanisms are established to promote, coordinate and monitor action in the above-mentioned areas: setting up national task forces, drawing up plans of action and optimizing existing resources in the health sector and other sectors.
- Conditions to improve the impact of education on the performance of health care workers and health services are studied and acted on.

At regional and global level, the monitoring of progress will be based on the following:

- increase in shared vision and commitment of national and international organizations and institutions to implement the World Health Assembly resolution;
- strengthening and enlargement of the network of institutions collaborating with WHO through joint plans of action;
- establishment of several international working parties (IWPs) to conduct multi-centred research projects to develop guidelines and models to implement needed reform at country level;
- production and dissemination of publications;
- wider availability of information on the status of reform in health care, medical practice and medical education.

Concurrently with the development of national strategy, a mechanism for reporting progress on its implementation would be set up in each country. National reports will be analysed and consolidated by the respective WHO regional office; WHO headquarters would prepare a monitoring report of the global situation. As a three-year cycle for the monitoring is advised, the first report would be prepared in 1997. The advisory board for changing medical education and medical practice (ABC), described earlier, will then consider the monitoring report and provide further guidance on improvements and new trends.

7. Contact with WHO

The WHO global strategy for changing medical education and medical practice hinges on coordinated reform in health care and in health professions practice and education which stems, in turn, from the need to improve relevance, quality, cost-effectiveness and equity in health care delivery. As no one institution, organization or country has the total response to these complex challenges, it is imperative that through international collaboration optimal use be made of the tremendous experience accumulated worldwide.

Synergistic links must be established and sustained between organizations, institutions, groups and individuals that share a vision of the changes needed in our health systems and that can contribute intellectual, material or financial resources. WHO stands ready to foster and participate in such links. WHO welcomes the opportunity to coordinate international collaboration to ensure that appropriate approaches and methodologies are developed to support endeavours in changing medical education and medical practice to attain the goal of health for all.

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