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**Comments**

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## COMMENTS

### Dr. Mercedes B. Concepcion

Inasmuch as the title of this particular session is "Population and Health", Dr. Bengzon thought it appropriate that population precedes health. In the recommendations and in the development of the report of the workshop, the role of the congregation was particularly stressed. However, I seemed to have missed any reference to the role of ministers. And in my particular experience locally, I have come across many examples of ignorance on the part of ministers and priests with regard to their exact role and to their understanding of the population situation in this country. I do not say that this is particularly true only of the Filipino ministers and priests. It is also evident in many other countries as well. But since we are talking of our situation right now, I would like to propose that we should also, first of all, develop a sense of participation on the part of our ministers and priests, as the recommendation reads: "engaging individually and jointly in a frank, open and vigorous search for effective and realistic ways of coping with the population problem".

Some five years ago I had already indicated that the people would only believe in the sincerity of the Church regarding their plight if they saw that the Church was really concerned, not by words but by action, and that the only way by which this could be developed was for the priests and ministers to engage in a more direct involvement with the population problem. A group of us who were called and invited by Bishop Gaviola two years ago to discuss what role the Bishops' Conference could play in the population problem, suggested that perhaps the first thing that we could help with was to hold seminars for priests, particularly those who were serving the rural areas. It was brought out here by Dr. Flavier that the priest is still "persona grata" in the rural areas. My impression is the same. However, this stems from the fact that the priests—and there are very few of them available in the rural areas—serve as guides and counselors to married couples. How can they guide properly and correctly if they do not know what the Church's stand is on the matter today? Many of them were trained 20 or 30 years ago, and the theology that they were trained in is certainly not the new theology that Father Blanco was referring to earlier. I have also noticed that there has been a hesitancy on the part of many priests to be directly involved because they feel that they know all about it already and there is no need for them to be briefed about the problem as it occurs in the

Philippines today. Many of them seem to think that we demographers and social scientists dwell very much more on the non-moral aspects of the problem, on the economic, on the social aspects rather than the moral. Now, of course, being social scientists and not being moralists and theologians, we cannot venture into fields for which we are not qualified. So we leave it to the moralists and theologians to engage in that, but if they have no understanding of the problem and no direct willingness to participate in this, how can we then have a very close cooperation with them and an open discussion of the problem?

So, with that I would like to stress once again that perhaps more priests, more religious, more ministers should engage in the discussion and seek knowledge on this problem. I would also like to point out here that what is needed, particularly now, is the change in our outlook towards the family and the size of that family. What we would like the priests and ministers, as well as the congregation, to realize is that the time has come for us to modify our basic attitudes and behavior, so that instead of idealizing large families in the abstract and creating them in flesh and blood, we should prefer smaller ones and act upon preferences already stated by many of our families in the Philippines. Instead of measuring our welfare by the amount of our consumption, we should become deeply concerned about enhancing the quality and preserving the variety of life in its numerous forms. Of course, this would require a consensus on the part of society to moderate the growth of our population. In fact, we should aim at a zero rate of growth perhaps not in one single generation but in two or three.

Changing the momentum of a society seems to be next to impossible but we have already noticed that there are changes going on. We have talked about the participation of our youth; their very energies are now concentrated in effecting change. Perhaps we should harness these energies of the youth of our society to assist us in confronting this very basic problem of our times. I would like to challenge not only Mr. Garilao and Mr. Mondejar here, but many of their colleagues to assist us in bringing to the people, especially in the rural area, a need for changing our concept and our values of a large family and for bringing about a consensus for a smaller family.

### Dr. Alfredo R. Bengzon

I'm supposed to comment on the health aspect of the subject Dr. Concepcion has talked largely about the recipients of health care; Dr. Villegas has alluded to the organizational structure of the milieu in which the health care is delivered; I would like to confine my com-

ments to what I call the provider or deliverer of health care, namely the physician population. I'd like to divide my comments as follows. First of all, I'd like to deal with a problem that is all familiar to you, namely, the so-called brain-drain problem. Second, how this problem has certain peculiarities in our local context. And third, I'd like to come up with some suggestions, some of them seemingly very wild, on how we can attempt to think of solutions to this problem.

With regards to the first topic of the brain-drain problem, I think perhaps one can look at it not only in terms of actual physician-population ratio but also in terms of distribution of physicians viz-a-viz the population. Some statistics here on the number of physicians in practice (in 1968 figures): there were something like 27,000 physicians in the Philippines registered with the Board of Examiners, of which 14,000 were in practice. Of these about 38% practiced in the Greater Manila area, and 27% in other urban areas. So that a total of 65% practised in urban areas, and only 35% in rural areas. At that time, the ratio of physician to population in urban areas was 1 physician per 1,200 inhabitants; in the rural areas there was 1 physician per 5,100 inhabitants. In the Greater Manila area, the ratio was 1 physician per 400 inhabitants, a very good ratio. In addition, 1/3 of our 1,400 municipalities had no rural health units. A rural health unit is composed of a physician, a nurse, midwife, and a sanitary inspector.

What about the number of our graduates who migrate outside of the Philippines? It is estimated that 1/3 of all new graduates from the 7 medical schools leave the country for the United States after their first year from graduation, and that a good portion of those who go abroad either never come back, or come back just to wait out the 2-year requirement (which incidentally has been abolished already by the United States Immigration Service) only to leave the Philippines permanently. So that is the statistical picture of the extent of the so-called brain-drain problem.

Now, what is the reason for this problem? We do not have many careful studies that have analyzed this problem. I think it is significant that a group of medical students, one of the first to venture into this area, one summer during vacation, went to five provinces and made a study of the physician population there. They came with some rather startling conclusions. (Most people kind of take the attitude of blaming the physicians for not practicing in the provinces. Nobody talks of a lawyer not having gone to the province, or an architect setting up an office in the province.) It was found out by the students, among other things, that many of the physicians who practised in the rural areas made the decision to go to the rural areas even before they were in medicine proper. It was also found out that a good number of these physicians who went back to the rural areas either

had private property interests to protect or close family ties. And thirdly it was found out that a good portion of their income came not so much from their practice but from their business interests. You might be interested to know, for example, that almost 70% of the doctors earned as much as 50% of their total incomes from sources other than their practice. At least 65% of the spouses of doctors (their wives or husbands) were engaged in business. It is not exactly accurate to say therefore that people who go back into the rural areas are necessarily so-called dedicated physicians, and that physicians who do not go back to the rural areas necessarily lack that dedication.

Another point should be brought up here. At least 44% of the total population in medical schools are urban. They live in the cities; those who come from the provinces spend anywhere from 9-15 years, the last 9-15 years before graduation, living in the cities. Consider then a situation where you have, say a student who has left the rural areas and has acclimatized himself to city life: would you now ask him to return to a place that he does not know anymore? Consider further that perhaps one of the reasons why he went into medicine in the first place is to get out of the social stratum whence he came. So I think that this question of the brain-drain problem and the maldistribution and lack of physicians is not as simple as it seems.

Again, going back to this study, it was found out that it was not just a question of a bleak outlook income-wise that acted as a barrier to physicians going back to the rural areas. Most of the physicians interviewed were economically stable. Rather, the factor of seeing or projecting a bleak, or slow, or stagnant professional stature is what prevented many physicians from going back to the rural areas.

Now, when we talk about this brain-drain problem and physicians, I think we should look at two types of physicians. There are those who would be a misfit anywhere except in the urban areas. These people also present a brain-drain problem because even within the city the present situation makes them very unhappy, and so they eventually migrate. These people would never go to the rural area unless it were changed very, very radically. Then there are people who will probably fit into a rural situation. Now, what can be done about this? Medical schools are now trying to change their curriculum. One of the steps being taken is to expose the medical students to rural conditions. The University of the Philippines, for example, set up five years ago a comprehensive community health care program in Laguna. However, there are many loopholes here. For one thing there is no plan to assess the results of the study. I don't think, for example, that there has been a change in the number of physicians returning from abroad, or going to the rural areas since this community health program was set up.

I'd like to echo what Dr. Flavier said earlier, that this is perhaps where the parishes can play a role in providing or acting as extensions of physicians in providing health care. After all, in the very beginning the providers of health care were the missionaries. The type of medicine that one sees in the rural area need not be very sophisticated, and yet it can be very, very down-to-earth and adequate. For example, let's take a look at the case of an industrial worker in the Greater Manila Area. He usually belongs to a union; the union usually demands certain types of pre-employment examination or annual physical check-up. Yet if you sit down and look at the components, what composes the demand of the union, even from a medical point of view a lot of the items there are unnecessary expense. The company merely insists on this because these are the demands of the union. An examination of urine, for example, for one who is a potential employee has absolutely no value in terms of detecting communicable illness. A chest X-ray certainly. But one urine examination will cost you from 3-5 pesos, and if a company has 800 employees, you multiply that by 5, that's a lot of money. There's another example. I'm sure if we poll the people in this room, we will discover that at least half of them are taking vitamin pills. Yet if you sit down and analyze it from the medical, scientific, bio-chemical point of view I would venture to say that everyone in this room does not need vitamin pills because you all look adequately nourished. Now, think of the amount of money spent on vitamins. If there is a representative of a drug company here, I'm sure I'll get it in the neck, but I think from a medical point of view this is absolutely not needed, except in a few specific instances like those who are always inebriated.

So this experience has been verified, the attitude of people. And yet what is the attitude if you go out not only into the city but also into the barrios. A patient comes to you for consultation and maybe his symptoms are psychosomatic. And all you need is a good ear and a good doctor like Dr. Flavier who will listen to his complaints. Yet our people have been so conditioned that if they leave the office of the doctor without a prescription, he is a no-good doctor. So the doctor who is not oriented to this kind of relationship or thinking finds it almost impossible not to dash out a prescription, and therefore to dash out a prescription that is harmless. What better prescription is there than vitamin pills. Instead of spending your money on vitamin pills, buy milk or vegetables, or buy fish.

I think the parishes can help in two ways: obviously as an educator. Here the university population and the physician population can educate members of the parishes who will in turn disseminate this, and secondly, even as extensions of providers of health.

Now, finally, what about those physicians who are not suited to rural practice. We have a very real problem because I think we

must recognize that we must begin to develop our own training centers. What happens to a lot of our urban physicians is that they feel so frustrated and they leave. Here is where a source like industry, for example, can come in. If industry can combine with schools and set up an Asian Institute of Management, I see no reason why industry cannot combine with physicians to pool their own resources to set up our own training centers here. If you look around the Greater Manila area, except for maybe three hospitals, all other private hospitals are corporations and their major stockholders there are physicians. I see no reason why industry and the physician population cannot get together and come up with something that can be tried not only in the urban areas but also in the rural areas.