with a strengthening of the infrastructure designed to provide primary care including improved nutrition. Neither oral rehydration nor immunization coverage, two of the pillars of the current drive for “Health for all by the year 2000,” were operative in 1975, although they probably played a part in the latter years of the decline. Neither breastfeeding nor improved environmental sanitation contributed to the decline’s initiation or continuum.

There are two principal lessons to be learned from the Nicaraguan experience. First, the infrastructure to deliver primary care of any sort must be in place before the care can be delivered. Second, as the Roemers also point out, a government must be committed to health as one of its priorities.

In 1990, the Sandinista regime was replaced by a new government whose commitment to health will be watched with interest. As Sandiford, et al, noted, the infant mortality rate will continue to monitor the effects of any policy change on child health and survival.

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References

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Social Origins, Medical Education, and Medical Practice

Education of health professionals is a high cost undertaking that society has learned to accept as essential, to some degree at least, because the need for health care is so pervasive and so urgent. Developing countries have an especially difficult time with these expenses because of the many other demands on public funds and the very high cost of medical education to the state, regardless of who pays the tuition fees. For all countries, moreover, the need to recoup the investment has put increasing emphasis on proper utilization of medical graduates.

In this issue of the Journal, Julio Frenk and his colleagues have made an unusual contribution to international studies of health manpower development by analyzing the situation of medical employment and unemployment in Mexico today. Their report is a fine example of the fact that international transfer of technology and information is a two-way street, a concept underlined in the recent shift in World Health Organization terminology from technical assistance, implying an hierarchical relationship, to technical cooperation, suggesting more of a partnership. The observations and conclusions of this study surely have relevance for many other countries, including those with so-called developed as well as developing economies. It is all too frequent to be faced with the paradox of “coexistence of underemployed physicians and underserved populations.”

Mexico has experienced a massive growth in medical schools and medical graduates since 1967. The growth was stimulated in part by two hardly unique factors—increased demand for higher education from the middle classes, and an enduring economic crisis that made university studies an attractive alternative to unemployment. As a result, a six-fold increase in the total number of physicians took place in Mexico in the quarter century between 1960 and 1985. Over the same period, there was a doubling of the population so that the proportion of available physicians reached 153 per 100,000 population. This is hardly an excessive number, yet the Frenk group, in a study based on Mexico’s National Survey of Urban Employment—a well documented and regularly visited sample of 41,000 households—found that 22 percent of Mexican holders of a medical degree were either quantitatively or qualitatively underemployed and an additional 7 percent had no medical employment at all. Physicians were classified into those working at only one task (either independent practice or a single salaried job), those who had multiple employment (which might be any combination of salaried and independent occupations), those who were qualitatively or quantitatively underemployed, and those not engaged in medicine. Thus, almost one-third of medical graduates were not properly utilizing their costly education; at the same time, nearly 10 million people, 11 percent of the Mexican population, had inadequate access to medical care.

To look for policy implications that could lead to corrective action, the authors examined such factors as social origins, gender, caliber of medical school attended, year of entering medical practice, and specialization, if any. Among their many interesting findings was that a substantially higher proportion of recent graduates were unemployed; this was true of 42 percent of those graduating after 1970 against 15 percent of older physicians. A similar observation was made for women, who have constituted a far higher proportion of medical students in recent years. Not surprisingly, an even higher proportion of those without a specialty and of those who were graduates of medical schools that were classified by independent observers as “inadequate” were not being properly used.

Some of the most cogent observations made by Frenk and colleagues relate to so-
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The proportion of whom were unemployed, were also more likely to have only a single salaried job. Furthermore, the shortage of experience that accompanies quantitative underemployment brings the additional probability of decrease in quality of medical care. Yet these unemployed and underemployed physicians seem unwilling to give up urban residence to serve in rural areas where they are needed. Frenk notes that "the process seems to lead the medical education and health care systems to reproduce, rather than ameliorate, pre-existing social inequalities."

While the authors' findings are, in their own words, sobering, there are a number of practical avenues for social action. These include fairly obvious steps, like improving the quality of poor schools, tightening academic qualifications for admission, not only to undergraduate but to postgraduate medical education, and affirmative action regarding opportunities for women physicians that will take into account their other social roles. Governments like that in Mexico need to take action "to redress the inequities that still mar the systems of higher education and health care." Far more thought needs to be given to ways to make rural practice attractive, besides purely financial rewards. With modern techniques of communication, much greater professional and scientific support could be provided that would enhance the prestige and sense of contribution of rural practitioners.

These are challenges to all governments, not just Mexico. □

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Reference


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RWJ Foundation Grant Aimed at Improving Services for the Disabled

Twelve community-based organizations run by and for people with disabilities have been awarded grants to improve services for disabled people under an $8.4 million program from the nation's largest health care philanthropy.

The one-year planning grants of up to $100,000, awarded by the Robert Wood Johnson Foundation, are intended to help agencies such as "Independent Living" centers make fundamental improvements in the way interrelated services are organized and delivered. In this way, they can enhance the ability of disabled people to live independently in the community. The grant funds will be used to:

- identify the unmet needs of people with disabilities within the community;
- coordinate and integrate existing health and supportive services and their financing with new services;
- improve access to this system of services for people with all types of disabling conditions; and
- help these organizations become increasingly self-sufficient by diversifying their financing through a mix of public and private sources, including developing entrepreneurial activities.

People with disabilities have problems locating existing services and determining their entitlements, said Steven A. Schroeder, Foundation president.

He further noted that health and related agencies often duplicate some services while failing to provide others. "We hope these agencies will become the central community resource for disabled people, and that model systems of services will be developed that communities may adopt," he added.

"Improving Service Systems for People with Disabilities" is directed for the Foundation by Lex Frieden, executive director of the Institute for Rehabilitation and Research Foundation in Houston, Texas. Grantee agencies that successfully complete the planning phase will be eligible for funding of up to $600,000 over three years to carry out their plans. For further information, or a list of the agencies receiving planning grants, contact College Road, PO Box 2316, Princeton, NJ 08543-2316. Tel: 609/452-8701.