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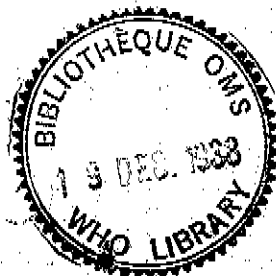
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

EUR/ICP/PHC 314
2723v
ENGLISH ONLY
UNEDITED



PRIMARY HEALTH CARE DEVELOPMENT IN SOUTHERN EUROPE

Report on a WHO Forum

Lisbon
10-12 November 1987

Document
1988
8.2
WHO
1988
10.2

1988

EUR/HFA target 26

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TARGET 26

A health care system based on primary health care

By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.

Index:

PRIMARY HEALTH CARE

GREECE

ITALY

MALTA

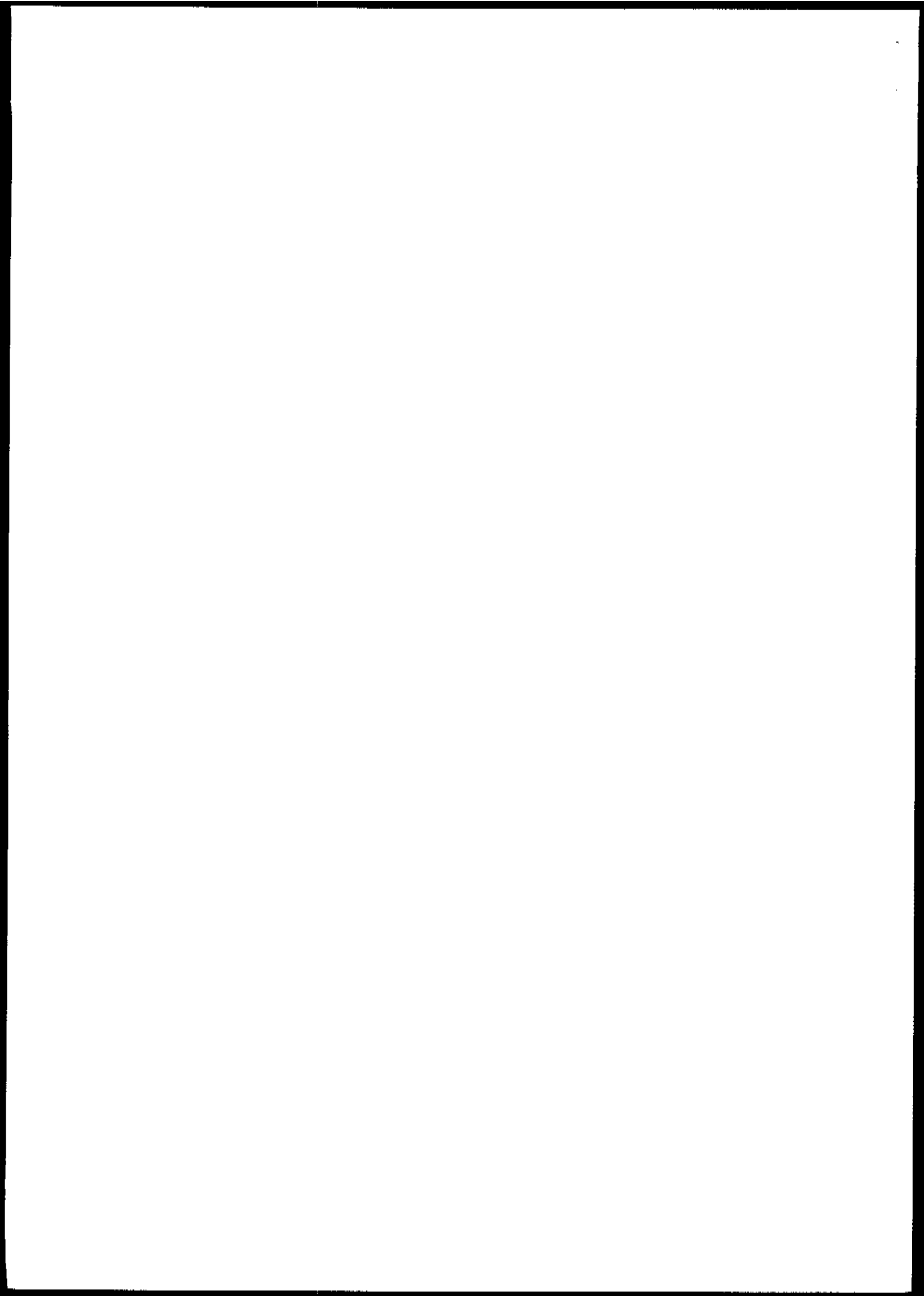
PORTUGAL

SPAIN

YUGOSLAVIA

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1. Introduction

The WHO Regional Office for Europe study on the organization of primary health care (PHC) in southern Europe was carried out with the participation of four countries - Greece, Italy, Portugal and Spain - during the period 1982-1985. At the end of this study, it was decided to continue the exchange of experiences on PHC development in southern Europe, and it was agreed that an annual forum would be appropriate for that purpose.

The first forum took place in Verona, Italy, in November 1986, and the specific topic discussed was "Management issues for primary health care development". Apart from the contribution of the four countries mentioned above, Malta also participated.

The proposal of the theme "Information systems for primary health care" to be the main topic for discussion during the second forum was accepted; so was the proposal of Portugal to host the meeting.

The group of four countries who started the WHO study on PHC was enlarged with the admission of Malta in 1986 and Yugoslavia in 1987.

2. Opening session

2.1 Statement by the Director, National School of Public Health

Professor A. Lobato de Faria, Director, National School of Public Health, presented a welcome address to all participants in the forum, emphasizing the opportunity given to the countries of southern Europe to share their experiences on PHC development and stressing the unquestionable value of the subject chosen for the discussion: information systems in PHC delivery and management. He also mentioned the honour and pleasure for the School, a WHO collaborating centre for primary health care, to host the meeting.

2.2 Statement by the General Director, PHC Central Department, Lisbon

Dr J.L. Henriques de Jesus, General Director, PHC Central Department, expressed his satisfaction for having the meeting, allowing the participants to be acquainted with the development of PHC services within each represented country. He stressed that Portugal is facing some challenges in improving the PHC delivery system, mainly in what concerns the quality of the health care provided. Three areas were pointed out as essential to attain that purpose. The first was the improvement of the technical qualification of health team professionals and a change of attitudes, which must be more adequate to the PHC strategy; an important part of resources has therefore been attributed to continuing education for all health professionals. The second was the acceptance of PHC in essence by the hospitals, which requires a long journey of cultural change; in Portugal, it is now generally accepted that the PHC strategy is very important in reducing the increasing demand for hospital care. Simultaneously with the development of PHC services and their efficiency, cooperation between hospitals and health centres must be intensified through a generalized medical reference system and personal links between professionals of both fields. The third was the integration of the mental structure, both organic and functional, in the PHC system; although organic integration exists only at central level, efforts have been made to change psychiatric hospitals into structures more closely linked to the community level.

2.3 Statement by the WHO representative

Dr Walter Hubrich, Regional Officer for Primary Health Care at the WHO Regional Office for Europe, greeted all the participants and representatives attending the opening session. Dr Hubrich said that the countries of southern Europe have, in a special way, been sensitive to the WHO policies that have taken place within the last year and which are very much in line with the regional policy approved by Member States. This is especially true for the reorientation of health care systems based on PHC. A permanent meeting to discuss development in this part of the Region is a very useful exercise and should be continued.

Dr Hubrich stressed that PHC services, firmly rooted in the community, are in a position to provide appropriate care at the lowest level, close to the people but, of course, of good quality. The local level, being the most decisive for implementing PHC programmes, requires better management and a broad range of skills for promoting intersectoral coordination and sharing resources and management among district-level services. A good baseline of information systems to assist managers and planners, at both national and local levels, is a necessary prerequisite. In this respect, WHO feels that one of its essential tasks is to collaborate with countries in developing information systems that allow the identification and collection of appropriate data for PHC and answer to both community and health service needs as well as measure and monitor the impact of PHC.

On this basis, it is clear that the task of the Forum is to deal with information both for and about PHC.

3. Updating reports on development of PHC in southern European countries

3.1 Greece

Greece is divided into 9 regions and 52 districts. A programme is being developed aimed at the coverage of the population by rural and urban health centres. This programme has been implemented in two phases:

- 186 health centres were planned for rural areas, from which 110 were in operation in 1987 (55 in 1986): a three-year training programme is still in progress for general practitioners in rural areas (during 1987, several general practitioners completed specialization and began work in the health centres); about 800 rural doctors work in the health centres under the conditions approved in 1983 (full-time and exclusive work); the number of nurses is increasing to meet the needs in nursing coverage;
- 123 health centres were planned for urban areas, with 462 peripheral clinics around them: in urban health centres, medical care is provided by doctors whose specialties correspond to the services of the hospital in that zone; in peripheral clinics, medical work is performed by family doctors (general practitioners, paediatricians or other specialists depending on the decision of the Ministry), and in the near future all family doctors will become general practitioners after training.

3.2 Italy

There are three levels of power in health matters: state, region and commune (management of the medical, social and school services by means of

local health units, which are operative instruments). The smallest functional units for the delivery of PHC are the districts, into which local health units are divided. Operative structures are the same all over the country, while the service sector may differ between regions.

The trend in Italy is in favour of implementing PHC, although there is a gap between north and south.

As far as the national level is concerned, there is no national plan, although three plans have been presented to Parliament. The regions of the south have never approved any of them. Ten regions out of 20 have their own health plans.

A great debate is still open on the opportunity of having a full-time doctor as a district health manager or a part-time manager to let him have some hours a day of general practice, so as to keep in contact with people's needs, avoiding the risk of excessive "bureaucratization", etc. There are several pros and cons, such as the time available to carry out both activities and lack of skills in one of the two professional activities.

Some people raised the issue that, for district health team management, there is no need for a medical degree. It should be someone qualified as an administrative officer or coordinator, with a low qualification in understanding and interpreting problems that are scientifically preventive, curative or rehabilitative. This issue is strongly rejected by general practitioners.

Investigations of general practice are being carried out with the objective of analysing morbidity at primary care level and the expressed demand of the users and developing an information system, starting with general practitioners.

*Studies on the reasons for contact with a general practitioner are being carried out with the collaboration of general practitioners on a voluntary basis. A growing concern with this type of study is registered in Veneto Region as an effect of continuing education programmes, which are now self-managed by general practitioners and carried out by continuing education "animators" or tutors who are general practitioners skilled in medical pedagogy. General practitioners self-assess their continuing education needs on the basis of the national collective working agreement of 1987 and implement programmes with active pedagogic methods, with the financial support of the national health service.

There is a development of PHC in Veneto Region in spite of several obstacles to multiprofessional teamwork owing to cultural, methodological and corporative reasons, obstacles that also interfere with integration between medical and social services. There are problems of identity and power and conflicting influences from economic systems that are in support of technology and drug consumption and are not in favour of a preventive and health-promotive approach to community problems.

3.3 Malta

The PHC system in Malta is based on a series of seven health centres or polyclinics: six on the island of Malta and one on the island of Gozo. The island of Malta is divided into three regions, each one served by a major

health centre and a satellite health centre; 41 peripheral clinics or dispensaries (with a doctor and a nurse) are located around the island in every town or village. The island of Gozo has 14 peripheral clinics.

Since the change of the Government about two years ago, there has been an increasing interest in PHC, which has led to the development of health services at this level:

- nutrition policy has been developed;
- there is a statement of intention for health education in connection with other departments;
- a major decision on community participation has been formally approved and implemented;
- the training of general practitioners has begun in collaboration with the Faculty of Toronto in Canada;
- according to the aging of the population, departments for care of the elderly, with social services, have been implemented.

3.4 Portugal

PHC in Portugal (the continental part of the country) is ensured by 335 health centres and 1802 health centre extensions; 148 have small hospital units with a national total of 4294 beds. Health care is provided by 8445 general practitioners, public health doctors and other specialists; 5690 nurses, including public health nurses and other specialized areas; 508 technicians (radiology, laboratory and physiotherapy); 375 sanitary technicians; and 12 459 administrative staff, clinical personnel and other less differentiated workers.

During the past year, much work has been done in the area of improvement and adequacy of the physical structures of health centres; new structures have been built, and health centres have been equipped with the minimum material resources needed to function properly.

Several aspects characterizing the evolution of PHC may be stressed.

First, there has been a more adequate distribution of health professionals, namely general practitioners. Many difficulties have been felt relating to the entering of new nursing professionals into the PHC area.

Second, much effort has been put into continuing education of human resources. The educational activities carried out have given special attention to aspects related to programming, management and public relations. Other educational activities have been areas such as school health education, family planning and maternal and child health, as well as areas related to the common health problems of adults. Still in the continuing education field, special efforts have been put into the development of family medicine. The specific education of general practitioners, including areas, programmes, evaluation and training as educational agents, is regulated by a new law. Specific areas such as the individual, the family, medical intervention in general practice/family medicine, the health centre and the community/society were established by this law.

Third, important efforts have been made to improve information systems, taking into account the implementation of pragmatic methodologies in programming activities for health promotion and maintenance and for health problem-solving.

Some activities have been carried out so as to involve the population, namely through health education.

3.5 Spain

The General Health Law of 1986 established a national health system for the whole country, whose main features are universal and comprehensive care, community participation, participation of services, and decentralized management (area).

The principal health programmes at PHC level are maternal and child health, communicable diseases, immunization, environmental health, the elderly and health education.

Based on new legislation and depending on the resources available, new health centres have been implemented. Until all the country is covered by the new health centres, there is also a traditional model operating in several zones.

In the autonomous region of Andalucia, 68 new health centres have been implemented during 1986, which corresponds to a coverage of 19.5% for the period 1987/1988; 60 health centres are planned to be in operation, which means a coverage of 18.6%. By the end of 1988, therefore, a coverage of 38.1% is expected.

In the autonomous region of Cataluña, there are nine health management areas, not all with a regional hospital.

Up until now, there have been 30 health centres operating according to last year's reform; the plan includes 300 health centres, to be implemented in 10 years (30 per year).

Continuing education of health professionals has been a major concern for both central and regional levels, especially as far as doctors are concerned.

3.6 Yugoslavia

Yugoslavia is participating in this group for the first time.

The health organization structure comprises several levels of responsibility:

- federal: administrative;
- republic: administrative;
- regional: laboratories, investigation, surveillance, etc., and a regional hospital with 15 different specialized types of care (secondary level);

- health centre: a PHC centre and polyclinics and/or a general hospital with surgery, obstetrics, gynaecology and paediatrics (primary and community levels);
- home of health: a sector of the health centre (local level).

The health centre is the basic unit for PHC activities. The principle of territorial coverage and accessibility is applied. In the dispensaries and surgeries of health centres, all services concerning PHC programmes and more specialized services are provided to all patients.

The health care system is regulated by the Republic Act on Health Care, which contains conditions and measures for providing modern and effective health care to the population and for applying the principles of prevention of diseases and promotion of health, based on a uniform territorial distribution of health care units, health professionals, equipment, etc.

Health professionals working at health centres are general practitioners, stomatologists, occupational medical doctors, gynaecologists, obstetricians, paediatricians, radiologists, specialists in internal medicine, nurses, public health nurses, and personnel with an intermediate and high level of education.

The Act also determines the minimum health care (obligatory modes of health care services) that is guaranteed to all people irrespective of socioeconomic status. These activities may be grouped as follows according to the categories of the population:

- health education for both healthy and sick people;
- complete health care for occupational diseases: maternal health (pregnancy, delivery and contraception), children aged 14 years and under, children and adolescents aged up to 26 years if they are regular full-time students, and people aged 65 years and over;
- complete health care in cases of infectious diseases, psychoses, rheumatic fever, diabetes mellitus, malignant neoplasms, endemic nephropathy, haemophilia, and progressive muscular diseases;
- provision of appliances for the prevention of hip dislocation.

Organized health care activities are accomplished at health institutions, which provide:

- permanent monitoring of the health status of individuals and groups;
- effective and high-quality medical care and emergency services;
- identification, follow-up and rehabilitation of people with psychological development problems;
- planning, monitoring and improving the living environment;
- school health.

To achieve the promotion of health, the prevention of diseases and the cure of certain sociopathological situations, and eventually diseases, it is

necessary to keep health personnel in health centres organized, trained and informed about the functioning of society as a whole. Basic education of the lowest social layers is also needed. Therefore, bilateral communication between health institutions and the community itself is maintained so as to attain these objectives and obtain the effective participation of the community.

3.7 General discussion

After presentation of this topic by the participants, it was not clear how the geographical health divisions related to the administrative areas in the different countries. To clarify the situation, an attempt was made to group the different PHC structures of each country according to the size of the population covered and the geographical and administrative level considered. Taking into account the different sizes of the countries involved, the number of inhabitants was not used as a criterion.

The health care provided in the health centres of each country may vary depending on their health systems' organizations and structures (Table 1).

4. Existing information systems for PHC in southern European countries

This subject was introduced by Dr Hubrich, who made general comments on the importance of information as a basis to PHC implementation and development.

To identify people's needs, it is necessary to have a knowledge of what is happening to the patients, the community and the health services. The information needed is related to political decision-making concerning PHC, patient administration and the medical decision-making system. Information and knowledge is needed not only of the patients to be cared for but also of healthy, creative and active individuals and members of the community and society. PHC is not only medical care; it is much more than that.

To improve the quality of care, not only in a technical sense but also in the sense of better coverage, integration, comprehensiveness and continuity of care, instruments are needed to ensure the continuity of information on patients' medical history and the way patients and the people around them live at home, at work and in the community.

A properly organized local information system could become the basis for generating more and more relevant and reliable data to be used for monitoring the health system at national or subnational level. However, the link between the local and national information systems should not be limited to mere transmission of data. Before transmission, local data should be digested in the form of the analysis of local problems and possible solutions.

It is not appropriate to conceive a single minimum data set for PHC, as this will depend on the existing situation in a particular country. The final report on the Kuopio meeting in December 1986 contains a list of data that should be considered as a minimum for PHC (Table 1); supplementary items are also to be seen.

Information to permit examination of coverage and to provide an epidemiological planning base at local level is extremely unlikely to be available unless data collected at local level are population based (for which services are being provided).

Table 1. Health services structure for PHC

Geographical/ administrative level	Greece	Italy	Malta	Spain	Yugoslavia	Portugal
Community	Peripheral station	Health centre districts	Peripheral clinics (or dispensaries)	Home of health	Health centre extension	Health centre extension
	Health centre	Health centre districts	Health centre or polyclinics	Basic health area (or zone)	Health centre	Health centre
Regional	District hospital (administrative board)	Local health units		Health management area	Regional institute for health care	Regional health administrations
	Regional hospital (administrative board)					
Central national	Department of Health	Autonomous region	Department of Health	Autonomous government	Republic institute for health care	Central Department for PHC
		National government	National government	National government	Federal institute for health care	

Health care professionals' requirements for information often differ from those for the community itself. This explains why community participation is important.

Adequate and regular feedback of information must be recognized as an essential incentive for increasing the motivation of local staff for information collection and use.

It is extremely important to stress the difference between data and information. While considerable amounts of data are often available, in many cases they are not transformed into information for use when planning, monitoring and evaluating PHC.

The key factors influencing the effective use of information are its presentation and dissemination. Sufficient resources have to exist to transform data into information and to effectively disseminate it. Appropriate training plays a significant role here.

Local-level staff, who are in the best place to interpret information on local trends, usually do not have sufficient time, motivation or training to use information in this way, and much of the data collected is never used.

An extensive overview of problems in collecting and disseminating information can be seen from the final report of the Kuopio meeting (Tables 2 and 3).

Ending his statement, Dr Hubrich underlined that information for PHC is not a means itself, but a powerful tool to managing PHC better, which is the main purpose of the Forum.

4.1 Greece

Respecting the health policy, the main concern in Greece is to develop or update strategies to attain health for all by the year 2000. To reach this goal, it is necessary to have proper information for continuing monitoring and evaluation of the progress of the strategies chosen; the main problem is to get a list of indicators suitable for needs.

The present regional indicators do not meet all the information needs, especially concerning the satisfaction of needs, efficiency, effectiveness and accessibility of services, lifestyles, health education and environmental health. In fact, very little attention has been paid to evaluation of the usefulness of the existing regional health indicators.

In Greece, the development of the information health system has a very close relationship with the implementation and development of the national health service itself, which started in 1985.

Regarding a defined population, the information available is the number of inhabitants, population by age and sex, socioeconomic status, occupation, income, the utilization and effectiveness of services, epidemiological data concerning health status, mortality rates, incidence and prevalence of selected diseases, and prevalence of health-related behaviour.

In the present situation, the information collected is used for the running of PHC facilities and services rather than for planning and research.

Table 2. Collection of information

	Greece	Italy	Malta	Portugal	Spain	Yugoslavia
How is information collected	Manually. Great involvement of the local staff on the collection of a list of routine data for each patient. Sometimes sample surveys are used to get information on special areas	Data are almost all introduced on the computer system	There is a national computerized system being implemented. A link between the central computer, hospital equipment and the health centre computer is now available	Manual in a routine manner; great involvement of the local staff. Computerized systems are being introduced at regional level; a few experiences for clinical purposes exist at local level. Community health surveys are being used, although not frequently	Some data are collected manually, but the computerized system is more and more in use (Cataluna and Andalucia). On special programmes (diabetes, obstetrics) collected using and on special areas, sample surveys are used	Manually; Great involvement of the local staff in the collection of the data, which is made in a routine manner. Some data are collected using sampling methods
Problems and trends	Considerable amounts of data that are never used or exploited at local level. Local health staff do not have the necessary motivation to collect, analyse and use the information. Lack of data about non-users of the health service, especially the non-active population. The new trend is the computerized system. The training of local health staff are a must to improve their involvement in the collection of data	Many computers are being used and lots of data produced, but a poor set of information is being exploited, analysed or interpreted. Very few people really analyse the data, transforming them into information. Much data is being collected for economic reasons or to answer hospital needs. Health professionals should be trained in the uses of the information	Much data is produced and little information available. Poor motivation of local health professionals to collect data at PHC level. Poor linkage between the different levels of care. Insufficient feedback. A national network of computers shall be equipped to full capacity by the end of 1988	Health workers at local level are not motivated to collect accurate data and to use them. Information from hospitals is not linked with information produced at PHC level. Information produced refers only to the users of health services and is not community based. Delay, incompleteness and lack of quality are common characteristics	Data available refer only to the users of health services; information is not community based. Information on morbidity has to be more health-problem oriented instead of clinical-problem oriented	Lack of quality of the data collected at PHC level. Health workers do not feel responsible for the accuracy of the data. Health workers are overloaded with registries, lists, protocols, reports, etc. Information from hospital services is not linked with PHC information. Local health workers very seldom have feedback from the other levels

Table 3. Dissemination of information

	Greece	Italy	Malta	Portugal	Spain	Yugoslavia
Is information disseminated to the right people but not in a proper and timely manner. The most common way of exchanging information between different levels of the health services is personal contact	Information is disseminated to different levels but is more oriented towards demands and offers than problems. Instead of lists of data, information should be available in a practical and useful manner	Data are disseminated to different services and levels but not always in a proper manner; too much data and little information	Data are disseminated to different services and levels but not always in a proper manner; too much data and little information	Information is disseminated to different levels but not always in a proper and timely manner. The flow of information is routinely established from the local services to the regional and central levels. Information is not disseminated to other services of the same level	Information is disseminated to different levels but not always in a proper and timely manner. The flow of information is routinely established from the local services to other levels is routinely established, but not the upside down flow. Information is available for those who need it but is not in time	Most of the data collected are processed, observed and analysed at all levels. The flow of information from the local services to other levels is routinely established, but not the upside down flow. Information is available for those who need it but is not in time
Problems and trends	Together with the process of development of PHC services, the manpower training and computerizing of the system will improve both the collection and dissemination of information	Too much hospital oriented. Dissemination of information is mostly dictated by economic and political reasons. The training of health professionals will help the use and dissemination of information	In future, there will be a health information unit, assuring linkage between the local, secondary and tertiary levels of care. All information will be on the computer and the different levels will all be linked	Dissemination is very late and very often is not there when necessary. Health professionals at local level should be trained to analyse and use the information available	Because of the overload of health staff at local level, the information flow is always late. Feedback must be improved	
	The administrative board of the district hospital receives reports from health centres and produces a bi-monthly information bulletin to the whole network of health services	Reports on reasons for contact, problems/diagnosis, and occupational status by age, sex and district are produced at central level (region). Reports on services provided and use of services	Reports on the results of the programmes implemented are produced regularly	Reports on the use of services, some health indicators and outcome results are regularly produced	The upper levels produce reports on a regular basis and covering different areas	

This happens because there is an urgent need to establish PHC services in previously "deserted" areas of the country, and the type and volume of the services, so as to reconsider whether the services should be kept.

4.2 Italy

The health information system of PHC has two main sources of data: people's needs and the services offered. People's needs are identified by the analysis of data concerning morbidity: infectious diseases and other diseases, reasons for contact (i.e. the expressed demand of the population) and the medical answers at PHC level (e.g. problems/diagnosis, treatment, prescriptions and referrals to hospital). The international classification of health problems in PHC (Wonca) has been used for this purpose.

Research into general practice is being carried out and aims at analysing morbidity at PHC level and developing an information system, starting with general practitioners. The study with general practitioners on the reasons for contact and problems/diagnosis is maintained on a voluntary basis. Reports are being produced giving data by age, district and site (health centre, home, telephone) and occupational status.

4.3 Malta

Contacts with health centres generate two types of data: clinical notes and administrative data, which are recorded on separate forms and used to compile rudimentary statistics on use of the services. Although the registration of contacts involves many items, including the reason for consultation, there is no routine analysis by any other item but the crude number of contacts, by health centre or clinic, and by region. For example, the percentage of contacts due to repeat prescriptions is not available from routine statistics. Records have to be analysed manually to get this type of information.

There are three selected information systems in PHC already in operation.

First, the national diabetes programme, which began in 1980, with a large sample survey to determine the prevalence of diabetes in the country and to recommend, on the basis of observed patterns, the means of improving health care services for diabetics. At PHC level, continuous individual monitoring is provided at health centres. New diabetics and difficult cases are seen at secondary level, in hospital. A number of beds are available at the acute hospital (tertiary) level. There is also active cooperation with the Diabetes Association, one of the largest self-help groups in Malta. Two record sheets were designed to record data on diabetics, with the intention of integrating the services at two levels of care: the metabolic assessment form, which is filled in at the first visit to diabetes services (usually secondary level), and the diabetes follow-up form, to be filled in at each subsequent visit (primary or secondary level).

Second, the obstetrics programme, which started with a routine survey of all mothers the moment they were discharged from the postnatal ward. Information on a large number of variables related to both mother and child was collected. An extensive computerized data base was developed over a number of years. In January 1987, a set of forms was designed based on the information produced: the initial encounter form, routine antenatal examination, the record for intrapartum examination, and data on an infant's

characteristics. The computerization of data on obstetrics allows for the production of extensive annual reports with detailed statistical analyses of activity and outcome (to be published). Yet the fact that the system covers every birth within the country has provided a valuable data base for research. The extension of this system to PHC level represents an important achievement.

Third, an information system is currently being evaluated. Eighteen forms have been designed for use in general practice. The first one is an initial encounter form asking for demographic and other data. Each one of the rest of the forms corresponds to a chapter of the International Classification of Diseases. At every subsequent contact with the services, doctors are required to enter a specific diagnosis or problem on the forms. Doctors are not satisfied with the system and consider it unwieldy; the data collected are not enough for clinical purposes, but are too extensive for pure administrative purposes owing to the wide range of possible diagnosis.

A programme to set up a decentralized but integrated computerized health information system began in 1984. The first priority was to provide health centres with this service.

The Health Services Information Unit is located in an annexe to St Luke's Hospital, the only acute general hospital in Malta. It contains the central hardware and software that maintain the national system.

The first task was to produce a master index whereby the population was uniquely registered. Each person is referred to by his national identity card number, which is assigned when his birth is registered (e.g. the ID No. 73563 M means that this was the 735th birth registered in Malta in 1963; a suffix G is the equivalent for births in Gozo).

At a second stage, all hospital and health centre files were converted to the ID number, thus automatically linking primary, secondary and tertiary records to a common reference number.

At a third stage, the existing selected separate systems will be linked to the master index on computer. By the second half of 1988, it is planned that six to eight terminals will be installed in each health centre served by a computer. The updating of information will be carried out at central level (demographic data) and local level (medical data). There will be a daily mutual exchange of information between the central and local levels, so that all changes or additions will be introduced within 24 hours.

4.4 Portugal

The daily activities performed at health centres generate large amounts of data concerning morbidity, risk factors, clinical and administrative data, resources, provisions and use, and some demographic data. Only a small part of these data is summarized and communicated to the regional level on appropriate forms, which vary from region to region. Such data allow a rough description of the morbidity and resource consumption profile and of activity in the priority intervention areas, such as maternal and child care, family planning, school health, immunization and prevention of some diseases.

A subset of information collected at local level, pertaining to the whole region, is sent from the regional to the central level, where an aggregation

for the whole country is made. Feedback reports are disseminated to the regional levels two or three times a year. Very few reports are received at local level.

As a sub-product of the accounting system of each regional health administration, data on medical prescriptions, laboratory analyses, X-rays, electrocardiography, electroencephalography, etc., and other procedures are obtained. The analysis of these data is much more oriented towards economic resources. Not all the information produced and available is population based; it concerns the users of health services.

The degree of data exploitation is quite rudimentary at local level. Paradoxically, this is the level where more data are available. An effort must be made to train and motivate health professionals of local health services to use information for management, planning and evaluation. To attain this, health professionals must be trained to improve the quality of the registered data and to transform it into information. However, an increased interest in information and its uses can be found at local health services. The fact that health services at all levels are developing health planning activities has greatly contributed to it. There is a need for information to produce annual health programmes and to evaluate them.

Health centres and regional health administrations are evolving from an ancient centralization of decision-making and know-how to a higher degree of local and regional responsibility. The health information system in use for PHC is based on routinely collected data, which should be used at all levels. An attempt is being made to collect, by sampling methods, data on morbidity, problems/diagnosis, and reasons for contact. Community health surveys are another alternative to be exploited, especially to obtain population-based data.

4.5 Spain (Andalucia and Cataluna)

Routinely collected data concern the following areas:

- use of health services: number of visits, vaccinations, doctors' prescriptions, X-rays, laboratory analyses, etc.; on the basis of these data, indicators are produced and used for planning purposes;
- mortality: cause of death and other items;
- morbidity: there is a well established reporting system on infectious diseases from the local to the central level; feedback reports are produced every three months; reasons for contact and problems/diagnosis are collected at health centres; analyses are made by age, geographical sites, etc.; a special clinical history form was designed and is in use in all PHC services; it is prepared to be used on the computer system.

Experience indicates, however, that morbidity data routinely collected at health centres are not so useful as was thought. Two different approaches are being adopted in this field: specific surveys are conducted every two years, aimed at extracting data from general practitioners' records to give a picture of morbidity at PHC level. The Wonca classification is used for coding.

Selected programme-oriented data is a new way of getting information, trying to identify problems, unmet needs and constraints, and finding the best solutions and answers (e.g. obstetrics and diabetes).

4.6 Yugoslavia

The health information system for PHC is defined by a number of laws and administrative regulations. A special act on health records regulates the extent of obligatory data, which are daily, monthly, quarterly and annually collected at local level and periodically sent to the Regional Institute for Health Care. At this level, the reports from the whole area are aggregated, and a quarterly report is sent to the Republic Institute for Health Care. The reports produced in each republic are then addressed to the Federal Institute for Health Care. At each level, the Institute for Health Care is responsible for the reports, produced on a regular basis, which are disseminated to all health services including the lower levels.

The most important indicators used in the health information system are demographic, socioeconomic, health resources, services provided and health status indicators.

The data and information available at all levels are the same. The difference remains on the aggregation performed.

An important characteristic of the system is that most of the information produced is analysed and used at all levels.

At local level, information is of special importance for the functioning of the basic health care community, which as a rule corresponds to one municipality. The health workers and health beneficiaries of this group establish health plans and programmes and define the circumstances under which health care will be provided.

The planning and programming of health care activities, especially for primary prevention, are established according to the health problem-solving methodology, taking into account analysis of the health status and the needs of the population, the identification of health priorities, and the financial resources available. To achieve this, reliable analysis of the current data is needed.

Another important characteristic of the health information system is that a regular feedback is given to the community itself. Efforts are made to inform and educate all people within the community, especially those belonging to the lowest social strata.

Health care plans, which are part of the social plan, are established from the municipalities to republic and federal levels, with the participation of health care communities and health services.

Besides planning, information is also used to coordinate the activities of PHC, to manage local health services and to carry out some research.

4.7 General discussion: main issues and problems

After presentation of the country reports on health information systems for PHC, the exchange of views and experiences proved that there are problems in common. All the participants agreed that it is difficult to establish what type or set of data must be collected for PHC. Each country has to solve this problem according to its health care structure and organization, the health problems encountered, resources available, and the objectives to be attained.

The amount of data produced at local level is very high and very time consuming; a large part of them are still not analysed owing to lack of expertise, motivation and available time.

The type and quantity of data to be collected must be carefully selected on the basis of the outputs needed. When a computer system is available for gathering and processing purposes (which saves time and work), a lot of attention must be given to the amount of data produced, which normally increases in this situation.

Several countries have developed special programmes based on health problems such as diabetes, obstetrics and hypertension. In these cases, the information collected is selective and more restricted to the problem involved; the quality of data improves and community participation is more easily obtained if the problem is also perceived as such by the population. With those programmes, all levels of health care are linked.

Ad hoc surveys or studies ought to be carried out more frequently as an alternative means of getting data. Small, well planned surveys may give better information, more useful and adequate to the needs and, above all, community based.

An effort must be made to increase the number of people trained to explore, analyse and interpret the data. Too much data are produced, but very few are transformed into information. Also, the presentation of data and information must be carefully prepared, using attractive models to facilitate use and interpretation by health professionals, who may be trained in a simple and practical way.

The power of the financial part of health services influences existing resources to produce data related to economics, whose knowledge is necessary to reduce costs, disregarding PHC. This situation is an obstacle to the development of information for PHC.

5. Information for PHC in a district - selected topics

5.1 Community participation (Yugoslavia)

In Yugoslavia, the Act of Health Care states explicitly that health care is only provided in the health care services organization. The only exception is for stomatological services, for which conditions concerning premises, equipment, records, team qualifications, etc., are very strict. According to this law, the promotion of health and the prevention of diseases are a concern common to all individuals. Preventive activities, regarded as having special social interest, are regulated by law and are developed through labour associations (enterprises), the community (individuals) and the self-management community of interests (SCI).

SCI are composed of the chamber of users (75%) and the chamber of providers (doctors, nurses) (25%), and represent a specific form through which the population and health workers all meet to discuss common interests in the health field. Their objectives are to define health care policy and the working plan, to identify health needs, to choose goals to be attained, and to allocate financial resources using the consensus method. There are SCI at community level (health centre) and regional and republic levels. Each group of 30 SCI has a representative on the next level.

The members of the two chambers are delegates from both sides: health services (e.g. doctors, nurses and hospital workers) and the community (e.g. the population). The organization of SCI is based on eight different areas of activity aimed at prevention:

- health: related to health education; the identification and eradication of social life-related risk factors and the improvement of workers' health conditions, aimed at preventing occupational diseases;
- social care of children: concerning the stimulation and development of health education oriented towards the family and nurseries;
- social care: related to the organization of preventive health care in homes for retired people, orphanages and rest homes for children, providing programmes for their protection;
- education: whose objective is to integrate health education with general educational programmes and to adapt those programmes and sanitary conditions (and others) to the psychological and physical level of children;
- basic community for retirement and disability insurance: allocating finance to improve working and environmental conditions, to prevent occupational diseases and injuries, and to build and equip medical institutions for rehabilitation;
- physical activities and sports: providing premises for sports activities and possibilities for their use in good conditions;
- infrastructure: implementing the use of health criteria and standards when building plans for houses and infrastructures are being drawn up, in close collaboration with specialized medical institutions;
- basic community for scientific affairs: initiating scientific research in the field of preventive health care and provides financial resources for this purpose.

At local level, the Municipal Institute for Health Care plays an important role in implementing and coordinating all these activities. Programmes are proposed to SCI, to be discussed according to local interests.

Information is essential to get both the population and health workers really active and effective. They have to be informed about health status, social conditions, health and financial resources, priorities and guidelines given at higher levels, etc.

5.1.1 General discussion

After presentation of the situation in Yugoslavia, it was clear that the involvement of the community has much to do with the culture and political organization of society itself. In fact, community participation may be formal or informal. The extent to which the community can decide on PHC is also important.

The participation of self-care groups (people with something in common group together to help each other) was stressed. An example was given: last

year, a group decided that a screening on scoliosis was needed in schools, and health services are now collaborating with them.

The role of private groups or associations of diabetics, alcoholics, etc., may be very important and helpful. They may work together with health services, especially in the health education field, with very good results, but they should not be looked on as possible substitutes of the official health services, no matter how important and powerful they are.

In other situations, the law establishes the conditions under which the community participates in health services. However, the lack of tradition, experience and knowledge of health problems does not give the population the necessary motivation to collaborate in a positive way. The more people are educated and informed of the health problems of the community, the better the participation.

5.2 Intersectorality (Malta)

An explicit policy statement does not exist in Malta to give power to intersectoral efforts. Nevertheless, on the Cabinet level, there is important cooperation between the different departments. The following are examples of intersectorality at central level:

- the Ministry of Social Policy, which is an intersectoral administrative structure linking many PHC-related government departments;
- the Health for All Committee, established by the Department of Health, which is composed of representatives from the health services, the social services and the police; its main task is to work out the contribution of each department to health for all, implementing activities to attain the targets and monitoring progress;
- the National Committee for the Handicapped, which combines executive power and some advisory powers;
- the National Committee on Food Nutrition, which was responsible for the First Conference on Nutrition in Malta in 1986; for the first time, nutrient and dietary goals for Malta were set up in quantitative terms, and this was possible because the food and health situation was analysed using routine data sources and special data collection: FAO food balance sheets, diabetes surveys, surveys of the monitoring of trends and determinants in cardiovascular disease project, and demographic data.

Some interrogations are, however, pertinent. Does an administrative structure for intersectoral action exist? In a community-based intervention, has a policy statement been made at a high enough level to give the power for action? What are the structure's duties: to monitor, to act? At local level, intersectorality corresponds to the individual level. Experience in this field shows that some activities may push intersectoral action in PHC:

- special surveys, conducted to define the situation and to help the setting of quantitative targets;

- routine sources of information may be used and are necessary for different personal services; for example, the linkage of the health and social service records to a common reference (identification number) may enhance cooperation between areas or sectors.

5.2.1 General discussion

Intersectoral action is not easy to get unless under certain circumstances. Collaboration between health and social services is common because the fields for action are very close; this happens in many countries. In some places, there are advisory councils that work and make proposals to the governments. Intersectoral action does not exist if there is no power to support it.

Collaboration is more easy to obtain if there are indicators to measure the situation. Information is the best weapon one can use to motivate other sectors to cooperate with health, especially at PHC level. At local level, it is very difficult to get intersectorality, but it can be done without any laws. This is why personal contact is so important and is used in PHC.

5.3 Research (Italy)

Not much has been done on research into PHC. Very few financially supported projects are being carried out in Italy. The most common studies accomplished are related to productivity of services, efficiency, efficacy, effectiveness, etc. The allocation of resources and cost-containment are the main purposes for which those studies are being carried out.

Research means understand better. What do we need to understand better at PHC level?

Research is required into the real needs of the population; people's self-care, the health services offered in terms of availability, adequacy, coverage, and answer to the needs; the development of information systems for PHC; and data collection and analysis.

Too much data is collected at local level, but very little information is produced or is available.

It is essential to define who needs the information, what information is needed, and when and where the information is needed.

Informatics technology and statistical methodology are very useful and necessary to transform data into information, which must be presented in an adequate manner to users. At PHC level, health professionals need ready-to-use information for planning, managing and evaluating services.

Discussions on engineering, equipment, software, instruments, statistics, etc., are useless but rather frequent at this level.

5.3.1 General discussion

It was agreed that all the subjects proposed are important because very little is done in this field, and it was stressed that information ought to be oriented by objectives.

Research is needed into the non-users of PHC, to detect problems and gaps.

Current information available at PHC level and for PHC may be regarded as a "deformation system". In fact, the needs of the people are forgotten, and the needs of professionals are not considered.

Is PHC enough? What are the real needs of information for PHC?

5.4 Manpower training (Greece)

There is an interaction between information and manpower training. Information is needed for the reorientation of health services. To achieve this, training is necessary to change the attitudes of health professionals. In the past, training was medical oriented, dominated by doctors.

The urgent need to train health professionals became obvious soon after the implementation of health centres. Because of the tasks and responsibility of the doctors at health centres, training began with them.

As in many countries, undergraduation is still hospital oriented, so the need to change this situation was evident.

A nucleus of training programmes was created to decide on the programmes to be used and their context.

A health worker exchange between hospitals and health centres was established. Health professionals in health centres go periodically to the hospitals to be trained; hospital doctors go and work at health centres to exchange knowledge and experiences. This training is ongoing, and for the moment results are very good. Information is essential to orient training of personnel. There is a close relationship between community participation, intersectorality and manpower training.

5.4.1 General discussion

During the discussion, it was underlined that information for PHC is required to identify real educational goals and to give physicians and other staff knowledge of PHC issues, which are not covered during university training or basic education.

Many countries have experienced continuous training programmes for PHC workers, namely doctors.

In the Cataluña region, there is great interest in continuous education, so as to change the attitudes of health professionals. In this region, there are nine health management areas, each one identifying needs and bringing them to the Institute for Continuous Education, where planning for training is made, in accordance with health management fields.

There are different levels of training:

- the basic course for PHC: performed to sensitize health professionals to PHC; using active learning methodology and a multidisciplinary approach (nurses and doctors); duration is three weeks (three and a half hours a day); the course is rendered in the afternoon for those working in the morning and vice versa, and is decentralized in the region;

- the teachers' training course, which has been held since 1986 at the Institute for Continuous Education; it is addressed to health professionals working at PHC level (doctors and nurses), and a certificate of the basic course is a prerequisite to attending this training module, which has a length of 33-35 hours;
- there are also small specific training units, oriented towards clinical intervention on special subjects, such as the prevention of chronic diseases; to apply to them, it is necessary to have participated in the other two courses mentioned.

Each year, there is a meeting to evaluate material, documentation and the methodology adopted.

In Italy, each region has a fixed budget for continuous health education. However, there are big differences between regions in the way education is developing.

Every two years, a job profile for task analysis (doctors, nurses and other components of the health team) is made to identify needs for continuous education.

A programme has been ongoing since 1981.

Continuous education for general practitioners is performed by continuous education tutors, who are general practitioners or paediatricians trained in pedagogic methodology.

General practitioners themselves have to find what their needs in education are. According to the law, a self-active learning methodology is used; the themes for training courses are chosen by general practitioners or paediatricians, but hospital training does not teach environmental risks, the tobacco problem, etc.

In Portugal, faculties of medicine still give hospital-oriented training, although there are some signs of change. An effort has been made to give adequate training to general practitioners as members of the health team providing health care at health centres, at PHC level, to improve the quality of health services.

The main areas of the training programme are related to:

- the individual, including health promotion for mothers and children, adolescents and the elderly, family planning, occupational health, mental health, and chronic diseases;
- the family;
- the health centre as the health unit responsible for providing PHC, and the importance of teamwork;
- medical care at this level;
- the community.

There are also continuous training programmes for nurses and social workers, all of them related to PHC.

It was stressed that very little attention is paid to the training of administrative personnel, who should have specific training.

The health information system may also be very useful as a way of linking the elements of the health team.

As stressed before, information for PHC is essential to analyse the task profiles of health workers, which is the basis for training and the improvement of health services.

5.5 Patient handling and care (Portugal)

The existing health information system for PHC concerns mainly the productivity and use of the service. An exercise aimed at establishing a basic information system for planning, evaluation, management and research purposes is being carried out at the health centre of Coimbra.

The main basic features of the system are the involvement of health professionals, the perceptible advantages for the users, and the possibility of easy standardization.

Data are collected using three different sources: administrative, nurse and doctor registries, and general consultations, nursing activities and characteristics of the population.

The information produced periodically concerns morbidity, risk factors (by age and sex), number of users/population in the area, reasons for contact, request for laboratory analyses and other procedures for diagnosis and treatment purposes, and nursing activities. All this information is presented by doctor, health centre extension and health centre. Feedback is sent to each doctor and nurse, health unit and regional health administration.

The registry on immunization gives the coverage of the population and allows the identification of children with an incomplete scheme.

5.5.1 General discussion

This presentation gives rise to some discussion on the uses and advantages of routine data collection versus other means of data registering, especially on morbidity. It became clear that both systems are useful. Although there was agreement that the information on morbidity and reasons for contact are necessary, there were different points of view on the frequency that the information is required and collected.

Wonca has been used in several countries to help the study on expressed morbidity, at family/general practitioner level. Another classification, based also on the International Classification of Diseases and adapted to PHC purposes, has been tested on several sites, under the responsibility of WHO.

It was proposed to use two different classifications (e.g. doctors, general practitioners and paediatricians) to analyse results and bring them to general discussion.

5.6 Conclusion

After discussion of all the topics, there was an open and general discussion on what was needed to overcome the current problems in establishing a proper information system for PHC in Member States. It became clear that the countries are not in the same health service developing stage, so it is difficult to establish a standardized set of information for PHC purposes. However, several basic principles were stated:

- it is necessary to have a clear-cut policy orientation so as to know the functions and decide on information needs;
- the objectives of the needs for information should be stated before starting data collection;
- health centres should be prepared to produce their own information needed at local level;
- problem-oriented information is an alternative way of producing selective but more pertinent information;
- feedback to the community has to be strengthened.

It was proposed that this Forum should be replicated at national level, so as to explain what is going on at different levels and places and to discuss the experiences of various countries.

The participants said that establishing a regional minimum set of data could help Member States and would allow comparability within the Region.

6. Site visits to health centres

Two visits were arranged for the participants, showing two health units where PHC is provided. The first visit was to the health centre of Sete Rios, situated in Lisbon. For the second visit, the participants were taken to the "distrito" of Evora and acquainted with the rural region health centre of Montemor-o-Novo, which beyond other facilities has a small inpatient unit.

7. 1988 forum

Concerning the forum for next year, several proposals were made:

- the theme for discussion should be community participation;
- the number of participants should be enlarged to 20;
- one participant from each country at least should have decision competence;
- the participants should change once in a while to allow better discussion; if they are the same every year, they add too little to the discussion;
- group work could be a good alternative to be adopted;

- the last day of the forum could be spent on analysis of the PHC concept of the host country.

Yugoslavia was the country proposed to host the next forum.

Annex 1

LIST OF PARTICIPANTS

PORTUGAL

- Dr Isabel Maria Jacob Albano
Coimbra Health Centre, Regional Administration of Coimbra
- Mr José Luís Andrade
General Subdirector, Serviço de informática da Saúde, Lisbon
- Dr Teodoro Briz
Lecturer, Escola Nacional de Saúde Pública, Lisbon
- Professor José Lopes Dias
Lecturer, Escola Nacional de Saúde Pública, Lisbon
- Dr Mário Dinis
Centro de Saúde de Sete Rios, Lisbon
- Dr António José Gomes da Silva
General Subdirector, Direcção Geral dos Cuidados de Saúde Primários,
Lisbon (Vice-Chairman)
- Dr José Luís Henriques de Jesus
General Director, Direcção Geral dos Cuidados de Saúde Primários, Lisbon
(Chairman)
- Dr José Ramalho Ilhéu
President, Administração Regional de Saúde de Evora
- Dr José Guilherme Jordao
Instituto de Clínica Geral da Zona Sul, Edifício do Centro de Saúde de
Sete Rios, Lisbon
- Professor António Lobato de Faria
Director, Escola Nacional de Saúde Pública, Lisbon
- Dr Luís Magao
General Director, Departamento de Estudos e Planeamento da Saúde, Lisbon
- Mrs Paula Page
Community Health Nurse, Administração Regional de Saúde de Santarem
- Dr Manuel Pinto
President, Administração Regional de Saúde de Lisboa

^a Participation expenses not paid by WHO.

Mrs Helena Pontes Carreira
Head, Division of Planning and Normalization, Departamento de Estudos e
Planeamento, Lisbon

Dr Joao Silva
Administração Regional de Saúde de Coimbra

TEMPORARY ADVISERS

Dr José Maria Bonet Bertomau
Subdirector Gral de Atención Primaria, Dirección Gral de Atención
Primaria, Servicio Andaluz de Salud, Seville, Spain

Mr C. Dervenis
Member of the Social Medicine Committee, Central Health Council, Athens,
Greece

Dr Amelia Esparteiro Leitao^a
General Directorate of Primary Health Care, Lisbon, Portugal (Rapporteur)

Dr G. Galea
Director, Health Education Unit, Government of the Republic of Malta,
Department of Health, Valletta, Malta

Dr D. Giatras
Member of the Executive Committee, Central Health Council, Athens, Greece

Dr J.M. Martinez-Carretero
Head of Continuing Education, Institute of Health Studies, Barcelona,
Spain

Professor B. Paccagnella^a
Professor of Hygiene and Preventive Medicine, University of Padua, Italy

Dr S. Sadikovic^a
Assistant President, Republican Committee for Health and Social Welfare,
Sarajevo, Yugoslavia

Dr Milica Stefanovic^a
Health Centre "Dr Milutin Ivkovic", Belgrade, Yugoslavia

Dr José Candido Vaz^a
Administração Regional de Saúde de Aveiro, Portugal

WHO REGIONAL OFFICE FOR EUROPE

Dr W. Hubrich
Regional Officer for Primary Health Care (Secretary)

^a Participation expenses not paid by WHO.