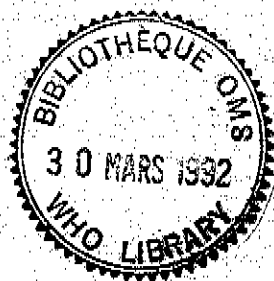


EUR/ICP/PHC 348

THE CONTRIBUTION OF  
FAMILY DOCTORS/  
GENERAL PRACTITIONERS  
TO HEALTH FOR ALL



WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE  
COPENHAGEN

## **TARGET 27**

### **HEALTH SERVICE RESOURCES AND MANAGEMENT**

*By the year 2000, health service systems  
in all Member States should be managed  
cost-effectively, with resources being  
distributed according to need.*

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THE CONTRIBUTION OF  
FAMILY DOCTORS/  
GENERAL PRACTITIONERS  
TO HEALTH FOR ALL

Report on a WHO Working Group

Perugia, Italy  
22 - 25 May 1991

## ABSTRACT

General practice is vital to the achievement of health for all, but is severely underdeveloped in many countries. WHO convened a meeting to define the ideal content of general practice and explore how it can best be developed. General practice needs to become a medical specialty that is taught at undergraduate, postgraduate and continuing medical education levels, and an academic subject for research. Recommendations were made about how academic departments of general practice should be set up or expanded, and what support should be sought from governments, ministries and national and international associations of general practice.

### *Index terms*

PHYSICIANS, FAMILY  
PRIMARY HEALTH CARE  
HEALTH FOR ALL  
EDUCATION, MEDICAL  
EUR  
CCEE

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## Introduction

The Working Group on the Contribution of Family Doctors/General Practitioners to Health for All met in Perugia, Italy, from 22 to 25 May 1991. The Group was convened by the WHO Regional Office for Europe in collaboration with the Research Centre for Health Education of the University of Perugia and the Region of Umbria. The 17 participants and 3 representatives of other organizations are listed in Annex 2. Professor Maria Antonia Modolo of the Research Centre for Health Education, the Dean of the Medical Faculty of the University of Perugia and Professor Giovanni Barro of the Region of Umbria welcomed the participants. Dr Walter Hubrich of the WHO Regional Office opened the meeting on behalf of the Regional Director.

## Purpose of the meeting

The Group was convened to consider general practice and its development at a time when two major factors are influencing current and future changes:

- the establishment of the single market in the countries of the European Community; and
- the major political and socioeconomic changes in the countries of central and eastern Europe.

Although health for all (HFA) continues to be the overall objective, the specific implications of the above changes for general practice, which is an important part of primary health care (PHC) services, need to be clarified in the context of the overall approach to PHC.

General practice has reached different stages of development in different countries, based sometimes on variations in trends and approaches. Bearing this in mind, the ideal content of general practice needs to be identified so that its possible contribution to PHC and HFA can be determined. Naturally, this will depend partly on the structure and composition of the various health services and on their interactions.

In all cases, general practitioners (GPs) require adequate training at undergraduate and postgraduate level and in continuing education; they should also be involved in research. GPs cannot perform their tasks in isolation, since comprehensive and continuous care is fundamental to general practice. Teamwork in PHC and cooperation with other medical, social and related services are thus essential to efficiency.

The aim of the Working Group was to examine new approaches in this area against the background of the changes referred to, and to discuss the action required by WHO, national bodies, GP associations and related bodies to further improve the development of general practice as a whole. This should serve as the starting point for further coordinated action.

## A review of general practice

### Its place within PHC and HFA

In 1977, the Member States of WHO adopted HFA as their main social target, and in 1978 the International Conference on PHC at Alma-Ata agreed that PHC should be the main vehicle for its achievement. PHC implies the universal involvement of the population in determining its own needs and includes four major elements:

- health promotion
- disease prevention
- curative medicine
- rehabilitation.

PHC is an approach and a first level of care. Of all the PHC staff, the GP (or PHC physician) is usually the main element. Curative medicine makes up the main part of the work of general practice, but GPs have great scope to become involved in disease prevention and health promotion. The key is personalized care provided by GPs and their teams.

The paradigm must shift from primary *medical* to primary *health* care. GPs should deal not only with individuals and families, but also with communities, applying the principles of risk assessment to identify

high-risk groups. Whether this actually happens depends on the structure of the system and the method of remuneration.

General practice varies greatly from one country to another, and many central and eastern European countries are now changing from very centrally controlled, rigid systems, to new systems based on sickness funds and insurance schemes. The changes in central and eastern Europe require GPs to take on a greater responsibility. They need a separate identity and this involves the development of general practice as a discipline or specialty, through research and education on the subject. Traditionally, GPs have been trained largely on the hospital model and thus have a limited understanding of the social context of illness, of the effects of environmental factors and of the application of prevention and health promotion. They need a different training, especially at the postgraduate level.

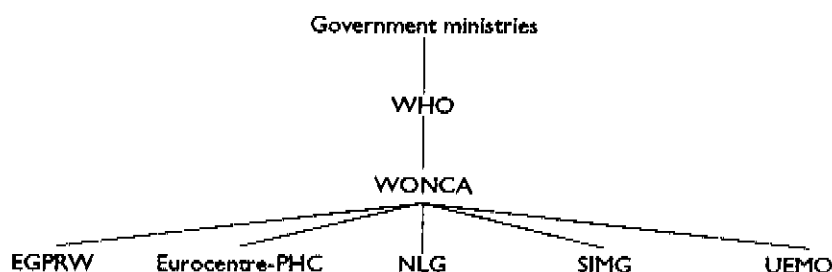
### **The role of international organizations**

The membership of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) includes 40 countries, grouped in three world regions, of which 18 are European. WONCA believes that the GP should be the primary focus for PHC and HFA and is working hard to unite the forces of general practice in Europe through conferences and collaboration with other organizations. WONCA is thus an umbrella organization, working with WHO, the European General Practice Research Workshop (EGPRW), the New Leeuwenhorst Group (NLG), the International Society of General Practice (SIMG), the Union européenne de médecins ordinaires (UEMO) and others.

The emerging model of collaboration between international organizations and liaison with government ministries is illustrated in Fig. 1. The collaboration between WHO and WONCA has already proved itself in a variety of settings because of the advantages of the dual approach (WHO mainly top down from governments/ministries and WONCA bottom up from the national organizations). To assist in the development of a European ethos, papers on all the relevant areas of development within general practice in Europe could usefully be written and disseminated.

Such a structure provides scope for the development of individual areas of interest (including research, consensus-building, education) by special interest groups, all of which can coordinate as a loose federation through the umbrella organization, WONCA.

Fig. 1. International collaboration



Specific initiatives, such as the European centre for research and development in primary health care (Eurocentre-PHC) to be established in Perugia, can provide a pan-European focus for certain aspects of general practice: in this case, it can provide an overview of research and identify resources in terms of funds and people.

### Trends in its development

The development of general practice varies greatly from one country to another, with a tendency for greater development in northern Europe. In the Scandinavian countries, and particularly in Finland, it is highly developed with comprehensive undergraduate and postgraduate facilities and excellent integration with other PHC professionals. In the Netherlands and the United Kingdom, the discipline is strong and developing, with increasing influence on the structure and management of health services in general. Southern Europe has seen a growth in general practice, particularly in Portugal and Spain where vocational training is well established, programmes of continuing medical education are aimed at general practice and undergraduate teaching is being developed. General practice is particularly well developed in Israel,

where conditions for GPs are favourable, and the prospects for the discipline are good. In other southern European countries the situation is less advanced, with little recognition of general practice as a discipline and a lack of undergraduate/postgraduate training.

In central Europe, general practice is firmly established, but the tendency is for it to be less comprehensive than in the north. In countries such as Germany and Switzerland, undergraduate and postgraduate training programmes are not fully established (Switzerland has no university departments of general practice and vocational training is not required). Instead they have a large component of "free practice" (the provision of primary medical care by specialists not trained in general practice).

In central and eastern Europe, including the Soviet Union, health care has traditionally centred more on a rigid centralized structure based on hospitals and polyclinics. This is generally perceived as inefficient and expensive, with inadequate funding for PHC. General practice has developed to differing extents in these countries; in most there is little undergraduate or postgraduate teaching of general practice, although in Yugoslavia, where decentralization is seen as a key feature, both are quite well developed, and Hungary has undergraduate teaching. In Czechoslovakia vocational training is a requirement and the state funds research. With the major political and economic changes that have occurred in central and eastern Europe, considerable pressures appear to be growing to abandon organized PHC models in favour of a free market, and the future role of general practice is unsure.

### **The interface between general practice and other services**

PHC systems, focused on individuals and the community, require the construction of a network of communication in a variety of directions and with different emphasis: either on more traditional issues, such as curative medicine, or on more innovative work in preventive medicine and health education. Before analysing some of the requirements of such a network, at least some of the qualities of the people who act as links at the interfaces must be defined. The first is that they should share the same aims and objectives. The second is that they should have a common cultural basis and share a view about the service they provide.

For example, they should share a common understanding of the role of general practice or PHC in the framework of HFA, in health promotion and in health education. They should understand the changes required to centre services on patients and not on disease, the principles of the continuity of care, the global approach to health and the importance of the community.

Patient care in the PHC setting will need at least two interfaces. First, the interface between the GP and what the patient needs to tackle his/her global health problems, in terms of nursing, social services, nurseries/schools and working conditions. Second, the interface among the services needed for curing and caring for patients, more traditionally described as secondary care (including hospitals and specialist out-patient and inpatient treatment). This interface is important not only for the GP but also for nursing services.

Above all, it is important to make sure that there is continuity of care centred on the individual. The interface should involve the GP, the nurse and the hospital personnel responsible for the treatment, with the GP maintaining primary relations with the patient and his/her family. Hospital staff may become involved in domiciliary care and in this case the interface would be between the GP, the hospital inpatient staff and the hospital domiciliary care staff. In this situation, preserving the continuity of care becomes more complex because of the various agencies involved.

Innovative issues include preventive medicine and health education, where the GP becomes a health agent. In dealing with an ill patient, the GP has to create the interface with the family to help them understand the character of the disease and to maintain the quality of care given to the sick member. In individuals or families at risk, a form of surveillance may have to be set up based on agreed protocols. This will involve promoting contact with families, to maintain a regular review, as well as with the PHC team for additional support (such as the nutritionist for a diet or an optometrist for a visual assessment), and with laboratories and specialists for more detailed clinical assessments.

In health promotion, the interfaces could be between family, schools and workplaces through a system of links with health centres. The objectives may be to collect information on local problems that influence individuals' health, in which case the sharing of information

becomes important for a number of reasons. The GP is in an ideal position to collect epidemiological information and construct a population health profile, and such work has been developed fairly widely through sentinel practice schemes in various countries. The GP and the PHC team are also in a position to apply protocols for community-based prevention programmes and develop health education. They may do this either with individuals, which is particularly suitable for GPs, or with groups, where other PHC professionals may be better suited.

In both cases, interfaces should be built between different PHC professionals, among the various GPs of the district and within the various parts of district health teams. They should also be linked to central epidemiological units capable of handling information on health profiles. Vital, too, is the need to develop the interfaces between these PHC professionals and the secondary health sector.

## Discussion

### **Management and strategies for development**

The philosophy of general practice lies close to the principles outlined at Alma-Ata. Sufficient epidemiological reasons exist to justify the crucial role of general practice as the basis for the health care system. The GP has a vital role as an agent for change and as an advocate for patients within complex health systems, not simply as a gatekeeper.

### *Management principles*

General practice is a developed discipline, and its essential nature and content have been defined (by WONCA and NLG). Nonetheless, the situation is dynamic and each country has the scope to develop a definition of its own in the context of its national health needs and economic/political situation (bearing in mind that general practice is constantly evolving). GPs in each country need to describe and define their contribution to HFA and identify the national potential for increasing that contribution. A national policy for developing general practice to its full potential is also vital, and would include appropriate

incentives to encourage best practice and define the key elements of general practice such as curative medicine, continuity of care, health education and chronic disease management.

Equity can only be achieved if each country has enough GPs and ensures their appropriate distribution. Both teamwork and networks can enhance the quality of care given in general practice. Interprofessional training would introduce GPs to these concepts and facilitate their realization. Group practices and health centres are positive features of general practice in some countries, and are particularly useful in facilitating good teamwork. GPs are in an ideal position to initiate integration within the health services and promote self-help groups.

### *Strategies for development*

Undergraduate education, vocational training and continuing medical education are vital to the development of general practice as a distinct discipline. These forms of education require the establishment and recognition of general practice as an academic subject in its own right. Education and research should take place in university departments of general practice, or failing that, in other institutions that are willing to act as a focal point until academic departments of general practice are set up.

Research needs promoting on all topics of relevance to general practice. These must be identified by each country according to its own needs. GPs themselves have an important part to play in such research, whether they undertake it alone or in collaboration with colleagues in health-related fields. International collaboration is also worth considering.

Professional organizations of GPs need to be strengthened, for they can identify ways of influencing public opinion about general practice through the media, and enhance GPs' potential as health advocates.

Technologies, such as personal computers, can be useful for general practice, in terms of health education, clinical diagnosis and information management. Such appropriate technology should be promoted, while at the same time preserving an appropriate balance that safeguards the doctor-patient relationship.

The development and adoption of quality assurance in general practice should be promoted on a broad basis from the bottom up. This has to be developed country by country, using existing experiences within and outside PHC. Priority has to be focused on the most common noncommunicable diseases or conditions.

### **Effective education and training in general practice**

General practice needs to be held in proper esteem as a discipline in its own right, with its own identity and a clear profile. This will create an appropriate context in which education and training can be performed.

The aim of the curriculum in general practice should be to educate the PHC physician to serve people better and improve their health. Vital general features of general practice that must be taught include the holistic approach and the concept of care as well as cure. Specific features of the GP's role, which should form part of the curriculum, include traditional clinical work, managerial tasks, education and research, and the GP's potential as an agent of change. The coordination of the three training levels (undergraduate education, vocational training and continuing medical education) can ensure the maximum interaction between them.

#### ***Undergraduate education***

General practice needs to be defined as a separate academic discipline. It requires a defined academic base within universities or medical schools, preferably identified as a department of general practice or primary health care.

General practice should be taught by an integrated team of academic and practising GPs. The academic GPs should have training and appropriate qualifications in both teaching and scientific/research methods and hold appropriate university appointments. The non-university-based GPs should combine teaching with regular general practice work. Contact between these two types of teacher needs to be as close as possible and structures should exist to encourage the integration of university teaching with the regular health services.

No particular stage in the undergraduate curriculum is especially suitable for general practice, but wherever possible, teaching should be multidisciplinary by integrating it with other clinical training courses, as is the case in the Department of General Practice at the University of Helsinki.

The curriculum should build on the principles of active learning in the relevant location, with a scientific basis and with early clinical exposure. It should be informed by actual patterns of work in general practice.

Mechanisms to facilitate change in the medical curriculum are needed, and the examples of parallel tracking, as used in Maastricht, Harvard and New Mexico, should be noted.

### ***Vocational training***

Students at this stage are better motivated, but require a clear career structure. Appropriate teachers/trainers need to be identified, as do the mechanisms for ensuring that their teaching and clinical skills are maintained at appropriate levels.

### ***Continuing medical education***

Continuing education should be structured and relevant to everyday general practice. Appropriately trained and adequately paid advisers have a role in continuing education. GPs may require incentives to take part in continuing medical education; these might include financial rewards and/or a contractual requirement to undertake this kind of activity.

Continuing medical education should involve other disciplines as much as possible, through integrated and team-focused teaching. Wherever possible, teaching should be problem-orientated and competency-based.

### **Developing academic general practice**

This section is relevant to all countries with poorly developed general practice, but particularly to the countries of central and eastern Europe.

The establishment of departments of general practice or primary health care in universities, or the strengthening of existing structures, is vital to the development of general practice. Responsibility for funding such initiatives is best left with each country and reliance on outside organizations ought to be avoided. Ministries of health and education and university faculties need to be convinced of the importance of such developments.

Before a new department is developed, the availability of appropriately qualified staff and resources must be ascertained. The first professor is critical to the successful development of the department and requires experience from general practice and academic qualifications, with an ability to organize teaching and research. In many cases, potential candidates may not have all these qualifications and may therefore require further training. Ministries should commit funds for such training, if necessary abroad. (WHO and other international organizations may assist by providing information about the availability of suitable courses.) Training should be in recognized units that provide appropriate degrees and research training.

Where successful teaching and research institutions already exist, they will need further support through the exchange of faculty and students with other universities. Bilateral exchange programmes in scientific research would be facilitated by the provision of government- and WHO-funded fellowships.

Active collaboration between university departments and service providers is vital, but teaching staff must have protected time off from their health service commitments, to allow them to carry out their departmental activities. These field teachers will need further training, facilitated by some system of reward (such as credits), and subject to quality control.

Ministries and the universities should be responsible for ensuring that the development of teaching, postgraduate training and research in general practice is continually evaluated.

### *The role of WHO*

An important aim of WHO is to support countries in restructuring their systems of health care. For this purpose, the Regional Office has

developed Eurocare, a health service project in which PHC development is an integrated element. This will be supported by a small project on general practice, which will aim at developing a charter for general practice in Europe. WHO expects to increase its focus on health services research to help countries develop their health services and policy. It also expects to continue developing its contacts and links with GP organizations such as WONCA, EGPRW and SIMG.

WHO is already involved in the collection and dissemination of examples of good practice, in areas such as prevention and the role of GPs in health promotion, and will visit countries that request assistance with the formulation of policies on general practice. It intends to produce a series of key documents about general practice, and this report will be an important component. The series will include packages for training GPs, produced in conjunction with other Regional Office programmes, as training modules for selected conditions and management areas. WHO will also provide support and advice, especially in undergraduate education and vocational training.

### *The role of international organizations*

A framework for coordinating European initiatives in general practice has been postulated (see Fig. 1). Existing networks need to be built on, within as well as between countries, working on clearly formulated agendas and with defined objectives. These initiatives need coordinating and common projects need promoting within Europe. A potential project is the production of a common medium, such as a journal or a videotape, or perhaps the use of electronic networks to enhance contact among GPs both within and between different countries.

### *Countries of central and eastern Europe*

Although the recent political and economic changes in this area of Europe are resulting in major revisions of the health services, a wealth of positive and important experience exists elsewhere in health care provision and organization, education and training. These countries are likely to need information on the structure and function of academic

departments of general practice and the nature of course materials for undergraduate education, vocational training and continuing medical education. This information should include the basic training elements of general practice, a checklist of GPs' skills and knowledge required for vocational training, the motivation and organization required for continuing medical education, the contents of postgraduate examination with some examples, books and journals on general practice, the content, structure and function of computer software, the means of improving the motivation of GPs, the minimum requirements for equipment, and information on quality assurance systems.

There may be potential for twinning existing academic departments (with established courses, research and related activities) with developing centres to provide continuing contact and support. Such contacts might include colleges of general practice, academic departments of general practice, institutions for primary health care, research and development and quality assurance, and international organizations such as WONCA, SIMG, EGPRW, UEMO.

International meetings will help maintain an exchange of views and funds will be needed to support participation in activities such as the international course in general practice, organized by three departments of general practice in the University of London.

## Conclusions

The main theme of this meeting was the importance of achieving recognition of the GP's key position in primary health care as a health advocate and the crucial role of general practice in the achievement of HFA. The development of general practice as a discipline in its own right and the provision of appropriate structures for education and training at all levels are of fundamental importance. The presentations at the meeting highlighted the particular need of many European countries, particularly in southern, central and eastern Europe, for substantial additional input to achieve this.

1. General practice is the primary element of the health services that will support the achievement of HFA.

2. The GP has a vital role as an agent for change within complex health systems, not only as a gatekeeper but also as a health advocate.
3. General practice is the ideal basis for the health care system in all countries.
4. The establishment of departments of general practice or primary health care in universities (or the strengthening of existing structures) is vital to the development of effective general practice.
5. The recognition of general practice as a distinct discipline, with its own identity and clear profile, is a prerequisite for the achievement of effective education, training and research.

## Recommendations

### **WHO and international organizations**

1. European Member States should be advised to strengthen the implementation of HFA by establishing chairs and departments of general practice or primary health care in countries where there are none and by strengthening existing departments where necessary.
2. WHO should work closely with WONCA and other international organizations in approaching governments, ministries of health and other appropriate agencies to underline and explain the role of general practice as one of the key elements in the health services in the achievement of HFA.
3. WHO should disseminate material on the key issues of general practice, including this report on the development of education, training and research in general practice.
4. With the support of WONCA and the national organizations of general practice, WHO should assist countries to identify the possible contributions of general practice within existing European, national and

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regional strategies of HFA and subsequently publish relevant materials to support such changes.

5. Existing networks of general practice organizations should be improved, within as well as between countries, working on clearly formulated agendas and with defined objectives. Such initiatives should be coordinated, and common projects promoted within Europe.

6. WHO should consider supporting the development of a common medium for general practice, such as a journal, a videotape or an electronic network to enhance contact among GPs both within and between different countries.

### **National associations and organizations**

1. General practitioners in each country should describe and define their contribution to HFA and identify the national potential for increasing that contribution.

2. National organizations in each country should support the adoption of a policy to develop general practice to its full potential, which should include the training of enough GPs and their equitable distribution.

3. Interprofessional training should be promoted, to develop GPs' abilities to work as part of a team and set up networks.

4. Undergraduate education, vocational training and continuing medical education in general practice should be promoted, even where academic departments of general practice have not yet been established.

5. Research should be promoted in all areas of relevance to general practice.

6. Professional organizations of GPs should be strengthened to enable GPs to fulfil their role as health advocates.

7. Research in general practice should be funded and international collaboration promoted.

8. Technologies, such as personal computers, that can be useful for general practice (e.g. personal computers), in terms of health education, clinical diagnosis and information management, should be promoted.
9. The development and adoption of quality assurance in general practice should be promoted on a broad basis from the bottom up.

### **Academic departments of general practice**

1. Wherever possible, undergraduate education, vocational training and continuing medical education should be coordinated to ensure the maximum interaction between these different levels of education/training.
2. General practice should be taught by an integrated team of academic GPs, with training and qualifications in both teaching and scientific/research methods, and practising GPs who continue to work in general practice.
3. Wherever possible, teaching in general practice should be multidisciplinary, by integrating it with other clinical training courses.
4. Continuing medical education should be structured and relevant to everyday general practice.
5. GPs should be offered incentives to take part in continuing medical education. These might include financial rewards and/or a contractual requirement to undertake this kind of activity.
6. Departments of general practice or primary health care should be established in universities. If such structures already exist, they should be strengthened.
7. The development of a new department of general practice should depend on the availability of appropriately qualified staff or potential professional candidates and teaching staff and adequate resources.

8. Further appropriate training should be provided for potential candidates, abroad if necessary.
9. Bilateral exchange programmes in scientific research should be facilitated by the provision of government- and WHO-funded fellowships.
10. Resources should be made available and legislation drawn up to ensure that teaching staff have protected time off from their health service commitments, to allow them to carry out their departmental activities.
11. These practising teachers should have further training, facilitated by some system of reward (such as credits), which should be subject to quality control.
12. Ministries and universities should be responsible for ensuring that the development of teaching, postgraduate training and research in general practice is continually evaluated.

*Annex 1***BACKGROUND DOCUMENTS**

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- From Alma-Ata 1978 to Barcelona 1990, by G. Almagor. *Atención primaria*, 7(11): 691 - 693 (1990).

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