DEVELOPMENT OF GENERAL PRACTICE IN THE COUNTRIES OF CENTRAL AND EASTERN EUROPE

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE
COPENHAGEN

TARGET 28

PRIMARY HEALTH CARE

By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.

41852

EUR/ICP/PHC 352
ORIGINAL: ENGLISH

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Report on a WHO Working Group

Benesov, Czechoslovakia
22–25 April 1992

1992

EUR/HFA target 28

ABSTRACT

General practice, as a key element of primary health care, is recognized as having a vital role to play in the achievement of health for all. But it does not yet have equal status with other medical specialties. A WHO Working Group met to evaluate the current stage of development of general practice, particularly in the countries of central and eastern Europe. They defined the role and profile of the general practitioner, and identified the changes necessary in qualifications and training as well as in the financing, structure and organization of general practice to produce such a health professional. They also recommended that academic and international bodies in western Europe should share their experience in the development of general practice with the countries of central and eastern Europe, to help build on the changes that are already taking place there.

Keywords

PRIMARY HEALTH CARE
FAMILY PRACTICE – organization/administration
FAMILY PRACTICE – education
PHYSICIANS, FAMILY
PHYSICIAN'S ROLE
CCEE

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Purpose

The purpose of this Working Group was to evaluate the current stage of development of general practice and its local equivalents in the different countries of Europe, with special reference to the situations in the countries of central and eastern Europe (CCEE). On the basis of this evaluation, the Group was asked to clarify the potential role and tasks of the general practitioner (GP) in these countries, discuss possible developments and ways of achieving them and make recommendations about the further development of general practice in the CCEE. These recommendations should be formulated so as to guide various activities in general practice in selected countries and serve as entry points for intensified international cooperation on this issue.

Participants

A full list of participants is provided in Annex 1. It was appropriate, in the light of the purpose of this meeting, that most of the participants should be drawn from the CCEE, including the host country Czechoslovakia. In addition to this core group, participants came from Austria, Denmark, Finland, Netherlands, Portugal and the United Kingdom. Two of these also represented international organizations for the development of general practice, the European Union of General Practitioners (UEMO) and the International Society of General Practice (SIMG). Dr Vaclav Benes of the host country was elected Chairperson of the meeting and Professor Zelimir Jaksic was elected Vice-Chairperson. Dr David Wilkin was the Rapporteur.

Background

Following a welcome by a representative from the Czech Ministry of Health, the meeting was opened by Dr Walter Hubrich on behalf of the WHO Regional Director for Europe, Dr Jo Asvall. The general trends in the CCEE towards democratization, the development of market economies, the redefinition of economic and national boundaries

and population movements are radically changing the environment of health care systems and the imperatives they face. The reform of health care systems to respond to these challenges has become an important policy question. European health care systems face some common issues and WHO proposes a strategic role for primary health care. General practice is already widely seen as the major element of primary health care, particularly in its role in the treatment of illness, but its work needs to be extended to cover disease prevention, health promotion and the provision of psychosocial support. General practitioners working as part of the primary health care team have a vital role to play in the realization of health for all but, if they are to fulfil this role in many of the CCEE, changes must be made to the financing, structure and organization of services. Such changes will be possible only if major developments also take place in education and training.

The European Union of General Practitioners offers a model of family practice that could be appropriate for all European countries. Despite the economic, social and political changes taking place in all European countries, but particularly the CCEE, family medicine provides an appropriate model for the development of the medical component of primary health care in all countries, since the family is and will remain the basic unit of social structure.

Changes in General Practice/Primary Health Care in the CCEE

The Working Group discussions were facilitated by a series of brief reviews of the current situation and the prospects for each of the countries represented at the meeting. While these reviews illustrated some of the differences in organization and development of primary health care services in different countries, they also emphasized many of the important similarities. First, and most important, all of the CCEE are moving away from systems with a high degree of medical specialization, even at the primary care level, and developing some form of general medical practice/family medicine as the core of the primary health care system. Second, all are considering replacing the

state financing of health care with various forms of insurance funding. Third, all countries now permit some form of private practice, which is expected to increase the incomes of doctors. Fourth, in all of the CCEE, these changes to the health care systems are taking place in the context of serious economic problems and varying degrees of political instability. The individual country reviews provided the basis for an agenda for sub-group discussions. The sub-groups considered the role of general practice in primary health care in the CCEE under three broad headings.

Under the first heading, the profile and tasks of the GP, questions to be addressed included: To what extent is a common definition of the role of the GP appropriate to all these countries? What should be the relationship between GPs and specialists? How far do existing doctors perform the role of a GP and what changes may be necessary?

Under the second heading, education and training for general practice, questions included: What changes are needed to the system of undergraduate medical education and postgraduate training? What should be the key features of retraining programmes for doctors wishing to become GPs and what systems of continuing education are required? What conditions need to be met to bring about changes in the system of medical education?

Under the third heading, structural and organizational conditions for the development of general practice, questions included: What are the main options for the financing of general practice and the payment of GPs, and what are the likely consequences of different systems? What methods of organizing primary health care services are most conducive to the development of general practice? How might quality assurance systems be developed? What is the role of professional organizations?

Discussion

Profile and tasks of the GP

Although countries' circumstances differ greatly, the participants agreed on the principal components of the GP's role. The definition drawn up by the Leeuwenhorst Group provides a succinct account of these.

> The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population irrespective of age, sex and illness. It is the synthesis of these functions which is unique.
>
> He will attend his patients in the consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in cooperation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community.

The Group did not see this as the only suitable definition, and recognized the alternative produced by the European Union of General Practitioners as also providing a suitable framework. Clearly, in the current situation of many countries, the ideals contained in these definitions will not be achieved in the short term. Nevertheless, they provide a model that should guide policy, organization, structure and education. Existing definitions perhaps give insufficient emphasis to the role of the GP as a member of the primary health care team and to the importance of prevention, health education and health promotion.

One of the fundamental problems facing the CCEE is that the development of the sort of GP role outlined above will require a very substantial shift from relatively high levels of specialization. Even where generalists exist, they are often performing very limited functions with high rates of referral to specialists, sometimes over 50%. Further, certain categories of specialist (such as paediatricians and gynaecologists) are functioning as primary care generalists for particular patient groups. There was considerable discussion about whether such specialists could be seen as GPs. The consensus was that during

a necessarily extended transitional period in which true general practice can develop, local circumstances will produce a variety of transitional roles, that may include the continued functioning of such specialists in a quasi-GP role. This should very clearly be recognized as a transitional phase, however, rather than an acceptable permanent solution. Nevertheless, in some countries, these specialists are likely to wish to retrain as GPs in the future.

A licence to practise as a GP will have to be established based on competence derived from appropriate education and training (see below). Transitional arrangements may require that, in the short term, existing doctors be allowed to enter general practice without formal training or qualification. This should be very clearly limited, however, in terms of which categories of doctor will be allowed to enter without formal training and over what time period. Beyond this period, all entrants to general practice must possess a qualification and licence to practise as GPs. Without such licensing arrangements, quality standards will be extremely difficult to maintain and patients will very probably lack confidence in GPs.

As well as large variations between countries in the current role and profiles of primary care doctors, wide variations also exist within countries. In particular, urban and rural areas often differ enormously. In rural areas, doctors often already function in a GP role, although they often lack appropriate training and the structural and organizational conditions to be able to fulfil this role effectively.

Existing generalists in primary care are often unable to diagnose and treat more than a small proportion of the problems presented to them. Not only is this a very inefficient use of resources, but it also has negative consequences for their professional morale. Future GPs should aim to diagnose and treat up to 90% of the problems presented without recourse to specialist intervention, although the achievement of this target will depend on many factors and will only be achieved as adequately trained GPs enter practice. The field of mental illness may raise particular problems, as in some countries it is perceived to be outside the competence of primary care physicians. Future GPs must nevertheless be able to deal with minor psychiatric disorders.

For GPs to be able to manage a high proportion of presenting problems, the relationships between GPs and specialists will have to

be defined. While patient access to specialists should ideally require referral by a GP, the implementation of such a gatekeeper role will encounter many obstacles. Not the least of these is patients' expectations of the right to consult a doctor of their choice. The right to choose is clearly closely associated with the political and economic changes taking place in the CCEE. For this reason, the gatekeeper role of GPs can only develop successfully on the basis of patients' confidence in their GP to refer appropriately; it may fail if it is seen as an administrative restriction on patients' right to choose.

Primary medical care necessarily has some administrative functions, particularly in the field of legitimizing absence from work due to sickness. The GP, as the doctor who knows the patient best, should continue to fulfil this role, but it should be undertaken in the best interests of the patient rather than as an administrative function for the state. In many countries at present, the administrative regulations for absence from work due to sickness, whereby medical certification is necessary for any absence, require unnecessary consultations for minor self-limiting conditions. As well as being inefficient, this does nothing to enhance the role and status of doctors working in primary medical care.

GPs' work as part of a primary health care team is very important, as is the role of nurses. Although large numbers of nurses work in primary care, their present roles are usually very restricted. The roles and competencies of all members of the primary care team should be extended if GPs are to function as part of a team.

Professional organizations have an important part to play in the development of general practice. While such organizations already exist in some of the CCEE, they are small. For the specialty of general practice to achieve widespread recognition both within and outside the profession, strong independent professional associations will be vital.

Education and training

Changes in the educational and training systems will be fundamental to the future development of general practice. At present in all of the CCEE, general practice is not widely recognized as a specialty and is therefore not taught either in the undergraduate curriculum or at the

level of postgraduate training. For the specialty to flourish, it must achieve recognition at all levels of education and training. This will require the establishment of departments of general practice in medical schools. The growth of such academic departments in western European countries has taken two or three decades to reach its present level, however, and in some countries such departments are still the exception. The rapid developments necessary in the CCEE require an academic base to be established in a very short period of time. Ministries of health and education will have to collaborate with each other and with the profession to make resources available for the creation of academic departments of general practice. More importantly, a first generation of teachers of general practice will have to be recruited and trained in a very short time. This is only likely to be achieved through collaboration with western European countries, where established departments can offer immediate academic training in the specialty and assistance with the development of both undergraduate and postgraduate curricula. A variety of international courses already exists and some departments are collaborating to establish short courses designed specifically to train the first generation of educators and trainers. The alternative to seeking the assistance of academic general practice in other countries is for other specialties to take a leading role in the development of GP training. This is undesirable, however, since the principle should be established from the outset that the education and training of GPs should be in the hands of GPs and should not be subordinate to other specialties.

Once established, the system of postgraduate education and training in general practice should be the only means of entry to the specialty. Just as in other specialties, however, the process of education should continue throughout a GP's career. Effective continuing education will be particularly important in the CCEE, because many of the first wave of entrants to the specialty will not have completed vocational training in general practice. A system of continuing education will thus have to ensure that they have the opportunities to develop further their knowledge and skills. Once again, many of the countries of western Europe have considerable expertise in providing continuing education that will be of assistance to the CCEE in designing systems to meet their particular needs.

Although the focus of this meeting was on the developing role of general practice in the CCEE, the Group recognized the importance of developing equivalent training programmes for other members of the primary health care team, particularly nurses, and for the training of GPs in the skills necessary to take part in a multidisciplinary primary care team.

Both the content of GP education and its stature in relation to other specialties will depend on its acquiring a strong research base. While only a small proportion of GPs will actually be engaged in research, it is an essential feature of a strong specialty. Clinical, educational and health services research should contribute to the content of education and training as well as providing the basis for health policy and practice. This will require inputs from other disciplines, such as social sciences and epidemiology, as well as general practice itself.

Finance, structure and organization

The development of general practice, its role in primary health care and its position in the health care system as a whole will be strongly influenced by the major changes in financing, structure and organization of health care currently taking place in all the CCEE. General practice will not be isolated either from the wider political, economic and social changes occurring in all these countries. The economic and political imperatives to move towards the introduction of market mechanisms and to remove responsibility for health care from the state have important consequences for the organization of primary health care and the development of general practice. The need to seek low-cost options in the development of health care is in potential conflict with the need to introduce market forces, which will inevitably push costs upwards. Whatever political choices are made about the financing and organization of health care, they should be made in the context of an overall health policy that includes a clear role for general practice.

The choice of method to finance and pay for doctors is sometimes seen as a simple dichotomy between the public (i.e. state) and private domains, with a strong political pressure to privatize existing state systems. The choices available are actually much more complex than

this and methods of funding should be separated from methods of payment. Each western European country has different systems of financing and payment. In most cases, health care is financed from a variety of sources including insurance, taxation and direct payments by patients. Similarly, the payment of GPs includes elements of salary, capitation and fees for items of service. The CCEE would do well to look closely at the range of different approaches and the mix of different elements in western Europe before making decisions about the most appropriate mix for their particular situation. The most appropriate mix will probably be different in each country, with none of the western European systems providing an exact model that can be adopted.

Each country will develop its own particular solutions to the problems of financing health care and creating new payment systems. Most governments are considering the introduction of insurance-based systems of financing and permitting private medical practice. This tends to create the potential for a mixed system that allows private practice to flourish alongside a more basic level of statutory provision. For the motivation of doctors and the quality of service provided, a substantial increase in the remuneration of doctors entering general practice is important. This almost certainly means a move away from salaries as the principal method of payment, but it should be noted that systems based on a fee for an item of service are likely to be costly and make it difficult to influence the quantity and quality of care provided. Capitation systems in which GPs are paid a fixed sum for each registered patient are better able to control costs and encourage continuity of care and teamwork. Varying combinations of capitation and fees for items of service might be the best option for most countries, since this recognizes the need to create direct incentives for GPs while controlling costs.

Patients' freedom to choose their providers of medical care is essential to create competition and improve quality as well as being politically imperative. This need not be absolute freedom, however, and patients may have to accept restrictions on their freedom to consult specialists. Where capitation payment systems are introduced, choice is inevitably restricted since patients must remain with the same GP for a defined period. Nevertheless, a substantial element of patient choice can

be retained in such systems. As to the freedom of GPs to choose their patients, some participants felt that GPs should have the right to refuse patients, while others argued that this would be inappropriate.

In most of the CCEE, primary medical care is provided through the polyclinic or health centre, particularly in urban areas. Where these serve populations as large as 100 000 or even 200 000, they are probably too large to be conducive to the development of good general practice. Emphasis should be placed on developing small-scale group practices of two to four GPs, which are local in character. This will facilitate multidisciplinary teamwork. A danger in some countries, however, is that the moves towards private practice will encourage many doctors into single-handed practice with poor facilities and inadequate primary health care teams.

Systems to ensure quality of care are needed, although there will be a variety of ways of achieving this. The emphasis on finance and the introduction of market mechanisms should not detract from the overall objectives of the health care system to protect and enhance the health of the population. Quality assurance should be based on patient outcomes wherever possible and information systems, including the use of computers, should be created at the primary care level so the data generated permit the monitoring of care. GPs can play an important part in setting and achieving population health targets and should be encouraged to do so through financial incentives.

Conclusions and Recommendations

Role and profile of the GP

1. General practice and the GP, as defined in the Leeuwenhorst statement and other similar statements, should play a key role in the provision of primary health care in all European countries. WHO should make a clear commitment to this role by preparing and promulgating a charter for general practice, with the support of governments and professional organizations.

2. The precise role of the GP will vary depending on historical factors and the particular demographic, economic and social circumstances prevailing in each country.

3. The GP should be able to provide first contact medical care for most presenting health problems without recourse to specialist intervention. Nevertheless, GPs and specialists need to develop effective communication and collaboration.

4. Where specialist intervention is necessary, it should ideally be provided through referral by the GP, rather than by direct patient access to specialists. This is in the interests of controlling expenditure on health care, but the success of the GPs' adoption of such a gatekeeper role will depend on patients' confidence in their GP.

5. The effectiveness and efficiency of general practice will be maximized only through GPs' participation in the primary health care team. In particular, GPs must work closely with nurses. In many of the countries of central and eastern Europe, however, this will require the redefinition of the existing roles of nurses working in primary and community care.

6. The GP, in collaboration with other members of the primary health care team, should provide preventive care and health promotion in those areas where the effectiveness of interventions has been clearly demonstrated.

7. The GP's administrative role in the certification of absence from work due to sickness should be limited, so as to exclude a large proportion of short-term minor self-limiting conditions in which medical care has no significant part to play.

8. All countries of central and eastern Europe have some doctors who are practising as GPs, particularly in rural areas. They have widely varying levels of competence, however. A variety of specialists (such as paediatricians and gynaecologists) also practise in ambulatory care settings as generalists.

9. Future GPs are likely to be recruited from a variety of sources, including existing generalists, specialists currently practising in ambulatory care settings and newly trained general practitioners.

Qualifications and training

10. All GPs, whatever their previous background or specialty, should in due course hold a licence to practise as GPs, based on a common

examination of competence in the speciality. Governments should ensure that the legislative framework of health care requires such a licence. Professional organizations should seek to ensure that all practising GPs are licensed to do so.

11. All countries should have a system of postgraduate training for general practice which will, in due course, constitute the only means of entry to the specialty. Professional organizations should play a major role in establishing and developing such systems of postgraduate vocational training.

12. All countries should have strong systems of continuing education that will meet the needs of GPs to develop and update their professional knowledge and skills throughout their careers. Professional organizations should play a major role in establishing and developing such systems.

13. Professional organizations should encourage general practice to be taught as an important part of the undergraduate education of all doctors. All branches of the medical profession should recognize general practice as an independent specialty, with equivalent status and rights to other medical specialties.

14. As well as vocational training, training will have to be provided in research methods.

15. Education and training in general practice at whatever level should be controlled and provided mainly by specialists in general practice, although supported by a variety of other disciplines.

16. Ministries of health will need to work in close collaboration with ministries of education, professional organizations and educational institutions to introduce the changes to undergraduate and postgraduate education and training that will be necessary to produce sufficient numbers of appropriately trained GPs. International collaboration should also be sought in the development of education and training for general practice.

17. The development of high standards in education and training will require that these systems are formally constituted and are the clear responsibility of an appropriate body that will also be responsible for setting and maintaining standards.

Finance, structure and organization

18. The appropriate financing, structure and organization of general practice will vary from one country to another. Nevertheless, all systems should be compatible with providing all patients with equal access to high quality primary medical care whenever needed, and ensuring them the maximum opportunity to choose their own GP freely and to change from one GP to another.

19. In the light of the economic circumstances of the countries of central and eastern Europe, the method of funding and payment of GPs should take into account its likely effect on health care costs, and therefore the ability of the economy to sustain high quality health care for the whole population.

20. A mixed system of capitation payments, fees for items of service and incentive payments is likely to provide the most cost-effective payment system for GPs.

21. While the methods of funding and payment of GPs will vary from one country to another, governments should seek to ensure that the systems chosen provide not only adequate control of costs, but also the ability to influence the content and quality of care, and adequate motivation for doctors to enter the specialty.

22. Incentive payments (such as for the provision of particular services, for particular types of organization, or for extra training) should play an important part in encouraging the desired characteristics and activities.

23. A substantial increase in GPs' present levels of remuneration will be required to attract the best doctors, to increase motivation and to enhance the status of GPs, both in medicine and in the community at large. Such an increase in remuneration should, however, be tied to clear quality standards and improvements in the service provided.

24. While organizational forms will necessarily vary, both between countries and within countries (such as between urban and rural areas), localized provision should be encouraged to ensure that patients do not have to travel far to receive appropriate care.

25. GPs should be encouraged to practise in association with other GPs (for example, three or four doctors working in partnership) and

in association with other professionals, rather than as single practitioners working in isolation.

26. The unit of management should be relatively small scale and should encourage the maximum involvement of the professionals providing health care.

Quality assurance and health outcomes

27. All countries must develop systems of quality assurance capable of ensuring high standards of care based on the outcomes for patients. Professional organizations should make a public commitment to quality assurance. International collaboration should be sought in the development of such systems of quality assurance.

28. Specific attention should be paid to establishing data collection on health outcomes in general practice for the purposes of improving clinical practice and undertaking research. Such data should be accessible and useful to GPs in their clinical practice and in medical audit.

29. All governments should prepare strategies for health gain, based on thorough analyses of existing health problems and methods of achieving improvements in the health of their populations. These strategies should include clear, measurable targets that are achievable over defined time periods. The specialty of general practice will have an important part to play in both setting and achieving these targets.

Institutionalization of general practice

30. Ministries of health should be encouraged to produce a clear policy statement on the role of general practice in their own health care systems, stressing the importance of a strong specialty of general practice and their commitment to its development.

31. Strong professional associations of GPs can play an important role in the development of the specialty, but these associations should be separate from trade unions.

32. The status of general practice as a medical specialty will require the establishment of university departments of general practice and the creation of professors, developments that should be encouraged by professional organizations.

33. Research in general practice will play a key role in enhancing the effectiveness and efficiency of the care provided, as well as enhancing the standing of the discipline alongside other medical specialties. This research should involve GPs.

34. Through its network of international advisers, WHO should offer advice and support to those countries that are attempting to develop or strengthen general practice. This might best be done through the setting up of permanent expert teams that can provide continuing support to countries over extended periods.

35. WHO can fulfil a valuable role in liaising with a variety of international bodies (such as the European Community, the World Bank and GP organizations) that might provide support for the development of general practice in the countries of central and eastern Europe.

Transitional arrangements

36. In all countries of central and eastern Europe, a medium- to long-term strategy will have to developed to achieve the changes outlined in this report. This will require a transitional period during which elements of the old and new systems function alongside each other. Ministries of health should prepare detailed transitional plans indicating what changes are to be implemented and over what time period. These plans should include temporary arrangements that may be necessary to allow sufficient time for changes in education, training, structure and organization to be effected.

37. High priority should be given to the development of training for those GPs who will be responsible for developing undergraduate and vocational training programmes in general practice.

38. Retraining programmes will be necessary for an interim period during which existing doctors can opt to retrain for general practice. These will need to be tailored to the needs of particular categories of doctor (such as existing generalists, paediatricians or gynaecologists).

39. Use will often have to be made of existing accommodation and facilities (such as polyclinics and health centres) even though they are not ideal. Nevertheless, they represent a considerable capital asset to the health care system. Ways should be sought of making the best

possible use of existing premises and facilities as part of a transitional plan.

40. During a transitional period, a mixed system may be desirable in which both GPs and specialists continue to practise in ambulatory care settings. In such circumstances, patients should probably continue to have direct access to specialists. As specialists move out of ambulatory care settings, access to them might be restricted to referral by GPs.

Annex 1

PARTICIPANTS

Temporary Advisers

Dr Vaclav Benes
Institute for Postgraduate Training of Physicians and Pharmacists, Department of General Medicine, Prague, Czechoslovakia (*Chairperson*)

Dr Wienke Boerma
Netherlands Institute of Primary Health Care (NIVEL), WHO Collaborating Centre for Primary Health Care, Utrecht, Netherlands

Dr Uldis Brouveris
Ministry of Welfare of the Republic of Latvia, Riga, Latvia

Dr Istvan Hidas
General Secretary, Hungarian Association of General Practitioners, Pilisvörösvar, Hungary

Dr Dimitar Ignatov
President, Bulgarian Physicians' Association, Sofia, Bulgaria

Professor Zelimir Jaksic
Director, WHO Collaborating Centre for Primary Health Care, Andrija Štampar School of Public Health, Zagreb, Croatia (*Vice-Chairperson*)

Professor Pertti Kekki
Head, Department of General Practice and Primary Health Care, University of Helsinki, Finland

Dr Margus Lember
Research Fellow and Lecturer in Internal Medicine, University of Tartu, Estonia

Dr E. V. Markova
Senior Researcher, National Centre for Preventive Medicine, Moscow, Russian Federation

Dr Robertas Petkevicius
Head, Department for Health Strategy and Policy, Ministry of Health of the Republic of Lithuania, Vilnius, Lithuania

Dr Jacek Putz
Senior Lecturer, Head, Department of Primary Health Care, Medical Centre of Postgraduate Education, Warsaw, Poland

Dr Vitor Ramos
Lecturer, Department of Public Health Administration, National School of Public Health, WHO Collaborating Centre for Primary Health Care Lisbon, Portugal

Ms Majda Slajmer-Japelj
International Manager, WHO Collaborating Centre for Primary Health Care Nursing, Health Centre of Maribor, Slovenia

Dr Cristian Stefan
General Practitioner/Paediatrician, Bucharest, Romania

Dr Milica Stefanovic
Dr M. Ivkovic Centre of Primary Health Care, Belgrade, Yugoslavia

Dr Libuse Valkova
Institute for Postgraduate Training of Physicians and Pharmacists, Prague, Czechoslovakia

Dr David Wilkin
Associate Director, Centre for Primary Care Research, Department of General Practice, University of Manchester, United Kingdom (*Rapporteur*)

Representatives of Other Organizations

International Society of General Practice (SIMG)
Dr Gertraud Rothe
Vienna, Austria

European Union of General Practitioners (UEMO)
Dr Ole Asbjørn Jensen
President, European Union of General Practitioners (UEMO), Danish Medical Association, Copenhagen, Denmark

World Health Organization

Regional Office for Europe
Dr Walter Hubrich
Regional Adviser for Primary Health Care