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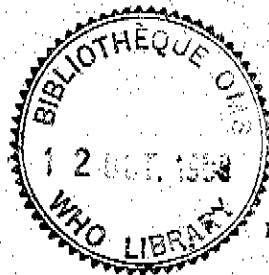
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DISTRICT HEALTH SYSTEMS IN ACTION - TEN YEARS AFTER
ALMA-ATA - EXPERIENCES AND FUTURE DIRECTIONS

Report on a WHO Workshop

Neubrandenburg, German Democratic Republic

5-9 December 1988



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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 - trends

DELIVERY OF HEALTH CARE

HEALTH FOR ALL

EUR

GERMAN DEMOCRATIC REPUBLIC

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Introduction

The Workshop met in Göhren-Lebbin, Neubrandenburg, in the German Democratic Republic from 5 to 9 December 1988. The meeting was hosted by the Ministry of Public Health of the German Democratic Republic and the Neubrandenburg County Council and organized jointly by the Institute of Social Hygiene and Organization of Health Services (a WHO collaborating centre) and the WHO Regional Office for Europe.

The main objectives of the meeting were:

- to review the development of primary health care in the European Region since the Alma-Ata Conference in 1978;
- to clarify the concept of district health systems as a vehicle for health for all;
- to exchange experiences from the different health care systems in the European Region; and
- to identify the main areas and issues within the district approach that Member States and WHO should focus on in future.

The meeting was opened by Dr Dieter Moewius, County Medical Officer of the Council of Neubrandenburg, Professor Rudolf Müller, Vice-Minister at the Ministry of Public Health of the German Democratic Republic, and Professor Otto Weiss, Director of the Institute of Social Hygiene and Organization of Health Services. Dr Walter Hubrich, Regional Officer for Primary Health Care from the WHO Regional Office for Europe, conveyed the greetings of the Regional Director to the meeting and outlined its scope and purpose.

Discussion

The development of primary health care in the European Region

The meeting was the first to be devoted exclusively to district health systems in the European Region. Member States have accepted primary health care as the key to achieving the goal of health for all by the year 2000, and significant developments have taken place in primary health care in the last 10 years. In almost all countries, there is a trend towards the decentralization of health planning as a means of identifying more cost-effective approaches to the delivery of care. While the degree of decentralization achieved differs significantly from country to country, many are aiming to extend care facilities beyond hospitals, to strengthen the links between primary care and hospital services in order to increase the efficiency and continuity of care, and to increase the responsibility of individuals and families for their own health. Many countries are also giving special attention to intersectoral collaboration, the prevention of disease and the role of general practitioners.

The recent emphasis of WHO on strengthening district health systems reflects many years of experience in many countries in the European Region and the realization that developments at this level could have a critical impact on efforts to achieve health for all.

The development of primary health care in the German Democratic Republic

An overview of the development of primary health care in the German Democratic Republic since 1949 provides an illustration of the progress and problems in one Member State.

In the 1980s, with rising public expectations, greater emphasis has been placed on the development of primary health care, the key coordinating role of the family doctor and the responsibilities of individuals, families and local communities for their own health. More attention is also being paid to the role of local assemblies in developing primary health care and health promotion.

Within districts, and particularly in rural districts, there has been a marked growth in the number of health centres, the number of doctors providing care outside hospitals and the number of people being treated. Diagnosis and therapy have improved, life expectancy has increased, infant mortality and industrial accidents have declined and the quality of life of the chronically sick and disabled has improved.

Currently, concern focuses on nursing care for the elderly, the relationships between family doctors, community nurses, social workers and specialists, mother and child care, and the need for greater continuity of care.

In future, the effective integration of social and economic policies and a greater emphasis on healthy lifestyles will be increasingly important. Specific targets for action include overweight, smoking among young people, the increased use of alcohol, and stress. Attention will also focus on improving the quality and effectiveness of care outside hospitals.

District health systems

WHO's emphasis on strengthening district health systems, with support from the national level, reflects the realization by a growing number of countries that the principal obstacles to achieving health for all are weak organization and management, particularly at the lower levels of health systems.

The concept of a district health system crystallized at a meeting of a WHO expert committee in 1985.^a This concept provides a conceptual framework for thinking about hospitals in relation to the people they serve and all the other relevant agencies, including those not usually considered part of the health system.

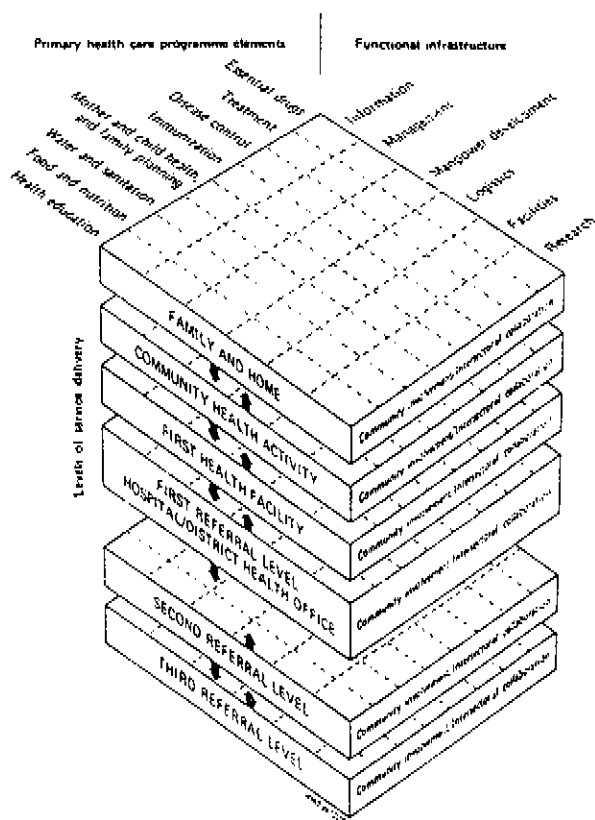
The model of a comprehensive health system based on the principles of primary health care (Fig. 1) emphasizes that the effective implementation of integrated primary health care programmes at all levels of service delivery is influenced both by the functional infrastructure and by community involvement and intersectoral collaboration.

The key features of a district health system are that:^a

- " - it is people-centred, emphasizing all the health-related elements of their behaviour and their environment, and their right to shape their own health care with professional help;
- it is based, whenever possible, on a discrete geographical area, within clearly delineated boundaries, and includes the whole population ... ;
- it need not be exclusively a government system, and may be composed of many elements, including, for example, nongovernmental institutions and traditional healers;

^a WHO Technical Report Series, No. 744, 1987 (Hospitals and health for all: report of a WHO Expert Committee on the role of hospitals at the first referral level).

Fig. 1. A conceptual model of a comprehensive health system based on the principles of primary health care



Source: WHO Technical Report Series, No. 744, 1987
(Hospitals and health for all: report of a WHO
Expert Committee on the role of hospitals at the
first referral level).

- it has substantial managerial autonomy in order to be able to settle priorities and problems, as far as possible, on a decentralized basis; and it incorporates the primary health care approach into all its activities."

In 1987, a WHO interregional meeting at Harare, Zimbabwe, called on Member States to adopt national policies that provide for the necessary support to districts, to decentralize financial and personnel management, as appropriate, in order to encourage flexibility within districts in adapting national policies for resource use, and to redefine the role and functions of hospitals as integral parts of district health systems.

In discussion, the participants noted that while acceptance of the principles of district health systems based on primary health care is fairly general at policy level, the extent to which these principles have been implemented varies between countries. For example, there are district health systems in the German Democratic Republic that conform closely to the WHO concept. In some other countries, on the other hand, district health systems do not exist as administrative entities, although there is a felt need for cooperation between health professionals and health and social services. The participants also noted that in some countries administrative and health district boundaries are coterminous, while in other countries they are not.

Aspects of primary health care at the district level

Management of primary health care

Oslo, Norway, a city with a population of 450 000, is an example of a district where the management of primary health care has been decentralized. This decision was taken in the early 1980s in response to concern about lower job satisfaction among general

practitioners in health centres than among general practitioners in private practice, about the poor image of health centres and about the declining number of patients attending health centres.

Management responsibility had been delegated to one doctor in each of 25 municipalities of 10 000-20 000 people and each had been made accountable, through the Department of Health and Social Services, to an elected municipal council. This move had succeeded in attracting doctors back to the cities and in improving accessibility. Patient turnover in health centres, however, remained higher in health centres than in private practice.

One of the lessons drawn from this experience was that one doctor, chosen for his or her leadership abilities, should be responsible in each municipality and that the management of social workers dealing with benefits should be separate from the management of primary health care.

Finland and Israel provide further examples of decentralized health systems and the problems that may arise if local personnel are not adequately prepared to manage budgets. Sweden highlights the dilemma of deciding whether management units should include primary health care with hospitals or with social services.

Intersectoral collaboration

Teterow, a rural district in the German Democratic Republic with a population of 31 000, provides an example of a district where recent efforts to involve all the relevant agencies, governmental and nongovernmental, in improving health, health care and social care have been successful.

This has been achieved largely through the District Assembly (the local representative body) and its

executive body, the District Council, advised and assisted by the District Medical Officer. Since 1980, the District Assembly has passed many resolutions relating to health promotion, the environment, working and housing conditions, and medical and social care. Council members have sought to implement these resolutions by inspecting rehabilitation facilities for the disabled, studying hospital and factory conditions, and monitoring the collaboration between different agencies. In this way, Council members have played a key role in coordinating medical and social care in the district and identifying planning priorities. They have also played an important role in raising funds for primary health care and involving agricultural and building cooperatives in building primary health care facilities.

Annual local health conferences, held under the auspices of the directors of outpatient facilities and mayors, and attended by the directors of schools and businesses, the chairpersons of cooperatives and the representatives of political parties and nongovernmental organizations, are another means of strengthening the links between health providers and the community. At these conferences, which are open to the public, the District Medical Officer presents an annual report and makes practical recommendations.

The recent growth of intersectoral collaboration has been accompanied by a continuing decline in sickness rates, a decrease in the number of smokers among health and educational workers, and increased participation in sport.

In discussion, the participants questioned whether intersectoral collaboration needed fora at other levels within the district and whether academic institutions have a contribution to make in the evaluation of the initiatives taken.

Community involvement

Seven issues were raised for discussion.

- What does community involvement mean?
- What structures exist for community involvement and what are the relative strengths and weaknesses of formal and informal structures?
- At what levels should the community be involved?
- What primary health care infrastructures can be used for community involvement?
- Who should mobilize the community?
- What proportion of people should be involved?
- Should top-down or bottom-up approaches be tried first?

Discussion focused on who should be involved in what and why. Community involvement can serve many different purposes: for example, consensus building, information gathering, health promotion and policy implementation. But the outcomes of community involvement cannot be predicted in advance since they develop from the negotiations between the parties involved.

For some purposes, some of the participants stressed the need to involve relevant opinion leaders and others with influence in the community. Others stressed the need to educate politicians, managers and doctors as well as the public about the importance of community involvement as a human right.

General practitioners and primary health care

The development of general medical practice and primary health care in the United Kingdom was outlined from the birth of the National Health Service in 1948, when the prospects for general practice were dismal. Following changes to the remuneration system in the mid-1960s, which aimed at raising standards by introducing various performance-related payments and financial incentives, general practice underwent a renaissance. Practice premises improved, group practice and the employment of practice staff increased, general practice became a popular career choice among medical students and compulsory vocational training was introduced.

Today, general practitioner services are accessible and acceptable. There is continuity of care and the health care costs in the United Kingdom are among the lowest in the developed world. Despite these achievements, variations in general practice, in both medical and organizational terms, are a cause for concern. In particular, there is concern about the extent to which general practitioners are involved in health promotion, the extent to which they monitor people with chronic illness, and variations in their referral rates and prescribing costs. In addition, a recent review of community nursing highlighted concern about the effectiveness of primary health care teams and the use made of nursing skills.

At present, the priorities are to make primary care services more responsive to the consumer and to raise standards of care, to promote health and prevent illness, and to improve value for money. To achieve these objectives, the British Government intends to make more information about primary care services available to consumers, to increase competition between general practitioners, and to link the remuneration system more directly to the range and level of services provided.

Discussion centred on the possible effect of changes in remuneration systems on the range and level of services provided by general practitioners and, in particular, on the care of the elderly and referral rates. The effectiveness of other methods of influencing general practitioners' behaviour, such as feedback about practice patterns, personal visits and discussions between general practitioners and specialists, was also considered. A combination of methods, rather than any one method in isolation, was thought most likely to be successful in bringing about changes in practice patterns.

Health promotion

One definition of health promotion used by WHO is "the process of enabling people to increase control over, and improve, their health".^a

As such, health promotion and primary health care can be regarded as complementary strategies for achieving health for all, with health promotion being concerned with the development of healthy public policies, the creation of a supportive environment, strengthening community action and reorienting health services.

Health promotion encourages the involvement of individuals, families and communities in health care, and health service planning at the district level needs to take this into account. The autonomy and creativity of people outside the health service has to be respected, and planning must be seen not as a means of control but as a tool for coping with environmental uncertainty and promoting a dialogue between the various parties involved.

^a Concepts and principles of health promotion.
Report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1984 (unpublished document ICP/HSR 602/m01).

In discussion, the participants noted that health promotion is important for people who are sick as well as for people who are healthy, and that new ideas about health promotion imply new roles for health care providers, including general practitioners, pharmacists, counsellors and health education specialists. Some felt that general practitioners, depending on their position, can and should be useful as health educators. Others questioned whether the traditional "active doctor-passive patient" relationship was compatible with the doctor being an effective health educator. Others considered there was a danger that, with health promotion aimed at changing individual lifestyles, this could obscure some of the socioeconomic influences that play a part in producing ill health. Research was advocated into the cost-effectiveness of alternative approaches to achieving specific targets.

Voluntary organizations

In the United Kingdom, the term voluntary organization covers a very wide range of organizations with different objectives, structures, resources and activities. Some are small, informal self-help/mutual aid groups; others are large, established organizations, employing paid staff as well as volunteers, with branches throughout the country. Voluntary organizations have a long history in the United Kingdom and are seen as having an essential role to play in enabling individuals and groups to be involved in health care and in containing health care costs.

In addition to the direct provision of services, voluntary organizations fulfil a variety of roles including those of self-help, advocate for individuals, campaigner, pilot of new approaches to services, an alternative to public and private sector provision, a source of information and expertise, and a bridge between the private world of the individual and the public world of the statutory services. All or some of these roles are often combined in one organization.

It is important, therefore, to involve voluntary organizations in an appropriate way, at all levels within a district where they can make a distinctive contribution to service planning. At the district level, voluntary organizations are represented on community health councils (the bodies that represent the views of the public to health service managers) and on joint consultative committees (the bodies that are responsible for advising the district authorities on services of common concern).

In discussion, many examples were given of other roles played by voluntary organizations in different health systems. Some provide funds, some help to implement new local policies, some disseminate information to minority groups and others provide a countervailing force to industrial interests. Examples were also given of the ways in which district health authorities provide encouragement and financial support for the activities of voluntary organizations. At the district level, general practitioners are seen to have an important role in linking individuals and voluntary organizations and supporting self-help groups in achieving their objectives.

Some reservations were expressed, however, about the role of some voluntary organizations. Statutory and voluntary organizations could have different priorities, voluntary organizations could be manipulated by vested interests, and the use of volunteers or cheap labour could lead to conflict. It was considered important, therefore, to study the actual contribution that voluntary organizations make to district programmes.

Mass media

A number of functions that the media can perform in the health field were identified. They can help to create a political will in favour of health by appealing to policy-makers. They can help to raise public

awareness of health issues and enable people to make informed decisions. They can publicize new advances in medical knowledge and health care and their impact. The mass media can also help to foster community involvement by reflecting public opinion and encouraging a dialogue between the community, health care providers and policy-makers.

The prerequisites for achieving the desired impact include an understanding of the knowledge, beliefs and attitudes of the audience, an understanding of the uses and limitations of the mass media, adequate resources and a continuing dialogue between health personnel and the mass media. If the intention is to influence behaviour, as well as public knowledge and attitudes, the mass media need to be used, not in isolation, but as part of a comprehensive strategy in which account is taken of the social constraints on behaviour, the activities of health professionals and conflicting communications.

Following a discussion of positive and negative examples of the perceived impact of the mass media, the participants concluded that they were powerful communication channels and that the appointment of press officers or specially trained health professionals could help to ensure more effective use of the mass media at the district level.

Planning

A range of possible approaches to planning was identified: the laissez-faire approach, disjointed incrementalism, muddling through, mixed scanning and rational planning. As well as a choice of approaches, planners have a choice of roles: they can act as technicians, as allocators of resources, as advocates for society, as reformers or as advocates for the government. Whichever approach they adopt, it is important for planners to understand the political system and to involve both health professionals and the

community in the analysis of community health problems and the design of interventions.

In some countries, such as the Netherlands, there has been a retreat from planning following problems of implementation and a move towards market regulation and the development of contracts between providers and financial institutions. Efforts are being made to develop high-quality, cohesive and cost-effective services for specific client groups, but at this point it is unclear whether it is possible to do so and to measure service outputs.

Measuring results

First, is it useful or efficient to measure results at the district level? Second, is it feasible to develop a common set of outcome indicators for use by districts in the European Region?

To measure results, it is necessary to identify programme objectives. This is not easy, however, because the primary objectives may be covert, different groups may have different objectives and different objectives may conflict.

In addition, a number of technical problems have to be faced. Outcomes are seldom attributable to a single cause. There is often a considerable time-lag between interventions and outcomes, and routinely collected data are often inappropriate for measuring outcomes.

Despite these obstacles, there are many outcome measures that may be considered for use at the district level. These include sentinel health events, avoidable deaths, the Nottingham Health Profile, the Sickness Impact Profile, achievable benefits not achieved and the short-term outcome measures developed for use in the Rand Health Insurance Experiment. The indicators developed to monitor progress towards the European health for all

targets, which allow comparisons to be drawn between as well as within countries and which some countries such as Czechoslovakia are already using, merit special consideration. Despite the availability of outcome indicators, the participants considered that too much emphasis is still placed in many countries on process indicators.

Conclusions

In the 10 years since the International Conference on Primary Health Care in Alma-Ata, many countries in the WHO European Region have based their national health policies on the concepts of health for all, emphasizing health promotion and decentralizing decision-making to the districts.

Many countries have also made progress in expanding primary health care and improving the health and wellbeing of their populations. Many countries have encountered difficulties, however, in implementing the changes called for by national policies and integrating the activities of different health personnel and different agencies into a cohesive whole at the district level.

Despite these difficulties, district health systems are seen as a key action point for accelerating progress towards health for all. District health systems provide an opportunity to decentralize responsibility and budgets for a defined population, to promote a dialogue about national policies between the central and local levels, and to encourage local initiative. District health systems can be flexible in adapting national policies on the use of resources to local needs, they can identify the underserved and they can integrate interventions to improve the health of the entire population. They can also provide support for health personnel and obtain relevant feedback from the local level.

At the district level, the key priorities for action are:

- making intersectoral collaboration a force for health for all;
- improving links between primary health care and district hospitals, particularly in relation to the care of the elderly and the chronic sick;
- raising standards of promotive, preventive, curative and rehabilitative primary care;
- promoting healthy lifestyles, and paying special attention to the role of the family doctor; and
- increasing effectiveness and efficiency.

To ensure effective action in these areas at the district level, political commitment and stronger health infrastructures are essential. In particular, it is important:

- to promote multidisciplinary cooperation in practice and research through the training and continuing education of health personnel;
- to develop managerial leadership in health through the training and continuing education of health personnel;
- to develop medical information bases to support improvements in the quality of care and the managerial process;
- to develop facilities for analysing and communicating population-based information to health personnel in the front line; and

- to develop health systems research as a tool for solving district problems related to resource allocation, manpower development and health promotion.

Recommendations

Member States

1. Member States should mount and sustain a political campaign to promote the primary health care approach and to ensure equity and efficiency.
2. They should reaffirm the importance of an intersectoral approach to health problems.
3. They should ensure equity between districts by allocating resources on the basis of objective indicators of need.
4. They should decentralize financial and manpower management to the districts, as appropriate.
5. They should provide districts with the necessary support in terms of guidelines on policy aims and approaches.

Districts

6. Districts should promote intersectoral action by making health issues a higher priority for other sectors and by helping each sector to define its role in health activities.
7. They should develop managerial leadership in health at all levels through training and continuing education.
8. They should mobilize all possible resources for health and make better use of the resources of communities, voluntary organizations and community-based nursing skills.

9. They should redefine the role and functions of hospitals as elements in the district health system.

10. They should develop information bases to support improvements in the quality of care and the managerial process.

WHO

11. WHO should continue to promote the establishment and proper management of district health systems, as appropriate, in the European Region.

12. WHO should cooperate with schools of public health, and other relevant training institutions, in reshaping management education and training in line with the district health systems approach.

13. WHO should support descriptive studies of district health systems in different countries and of the outcomes of district-based initiatives to improve health and the health and social services.

14. WHO should intensify the efforts to collect and disseminate information about the development and use of indicators and tools to monitor changes in health and health services at the district level.

15. WHO should ensure the wide dissemination of existing reports on district health systems.

Annex 1

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