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*Education, Continuing
Нача всеобщего - образования
Приману класки сам-
науровня.*

Европа

STUDY ON SYSTEMS AND ORGANIZATION
OF CONTINUING EDUCATION AT COUNTRY LEVEL

Report on a WHO Meeting

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1. Introduction

Within the perspective of the health for all movement, systems of continuing education (CE) should be developed that will allow practising health professionals to bring their work more closely in line with the health needs of the population and to improve their qualifications. This task is clearly expressed in the regional targets in support of the regional strategy for health for all by the year 2000 (HFA2000), approved by the European Member States. Target 36 states that "... in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach"^a.

CE programmes should take into account the need for existing health workers to adapt themselves to the changing patterns of health care and public health administration and to give better service to the community. Since most of the health professionals who will be working in the year 2000 are studying now or have already completed their studies, CE programmes are needed that take into account changing national health needs and policies.

Consequently, the European programme for health manpower development (HMD) has given priority to promoting the development of organizational systems and proper methodology for the CE of health personnel. The Consultation on Multiprofessional and Continuing Education, held in Copenhagen from 31 October to 2 November 1984, gave new impetus to the activities in this field.

As a follow-up to the Consultation, a "Study on systems and organization of continuing education at country level" has been implemented to accumulate evidence and prove the feasibility and potential efficiency of CE programmes for primary health care (PHC) teams. The Study demonstrates that CE is one of the important instruments of health services manpower development (HSMD) leading to the gradual achievement of the regional PHC targets related to the HFA2000 goal. At the same time, the Study supports and enhances efforts already being undertaken in Member States and stimulates new initiatives in promoting CE programmes for members of PHC teams.

As part of the Study, an initial survey was undertaken to collect selected information on the existing situation and tendencies concerning CE activities in eight countries of the European Region, with particular reference to CE programmes for PHC teams. Within this framework, the present meeting of country investigators involved in the initial survey was convened in order to discuss the outcome of the survey and to plan further collaborative activities in the Study.

2. Purpose of the meeting

The objectives of the meeting were:

- to analyse the present situation and trends in the field of CE in the European Region;
- to discuss priority issues and to outline strategies with regard to the CE of health personnel;
- to plan in detail the case studies in selected European countries providing evidence and identifying the prerequisites and circumstances leading either to the success or failure of CE programmes for members of PHC teams and indicating any visible impact on the quality of health care.

The meeting was attended by the eight country investigators, the study coordinator and five WHO staff members (see Annex 2). The background documentation consisted of eight country reports prepared by the respective country investigators and a review of the overall situation by the coordinator (see Annex 1).

The meeting was opened by Dr A. Wojtczak. He emphasized that the PHC approach is the key to implementing the strategy/philosophy and targets relating to the goal of HFA2000 in the European Region. CE systems must provide new competencies, attitudes and motivation for efficient PHC.

Professor B. Paccagnella was elected Chairman and Professor J. Vysohlid Rapporteur.

^a Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985.

3. Review of initial survey

3.1 Country report

The following countries were included in the initial survey, or first phase of the Study: France, Hungary, Italy, Spain, Sweden, Union of Soviet Socialist Republics, United Kingdom and Yugoslavia. The authors and titles of the reports are given in Annex 1.

In general the country reports covered all basic issues and took into account the policies, existing situation and problems as well as future trends in the respective CE systems. On the other hand, one had to recognize that country reports compiled by a single investigator, assisted perhaps by a small group of collaborators, could not include all relevant information and facts concerning an entire country.

3.2 Characteristics of health care systems

The particular health care system in a country forms the environment in which CE systems develop and function. Among the countries involved in the survey, various types of health care systems can be found: systems whereby fees for health services, mostly private, are reimbursed partially or fully through insurance schemes or sick funds; combinations of state health insurance and private health services; national health services; governmental, state budgeted systems with free health services; an independent system based on decentralization and self-management.

In all countries, a tendency was revealed towards central policy-making and decentralized decision-making to a greater or lesser degree, bearing in mind local needs and conditions. At least some attention is being paid in all countries to enhancing efforts made to develop or strengthen existing PHC systems oriented towards prevention, health promotion and community participation.

3.3 Health services manpower development policies and process

The policies and process of HMD, i.e., planning, "production" and management, are closely related to the different systems of health care. In countries with pronounced state responsibility for health care policy and process, the two are usually coordinated. This coordination includes all phases of education: basic/undergraduate, postbasic/postgraduate and CE. It covers most categories of health workers and members of PHC teams. In other countries, policy and process are less comprehensive and coordinated, including only some of the above spheres. In countries where reforms in PHC are taking place, a close relationship to the HMD mechanism is maintained. In a minority of cases, responsibility for health care and HMD lies with the ministry of health; more frequently, responsibility for university education is placed under another ministry (e.g., ministry of education or culture).

As stated previously, a tendency can be observed towards establishing policy and concepts in the HMD process at central level, while at the same time promoting decentralized decision-making in accordance with local priorities and conditions. Qualitative aspects of HMD are more pronounced now than in the past, but one cannot overlook problems in relation to quantitative aspects, e.g. overproduction of some categories of health personnel and shortages of others. Although basic/undergraduate and postbasic/postgraduate education still occupy a priority position, CE - especially for members of PHC teams - is attracting more attention.

3.4 Strategies for continuing education with particular reference to primary health care

Some promising developments in CE are being observed which support and enhance existing activities. Specific bodies and institutions have been created and are furthering the planning, provision, management and evaluation of CE systems for health personnel, including PHC teams. They are either part of the formal health care structure or are in some direct or indirect relationship to it, e.g., a professional voluntary movement in a country. These resources operate at central and regional levels, and sometimes at district or local levels, and include:

- institutes/schools for postgraduate (advanced) medical education; colleges for other professionals;
- the organizational structure of postgraduate education within the National Health Service of the United Kingdom, which includes postgraduate deans, clinical tutors and regional advisers in general practice, and a national health service training authority;

- professional organizations, e.g. union of associations for continuing medical education, association of district physicians;
- local authorities/governments, e.g. federation of county councils;
- health manpower research groups bringing together experts from both the health and the education sectors.

Nearly all these institutions and bodies include various committees to ensure necessary coordination in planning, implementing and evaluating, as well as funding and supporting activities. Such coordination usually operates within the health sector. Sometimes it is intersectoral including, for example, education, social services and trade unions of health workers.

The systems of CE are set up either with compulsory, regular or periodical attendance, or with participation on a voluntary basis. Depending upon the specific characteristics of the health system, CE systems are either fully budgeted by the State or subsidized by governmental, semiprivate or private funds with or without enrolment fees.

Interestingly, one can observe a recent tendency to view the CE of health workers as an important agent and impetus for speeding up foreseen changes, including a new orientation of health services towards the targets of HFA2000. CE should not only update knowledge and skills, but ensure necessary changes in competencies relevant to health service orientation and development. Curriculum planning for CE activities is based increasingly on objectively established needs and priorities in health care (e.g., programmes oriented toward care of elderly, families with children, the mentally ill, the handicapped, drug addicts). Although there are still many problems of a personal, financial, material and/or organizational nature, community-based educational experiences are being introduced more and more often within CE programmes for PHC teams. Past experience is a motive force for devising and establishing of more efficient coordination in CE activities through some of the bodies mentioned above.

3.5 Providers, participants and teachers involved in continuing education programmes

With regard to providers of CE activities, two types are mentioned most often: main providers and partners.

The main providers in some cases are central authorities, such as the ministry of health, ministry of health and social security, or national board of health and welfare, which are represented in some instances by institutes/schools for advanced/postgraduate education or by other postgraduate education organizations or networks. In other countries, the main providers are the local governments or county councils, independent health organizations, professional associations and private establishments (e.g., pharmaceutical industries).

The partners to these main providers are usually, among others, medical schools, schools of public health, or other educational institutions; scientific and research institutes; regional/teaching hospitals; and professional non-governmental organizations.

Physicians are the principal participants in CE programmes in almost all countries. Nevertheless, other health professionals are an important component, e.g., nurses, midwives and social workers. Since the greatest emphasis is still placed on training members of one profession or specialists in one particular narrow field, it is more an exception than a rule that multiprofessional and multidisciplinary groups of health workers are trained together. Whereas in some countries compulsory attendance in CE activities is fully accepted and considered an asset, in others attendance is voluntary or facultative.

In most instances, teachers of CE are high level experts, university teachers, teachers of postgraduate schools, heads of departments of teaching hospitals, etc. Only recently have the teachers of PHC teams themselves begun working at this particular level of health care. In most countries, courses in medical pedagogy have been organized for teachers of CE; in some others, courses are considered a necessary prerequisite for teaching.

The country reports revealed efforts to ensure regular, periodic and sequential attendance of health professionals in both systems, i.e. with obligatory and voluntary participation. Another tendency, still more an exception than daily practice, is to organize multiprofessional, community-based CE activities for members of PHC teams at the place of work. This is closely linked to an effort to prepare teachers for PHC from among the experienced members of PHC teams.

3.6 Current forms and methods of learning/teaching

In principle, there are few major differences among individual countries in either the forms or the methods of learning/teaching.

The usual forms include courses, seminars, workshops, meetings and conferences. Sometimes week-end or evening sessions are offered.

It is worthwhile to mention several organizational approaches used, although they are not necessarily common in all countries:

- distance learning with controlled homework and exercises as a prerequisite for participation in a formal course;
- CE courses/activities provided in selected field settings to local health personnel by travelling/mobile teams of teachers from postgraduate or other educational institutes (these courses may be combined with consultations on patients);
- regular CE activities involving one half-day release per week over a two-year period;
- distance learning based on printed materials for individuals or groups with a possibility of self- or formal assessment.

Again, learning/teaching methods are rather similar: e.g., lectures, group work followed by discussion, project work, problem-based learning using real or simulated situations. Medical literature, textbooks, hand-outs, periodicals with quizzes, selected self-learning materials with self-assessment, etc., are common. The use of audiovisual and other didactic resources is no longer an exception. Regular television programmes for physicians are available in few countries. Computer-based or computer-assisted instruction and learning have been rare up to now.

In general, one can conclude that growing attention is being paid to self-learning and self-assessment, to problem-solving and decision-making, and to structured and well-organized reviews or summaries devoted to specific, priority health areas.

3.7 Outcome and impact of continuing education

Almost all the reports referred to evaluation of the outcome and impact of CE activities as a problem which has not yet been sufficiently tackled and is not certainly solved. This does not mean that evaluation is not performed in CE. The usual method is that gained and memorized knowledge, and sometimes also skills, are assessed immediately at the end of the educational activity. Often pre- and post-tests are administered. In one country, short papers or bibliographic surveys are required at the end of a formal course. CE activities are usually assessed through the completion of a questionnaire or by expressing personal opinion on the quality, usefulness and adequacy of the activity. It is generally accepted that evaluating the long-term (delayed) impact of CE on improved competence, and thereby quality of health care provided, is essential. So far, there are no proven methods for assessment of this type. Such assessment should necessarily involve teachers, health care specialists and preferably also the community.

Although the situation cannot be considered optimal, some reports mentioned interesting initiatives. Specialized bodies dealing with quality of health care have been established, e.g., a national committee for evaluation of quality of health care, and a foundation for the evaluation of medical practices and techniques through conferences of consensus. In some countries, experiments are under way to measure the impact of CE on the quality of PHC.

In conclusion, the survey on CE systems in eight European countries has, without any doubt, improved knowledge about the state of the art and has provided an impetus for further efforts in this field.

4. Discussion of key issues in continuing education

4.1 Background

The above review of the existing situation and of plans to improve the relevance and efficiency of programmes, especially for the members of PHC teams, demonstrated the need for addressing in depth a number of key issues.

4.2 Continuing education within primary health care

All eight countries have already formulated new national strategies or are in the process of reviewing or adjusting existing strategies to bring them into line with the PHC approach. They have accepted that the essence of PHC is "democratization", which is the reason why sometimes rather radical changes are foreseen or are being made. Primary health care from this point of view requires an active and collaborative approach, including efforts on the spot and substantial support from higher levels of management. Such an approach requires both decentralization and input from the most peripheral parts of the system.

Collaborative aspects can be seen in two dimensions - vertical and horizontal. Regarding the vertical dimension, PHC should form a broad base for the overall health services system. PHC, however, cannot be separated from the secondary and/or tertiary levels of health care. It should therefore be stressed that CE should be an efficient and meaningful tool, and be instrumental in strengthening professional links with PHC at the higher levels of a health care system. This function is important not only within the health sector, for an intersectoral link may be enhanced with other providers of care, i.e., the social welfare services. Such collaboration has been confirmed as useful many times, and is considered as essential in various areas such as care for elderly and handicapped persons.

CE activities can, by shaping interests and commitments, foster support for the PHC approach, but opposition does still exist. Efforts at reorienting existing systems are still problematic in some places. Apart from well-known constraints (e.g., shortage of funds or manpower, limited technology), there is also resistance to change from within the health system, from the educational institutions serving it and sometimes from the community itself.

The most important dimension, however, is the horizontal dimension. Horizontal links are of direct relevance to the function and role of the PHC team. CE activities can prepare the way for development of a team approach for community-oriented health work. Although the principles of team training may seem obvious, their introduction in practice is often difficult. The reason for this is that not only do the participants in CE need to be reoriented, but also teachers and existing managers and leading health workers. Each of the team members must be prepared to contribute to common objectives and targets.

4.3 Strong and weak factors in continuing education for primary health care in eight European countries

It was recognized that a system for CE in a country generally reflects the system of health services in the country. Those countries with uniform national health services are those with the most structured system of CE. The more pluralistic and decentralized a health services system, the less compact and visible its system for CE.

(a) Nature of continuing education

CE should be continuous and sequential, as well as pluralistic and flexible, with reference to content, design and methods. In most of the eight countries under review there is, for instance, a plurality of providers. While plurality has its value, a more centralized and unified system of providers cannot, at the same time, be underestimated. In those countries with numerous and various providers, it is no doubt necessary to strengthen the links among the different providers so as to ensure greater coherence in analysing the needs of CE and more efficient utilization of resources. The importance was stressed of establishing close links and collaboration between the network of providers and those making decisions on strategies and policies for CE and health care. This is especially true in those situations where decision- and policy-making bodies are not identical with those providing the CE activities and programmes.

Although it was not possible to penetrate in depth the issue of strategic approaches to CE in the different countries, it was considered to be a major and important one needing further clarification and investigation. The following questions may be asked in this connection:

- Who is responsible for formulating the strategy for CE and what are the essential elements for developing a systematic strategy?
- What kind of input must there be from the health services system?
- What kind of mechanism is supportive of the observed tendency towards decentralization of health services and CE?

(b) Communication and collaboration

While recognizing the positive aspects of plurality in CE activities, it is important to investigate whether there are easily available, functional channels and means of communication and collaboration. The formulation of CE programmes is heavily dependent on the existence of diverse and reliable information, inter- and intrasectoral consultation and negotiation; a critical appraisal of the needs and priorities of health teams and the community; a systematic examination of existing policies, procedures and strategies concerning the PHC; and a clear understanding of the resources available and the possibilities of transferring the resources in the direction indicated by new policies. Communication and collaboration are necessary, preferably on a permanent basis, between policy-makers, providers, participants and employers in order to guarantee the required result.

(c) Continuing education as part of Health Services Manpower Development (HSMD)

Most of the eight countries appear to have some integration between health services planning and health manpower development. According to tradition, the health services manpower development mechanism in the past concentrated mainly on quantitative needs, such as producing a certain number of physicians, nurses or other category of health workers in accordance with estimated needs expressed by the health services system. In most cases, CE was not focused upon the integrated planning represented by the HSMD mechanism. The fact that initiatives are being taken to develop methods to facilitate the integration of CE in the HSMD mechanism was considered to be very rewarding. Nevertheless, there was a consensus that this area needs even more effort and investigation.

Several aspects were highlighted:

- What would be the consequences for the health services sector if CE activities were a part of health services planning?
- What kind of background documentation and information is needed?
- Would the creation of quantitative norms for participation in CE activities be necessary, and what would be the practical consequences?

(d) Legislation

Some of the eight countries have adopted legislation specifying whether attendance in CE activities is directly or indirectly compulsory for selected programmes. In other countries, no such legislation exists. The matter of legislation concerning CE is an important area for further investigation in relation to the following questions:

- What would be the practical consequences of recently issued legislation declaring that attendance in CE is obligatory in a country where participation was previously voluntary?
- What are the advantages and disadvantages of such legislation?
- Would sufficient human resources be available for replacing those participating in CE programmes?
- Does compulsory attendance interfere with the quality of and personal motivation for further education in different health care settings?

(e) Funding

In almost all the countries reviewed, the major funding body is the national health services system. Financial aspects of CE have two dimensions: direct costs of providing CE and indirect costs of participating in CE activities.

Direct costs are easy to estimate and measure, but indirect costs are more important and amount to approximately 75% of the total costs. These are thus a matter for negotiation between employers and employees.

The problems related to indirect costs involved in CE are especially sensitive, and may sometimes become a factor hindering participation. Various situations need to be investigated:

- Is it possible and feasible to close a health centre when the team participates in CE?
- Who should take over the activities and responsibilities?
- Is the employer willing to replace the team with other health workers?
- Will such replacement influence the quality and continuity of care?
- In which way should the HSMD mechanism, and particularly health manpower planning, avoid problems connected with absence from work due to participation in CE activities?

(f) Incentives and career prospects

In most of the countries concerned, there are neither financial nor career incentives for participating in CE programmes. Only in countries with relevant legislation and obligatory attendance in selected CE programmes was there an evident link to career development. The importance of linking CE systems to better career prospects was confirmed. The importance of more intensive investigation and study in this sensitive area was also stressed.

(g) Monitoring and evaluation of continuing education

Whereas it was unanimously agreed that monitoring and evaluating of impact are indispensable in the management of CE systems, the current methods utilized seem to be the weakest link in the CE chain. Evaluation and monitoring were viewed as a decision-oriented process closely linked with decision-making at both operational and policy levels. Conclusions drawn from the evaluation and monitoring process could provide feed-back information and data necessary for subsequent improvement and the development of new programmes, policies and strategies.

There is a need to monitor CE systems with regard to the number of activities and participation, main focus and orientation, costs incurred, etc. Aspects of impact to be evaluated include the quality of health services provided and community satisfaction.

The need for a very realistic and pragmatic approach adapted to these desiderata was stressed. For instance, it is very costly to develop new systems of monitoring based on a large amount of quantitative data. One should consider what kind of information is indispensable. Qualitative and process-oriented data may be very useful in achieving a better understanding of a situation and in analysing difficulties, and may offer a useful tool for effective management.

All relevant quantitative data are already being regularly collected in some of the countries reviewed. These data, concerning staff, are usually collected in an indirect way within the administrative and managerial system. In such cases, it is important to develop programmes and means for effective utilization of the existing data within the HSMD mechanism.

(h) Team training

The team approach in CE for PHC was considered of major concern. The best method of team training would apparently be for team members to participate together in CE activities in their practical work. This provides an opportunity for each person to consider and solve relevant health problems from the particular viewpoint of his/her own profession. However, it was observed that most health workers take part in CE activities separately, for the compartmentalization of various professions has not yet been broken down everywhere to produce a situation which would allow multiprofessional and multidisciplinary learning/teaching experiences. Nevertheless, evident trends in the direction of strengthening of the team approach have been observed in many of the countries reviewed.

In order to enhance these positive trends, it would be useful to undertake further studies to determine the proper balance between CE activities for undisciplinary groups and those designed for multiprofessional and multidisciplinary attendance. In this connection, a need was indicated for more appropriate and realistic job descriptions and job profiles. Health manpower could support health systems development more effectively if the roles and responsibilities of each team member were defined. This would also allow closer linkage of health manpower planning and health manpower management.

(i) Training of teachers and continuing education managers

The adequate preparation of teachers in CE may have critical implications for the changes foreseen in the education and training of health workers. Teachers need to be trained so that they understand their role as teachers. They should be able to promote the process of learning by guiding and assisting participants in CE to achieve learning objectives. They should also be able to understand the working conditions and social atmosphere within PHC teams. Teachers in possession of these traits are better prepared for programmes with a multidisciplinary orientation.

In addition to teacher training, the need for training of CE managers was stressed. A very close relationship exists between health manpower management as a whole and the management of CE programmes, the latter being an indispensable part of the former. A systematic approach to CE management means much more than simply arranging courses or workshops. Rather, one must bear in mind all aspects of health manpower management when dealing with the management of CE.

5. Planning of future case studies

5.1 Background

In accordance with the Study design, the next phase will consist of the preparation of case studies on CE for PHC personnel in selected European countries. The country reports and discussions on key issues in CE served as very useful background for formulating some specific suggestions on the orientation and content of these case studies. Detailed plans were drawn up for the future case studies as follows.

5.2 Nature and aim of case studies

A case study is a detailed study of a single and well-defined unit - the case in its natural environment. The case may be a class of students, a health centre, a system or subsystem studied as an entity. The aim of the case study is to help understand how a unit or a system functions as a whole; to discover the comprehensive relationship that exists within a particular entity; and to study relations among human attributes and activities. Although statistical methods may be used, the case study is normally associated with a qualitative approach. The information is collected by the investigator(s) through a variety of techniques: interviews, direct observations, review of records, reports, tests, etc. The information collected is to a large extent descriptive and presented in narrative form. The researcher examines a complex, dynamic, bounded social system. In the process of data gathering and interpretation, he looks for patterns, connections, trends, etc.^a

5.3 Objectives of case studies

In the future case studies, the following objectives should be borne in mind with the understanding that it may not be possible to adhere to all of them in every case:

- to describe the current situation regarding the CE of members of PHC teams, taking into account the health care system in general and the PHC subsystem in particular (both previous evolution in these fields that is important and relevant development should be investigated);
- to describe mechanisms for allocating and using resources for CE activities and programmes and to assess how efficiently the resources are used;
- to investigate the use, appropriateness and effectiveness of educational methods and techniques;
- to assess - whenever feasible and demonstrable - whether specific CE activities have ultimately resulted in improved quality in particular fields of PHC;
- to identify the structures which enable on a continuous basis the planning, development and evaluation of CE in the context of health manpower planning and management.

^a Bankowski, J. & Bryant, J.H., ed. Health for all - a challenge to research in health manpower development. Proceedings of the XVth Round Table Conference, Ibadan, Nigeria, 24-26 November 1982. Geneva, Council for International Organizations of Medical Sciences, 1983, p. 32.

5.4 Organization of case studies

The following sequential steps were suggested to prepare and carry out a case study:

- designate a reliable institution or a small group of knowledgeable persons to compile the relevant information available from different sources concerning the evolution and the existing situation of the chosen case;
- analyse, interpret and/or complement the information and prepare a succinct statement on the case, which can be used for the first version of the case study;
- convene a two- or three-day meeting when possible and feasible, bringing together 10-15 well-informed experts in the field of CE from health and other relevant sectors in order to examine the first version of the case study.

The case studies may assist in enhancing initiative and interest in the further development and improvement of CE systems. In particular, the case studies should:

- stimulate increased interest in the development of CE strategies and programmes;
- provide guidelines for the improvement of CE systems, activities and programmes in the European Region;
- develop collaboration within and between countries through the identification of resources, including learning materials, training techniques, expertise and supportive frameworks, for the development of CE initiatives;
- identify major trends and new developments in CE systems, programmes and activities;
- provide information to other professional associations or organizations which might take part in CE programmes;
- promote the implementation of work studies to develop relevant and realistic objectives for CE systems, to inform decision-making bodies and thereby to improve resource allocation.

5.5 Main aspects to be followed in the selection of cases

The following main aspects should be followed as far as possible in selecting CE programmes to be included in case studies.

- (a) The programme should be part of a HSMD system which in turn should be an essential component of health manpower planning and educational planning. It should take into account and provide evidence of the existence of a structure enabling CE to be planned, developed and evaluated in the context of the HSMD process. The activities should be continuous, forming part of an on-going process of life-long education and training. They should not be viewed and provided in a spasmodic way, oriented only to the updating of knowledge. Direct or indirect links should be established through a feed-back mechanism, and necessary relations should be established and maintained with basic/undergraduate and postbasic/postgraduate education.
- (b) The programme should be a part of an existing health service infrastructure (PHC facilities) in one or more specific areas: rural and/or agricultural; urban and/or industrial.
- (c) The programme should be relevant to the specific needs and priorities of PHC. Its orientation and content should be based on the realities of the situation. It could even be related to PHC activities for a particular target group of the population, such as industrial and/or agricultural workers, elderly or handicapped persons, mothers and children, abusers of drugs and/or alcohol. Teaching/learning should be problem-oriented as far as possible.
- (d) In addition to knowledge, the programme should develop attitudes and skills appropriate to changing demands in PHC. Motivation should be enhanced both for furthering continuous learning and for accelerating the implementation of new trends in PHC. Teaching/learning methods should preferably follow a problem-solving approach.
- (e) The programme should assist as much as possible in developing multiprofessional and multidisciplinary teamwork within PHC. This leads to more efficient utilization of skills and resources.

- (f) Career development prospects for staff should be given importance, making CE an essential part of professional development and integrating it, whenever possible, with supervisory activities.

5.6 Content of case studies

The case studies should describe, analyse and make judgements in a detailed manner regarding how organizational aspects facilitate or inhibit the planning, implementation and evaluation of CE activities and programmes.

(a) Organizational pattern of continuing education

With regard to the organizational pattern of existing CE systems, activities and programmes, the following aspects should be explained in the case studies:

- How does the organizational pattern of CE relate to the policies and strategies of both health services development and CE? The existing situation as well as foreseen changes should be considered.
- Is CE a part of the health services system and thus provided exclusively within the structure and resources of health services? Or is CE offered on a private or public basis, or by combining several providers? What is the responsibility of different providers and their direct or indirect participation in CE activities?
- What is the structure of the CE system or subsystem, and what are the levels in decision-making and execution of the activities?
- Who are the trainees involved in CE programmes for PHC teams, and what are the reasons for their attendance? Is participation in CE compulsory or voluntary, and what are the reasons for this?
- Who are the trainers (physicians, nurses, administrators, etc.) and from where do they come (PHC settings, hospitals, educational institutions, health care management, etc.)? In what way, if any, were teachers trained for CE activities?
- Where do the CE activities for PHC teams take place (PHC settings, hospitals, polyclinics, health centres; educational institutions; community; etc.)? Are CE activities performed within or outside working hours? How is a replacement, if any, ensured for those participating in CE?
- Are CE programmes carried out consistently on a long-term or mostly on an ad hoc basis? What is the frequency and time allocation for CE activities? Are there any quantitative norms for attendance?
- Who belongs to the team which manages the CE programmes at the PHC level?

(b) Pattern of planning, allocation and utilization of resources for continuing education programmes

- Who participates in the process of planning resources (human, financial, material) for the CE programmes of PHC teams?
- By whom, and at which level of management, is the allocation of these resources made?
- Who is responsible for ensuring that the resources allocated are efficiently utilized, and what is the system of control?
- How are the facilities (buildings, classrooms, catering, transport, boarding, etc.) provided?
- How are teaching resources (visual, audiovisual, textbooks, etc.) provided? Are they prepared locally or centrally? What is the system for their distribution and utilization?
- What kind of ancillary personnel, if any, are used for the execution of CE programmes for PHC workers?
- What is the cost of various CE activities?

(c) Pattern of information and communication

- What is the system of information for those interested in CE programmes for PHC workers, and who is charged with disseminating such information?
- Is the information on CE programmes disseminated in the health sector only, or also in other sectors which may be interested or involved?
- In what way are intrasectoral communication and feed-back of CE activities and programmes carried out? Are there any intersectoral communication channels, and what kind of communication is used for different problems?
- Are participants involved in the planning, formulation and implementation of training programmes?

6. Conclusions

Although CE activities have been and continue to be available practically in all the European countries, their role is not yet fully recognized everywhere. Education in health sciences is a life-long process, and not a single event. During this process, initial learning experiences must be improved and enlarged upon continuously, and higher levels of competence achieved. Planned educational programmes relevant to service needs must be established and introduced. Improved work performance, enhanced competencies, more appropriate work attitudes and greater productivity should not be left to chance, but pursued through CE.

The basic concept of CE is not new. What is, however, new in the eight countries reviewed is the emergence - or more meaningful awareness - of CE activities as key factors in the expected reorientation and restructuring of health services with emphasis on PHC. CE is an impetus for change, and thus must be a concern not only for individual health workers wishing to keep abreast but also for the entire health system, and for society as well.

CE needs to be made visible and to be recognized by politicians, administrators, health managers and health workers themselves as a necessary component of their life-long professional careers.

In most countries under review, however, CE has not been integrated into strategic planning, nor is it regarded as an important component of HMD. In these countries, the majority of CE programmes are still planned and carried out in an uncoordinated and piecemeal way. CE activities have sometimes been episodic events without well-defined objectives. The result is often that most of the programmes are not effective enough and are even inappropriate. Such programmes are not relevant to national health needs, nor do they rectify deficiencies in the current performance of health workers.

The new awareness of the importance of CE for restructuring and reorienting health services towards the targets for HFA2000 has reinforced the need for countries to develop a more systematic approach to CE. A CE system requires a comprehensive approach, for it involves a diversity of issues, considerations and decisions in various sectors. Only seldom can all necessary support, expertise and resources be provided by a single institution in a country. A systematic approach must be taken to CE, having consequences for organization, need assessment, resource allocation and setting of objectives. The development and introduction of methods and measures for monitoring and evaluating CE activities are also necessary.

In conclusion, the initial survey of CE systems in eight European countries contributed to a better understanding of the situation. The survey also provided important and stimulating input regarding the orientation and objectives of the case studies planned as a subsequent phase of the Study.

7. Recommendations

7.1 National level

The initial phase of the "Study on systems and organization of continuing education at country level" was successfully completed with the submission of the eight country reports by the country investigators. Following the discussion of the country reports at the meeting, the following recommendations were formulated:

- to start the next phase of the Study and undertake the case studies on CE in selected countries (this will involve the preparation of a protocol based on the suggestions made by the participants which will serve as a guideline for the country investigators);

- to request other countries of the European Region, particularly those which are less industrialized, to prepare country analyses similar to those already submitted.

7.2 International level

Appreciating the initiative and action taken by the Regional Office, it was recommended that WHO should:

- continue to support the collaborative study on systems and organization of CE for PHC teams as a basic prerequisite for the governments to improve CE in pursuance of the targets for HFA2000;
- prepare and publish the results of the Study and distribute the publication within the Member States;
- maintain close contact and collaboration with the Association of Medical Deans in Europe (AMDE) and the Association for Medical Education in Europe (AMEE) in order to improve CE systems in general and to improve them for members of PHC teams in particular;
- convene, at the end of 1987, a seminar on systems and organization of CE in the European Region which will examine the outcomes of both the initial surveys and the case studies.

Annex 1

AUTHORS AND TITLES OF COUNTRY REPORTS

France

The present state of continuing education of primary health care personnel in France (early 1986) - by Dr P. Klotz

Hungary

Health, health care and its institutional basis: health and health care in Hungary - by Professor I. Forgács

Italy

The present situation and current tendencies in the system for the continuing education of Italian health professionals - by Professor B. Paccagnella

Spain

Study on the current situation and trends in continuing education systems in selected European countries: Catalonia report - by Professor A. Oriol-Bosch

Sweden

Continuing education within primary health care in Sweden - by Mr B. Eklundh

Union of Soviet Socialist Republics

Continuing education of personnel in primary health care (review) - by Professor F. Vartanian

United Kingdom

Continuing education programmes for primary health care teams: a survey of existing provision in the United Kingdom - by Dr A.M. Gray

Yugoslavia

Initial study on the state and development of continuing education for primary health care - by the Working Group of the Andrija Stampar School of Public Health, University of Zagreb

Review of eight country reports

Short review of eight country reports - by Professor J. Vysohlid

Annex 2

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