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Report on the Second Coordination Meeting of the
Study on the Organization of Primary Health Care in Southern Europe
Lisbon, Portugal, 27-29 June 1983

1. Introduction

The first coordination meeting for this study was held in Vicenza, Italy, 10-20 November 1982, aiming at defining the main orientations of the study protocol and establishing a program for implementing the various activities related to this study.

At the Vicenza meeting it was decided that the study should be subdivided into two parts: Part I comprises a general description of the health care systems in the four countries involved - Portugal, Spain, Italy and Greece (to be developed in the first semester of 1983). Part II develops a detailed comparative study of selected aspects of the health care systems (to be done during the second semester of 1983).

Following the Vicenza meeting a study protocol was prepared (Annex 1) and was implemented by the four national study groups during April and May 1983.

A second coordination meeting was then prepared to be held in Lisbon by the end of June of 1983 with the following objectives:

- (1) Report, discuss and summarize the findings of Part I of the study and define the main orientations of the related interim report.
- (2) Identify the main components of Part II of the study and develop a programme of work for the second semester of 1983.

2. Second Coordination Meeting

2.1 The meeting was held at the National School of Public Health in Lisbon. The opening session was attended by the Portuguese Minister of Health and all the Director Generals of the Ministry. This was the Minister's first public appearance after taking office, and he delivered a very supportive opening speech (please find as Annex 2 a translation of this speech).

2.2 Other than the members of the national study groups (please find list of participants as Annex 3) the following observers also attended the meeting:

- (a) The coordinators for the general practitioners' training programmes in the northern and southern regions of Portugal.
- (b) The President of the newly formed Portuguese Association of General Practitioners.
- (c) The Director of the Department of Primary Health Care of the health administration of Andalucia (Spain) - Dr J. M. Freire.
- (d) The Director of the Madrid Mental Health Institute representing the health administration of the Madrid region - Dr Alfonso Calvé.
- (e) Dr Maria Sofianapoulou, a Greek working as consultant on the organization and planning of hospitals in Frankfurt, Federal Republic of Germany.
- (f) Dr E. Moraitis and Dr K. Apostolou, two Greek doctors involved in the Greek Health Center Development Programme.

2.3 The first two working sessions comprising the first day of the meeting were dedicated to the reporting and discussion of the findings of Part I of the study. Each study group presented a written report of their findings and an oral summary presentation of the report. However, because of the fact that the study groups did not have a chance to become acquainted with each other's work before the meeting, the discussion of the findings reported could not be developed as far as expected. Dr Sakellarides, PHC/C, will prepare an interim report on Part I of the study during July 1983 on the basis of the reports presented and the discussions regarding them. The report will then be sent to the study groups for comments before finalizing it.

During the working sessions that took place on the second and third day of the meeting the participants became involved in the identification of the main components of Part II of the study and also in establishing a programme of work for the second semester of 1983.

The participants chose to select the following areas for further study:

- (a) community involvement in health care;
- (b) health care user dissatisfaction;
- (c) professional profiles for the elements of the health care team;
- (d) factors influencing primary health care budget formulation; and
- (e) training for primary health care.

Some considerations concerning the variables to be used for further describing the areas indicated above and on the methods to be used for that purpose were also made. A study protocol for Part II is now going to be prepared on the basis of these indications.

A programme of work for the second semester of 1983 detailing the different activities that are expected to occur during this period can be found as Annex 4.

The third and final coordination meeting for this study has been planned tentatively for the end of January 1984. The Greek group has indicated that a decision will be taken by Greece before the end of September 1983 as to the possibility of organizing the meeting in Athens. If this turns out not to be possible, the Spanish group has already offered Barcelona as an alternative.

2.4 During the Lisbon meeting a public session was organized where the Greek, Italian and Spanish groups presented to a Portuguese audience a summary review on the organization of primary health care in their countries and what might be the present trends for development.

During the meeting a study visit was organized to the health centre of Oeiras in a suburb of Lisbon. During this visit professionals from three other health centres presented to the participants some aspects of their experiences.

3. General Comments

It has been explicitly stated that beyond the results of this study as such the process of developing the study should by itself constitute a contribution towards the development of primary health care in the participating countries. Thus far this objective seems to have been successfully achieved:

(a) The study is contributing to the development of a southern European network of professionals interested in the improvement of primary health care in their countries.

(b) The panel methodology that has been used in Part I of the study has brought a large number of health professionals, politicians and lay people of the participating countries into close contact with the issues of primary health care.

(c) The coordination meetings themselves have been successful in calling attention to primary health care as a key element of the development of the health care systems in southern Europe.

It was suggested during the meeting that WHO continue to support the cooperation among southern European countries in the area of primary health care that this study has initiated.

PHC/C took advantage of the presence in Lisbon as observers in this meeting of Dr Moraitis and Dr Apolstolou and also of members of the Greek Central Health Council to review the present status of the Greek program (a separate note for the file is being prepared on this subject).

Similarly, PHC/C discussed with Dr Alfonso Calvé from Madrid and Drs J. M. Freire and Mercè Casas from Andalucia some aspects related to a participation of Spain in the study on indicators for monitoring primary health care and other issues (on this matter please see briefing on Spain for DPM as Annex 5).

During the meeting PHC/C was also approached by the President of the Portuguese General Practitioners' Association on the possibility of organizing in Portugal with WHO sponsorship an international meeting on the development of primary health care in southern Europe with the possible participation of general practitioners from Portugal, Spain, Italy, Yugoslavia and Greece. (A separate note for the file is being prepared on this matter.)

THE STUDY ON THE ORGANIZATION OF PRIMARY HEALTH CARE
IN SOUTHERN EUROPE

STUDY PROTOCOL

SECTION 1:

Annex 1

Introduction

The first coordination meeting for this study was held in Vicenza, Italy from 10-12 November 1982 and was aimed at defining the main orientations for the study protocol and at establishing a programme for implementing the various activities related to the study.

This is an introductory work in this area. No previous experience of comprehensive cross national studies of the Southern European health care systems (Portugal, Spain, Italy and Greece) is available. The members of the national study groups met in Vicenza for the first time. Under these circumstances it was felt that a two-step approach to the study planning and implementation is highly advisable:

First step (Part 1) - a general description of the health care system in the four countries using a common protocol for collecting and summarizing information. This part is to be implemented during the first semester of 1983. It is designed to establish a commonly agreed conceptual frame for the participants to identify the more sensitive aspects of health systems development in the Southern European context and to generate a basic description of primary health care in the countries involved.

Second step (Part 2) - a detailed comparative study of selected aspects of the health care system to be designed taking into account results of part I. This part will be implemented during the second semester of 1983.

Consequently this study protocol refers only to Part 1 of the study. It is, however, important to stress that Part 1 of this study can be considered a preparatory phase for Part 2.

Section 2 deals with the theoretical background of the study to be summarized.

Section 3 described the study design.

Section 4 details the organizational aspects of the study.

SECTION 2:

Theoretical background and study objectives

1. The health care system and primary health care principles.

The 1978 International Conference of Alma-Ata established a set of concepts defining the scope and purpose of primary health care. These principles were unanimously accepted by WHO Member States.

Point 6 of the Declaration of Alma-Ata attempts to summarize a primary health care definition:

"primary health care is essential care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and selfdetermination. It forms an integral part both of the country's health system of which it is a central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process." (1)

Three types of statements can be identified in this definition:

- (a) a philosophy of care where both "service" ("practical and scientifically sound methods and activities made universally accessible") and "community" ("socially acceptable through full participation in the spirit of selfreliance and selfdetermination") aspects are considered.;
- (b) an emphasis on the high relevance of primary health care within the national health system ("it forms an integral part of both the country's health system of which it is the central function and main focus and of the overall social and economic development of the community");
- (c) a focus on primary health care activities as being those "in the first level of contact of individuals, the family and community with the national health system, the first element of a continuing health care process".

A frame of reference derived directly from the primary health care conceptual construct is consequently suggested for this study. The health systems of the participating countries are going to be described in their "service" and "community" components, and of course service/community interface and interaction will also be considered. Aspects related to the health systems control are necessarily examined in some detail since they closely relate to the development of primary health care as a philosophy of care.

2. The Southern European context

The social insurance institutions in Southern Europe implemented a medical care system where care was frequently delivered in facilities owned by the social insurance by mostly salaried medical and nursing personnel. Specially after World War II this system developed to become the most important source of ambulatory medical care in these countries.

This model has passed practically unnoticed in the health services literature. For example the Southern European model is ignored in Milton Terris (2) oversimplified classification of "three world systems of medical care" (public assistance; national insurance; national health services). Milton Roemer (3) while attempting a more detailed classification (free enterprise; "welfare state"; transitional developing; undeveloped; industrialized socialist; agrarian socialist) fails to recognize the Southern European model and some of its similarities with the health care system he has identified in the Eastern Mediterranean and Latin America (3) (4).

This medical care system has been under mounting pressure for change over the 70s and early 80s. In Italy its complete integration in a national health service structure was decided in 1978. In Portugal the central administration of this system was placed under the control of the Ministry of Health by 1977. A process of reorganizing the social insurance medical clinics under regional health administrations while implementing a career in general practice is in progress. Greece is reorganizing health services mainly through regionalization, health centre development and a new medical career. In Spain during 1982 the political process of regional autonomy has favoured some transfer of health care responsibilities from central to regional level and further developments are expected under the present government policies.

Some common and highly relevant issues in this process of change in the Southern European context can be identified:

- (a) decentralization - political and administrative aspects;
- (b) "administrative" versus "developmental" approaches for change in health care practices;
- (c) "planning" "management" and "organized efforts" - cultural determinants and constraints;
- (d) the role of the state in the provision of health care;
- (e) public services structure and "professional independence";
- (f) political authority and administrative authority - what balance?;
- (g) implications of medical manpower size and rate of growth;
- (h) nursing and social workers' roles in primary health care;
- (i) the transition from medical clinics to health centres or local health units;
- (j) the rebirth of medical general practice;
- (k) primary health care doctors: public health officers, community health administrators and general practitioners.

3. Cross national health care research and study objectives

The objectives of this study were established by considering both the primary health care conceptualization and the Southern European context just described. A description of primary health care requires some sort of a comparison or matching exercise between what the theoretical understanding of the primary health care concept is and the characteristics of a given health system under consideration. Corresponding statements between the conceptual construct of primary health care and the structures, processes and events of a given reality are thereafter established. Health care system description becomes then an essential mechanism for further elaboration an improvement on the primary health care conceptualization.

The Southern European model of primary medical care delivery under social insurance, the pervasive pressures for change that are being observed in this area and the main issues involved in this process of change need to be taken into account as well in determining the study objectives.

Furthermore, the potentials and limitations of cross national health care research as illustrated by previous work and current thinking are considered. Although the theoretical base of cross national health care research is insipient, some important contributions should be emphasized (5) (6) (7) (8) (9) (10). Most studies rely on a usually implicit causal model although more "structural" oriented approaches can be identified (10). Often the relationship between the study's purpose, objectives and variables to be ascertained is not clear. Information on national characteristics is often based on individual contributions (11) others on a collection and treatment of available information from national official channels (12). Sometimes attempts are made to design a listing of comparative descriptive items to be collected (13) (14). Rarely a detailed study protocol is established (9).

The objectives of this study are therefore the following:

Main objectives:

- (a) to identify, innumerate and classify the primary health care elements of the Southern European health systems and their development in the last three decades;
- (b) to contribute to the understanding of the main factors associated with health care development in Southern Europe by:
 - (1) replicating observed intra-country relationships over the four countries involved in the study;
 - (2) attempting to explain intercountry differences in health care on the basis of a set of differential socio-economical and cultural factors;
 - (3) elaborating and interpreting Southern European similarities;
 - (4) contrasting Southern European similarities with health systems of other European subregions.

Complementary objectives:

- (a) to develop a descriptive methodology with hypothesis generating potentials in health service research but also useful in the area of health services planning and management;
- (b) to contribute to the development of a Southern European network of professionals interested in the improvement of primary health care in these EURO subregions.

SECTION 3:

Study design

1. Primary health care description

1.1 Concept selection

As already indicated the descriptive frame of this study considers four section:

- community subsystem;
- service subsystem;
- community - service interaction; and
- systems control

In each section a number of primary health care concepts are considered. These are innumeraed in Table 1. The high degree of comprehensiveness of the primary health care concepts imply a very extensive conceptual domain. Therefore, for reasons of parsimony and practicality a selection is necessary. Such selection takes into consideration the theoretical background outlined above.

1.2 Since all the primary health care related concepts relevant in this context cannot be assigned to one and only one of the four sections indicated above, either repetition or a rather arbitrary unique assignment can be noted.

Ascertainment of the concepts included in this study's description frame, needs to be performed on the basis of a number of variables. Since in most cases only a large number of variables can reasonably cover the domain of the concept involved, a second selection level had to be considered at this point. A relatively few variables were chosen to describe the concepts involved (Annex 1 - guidelines for information gathering).

A number of different types of variables are to be considered according to the measurement strategy chosen.

Two kinds of measurement are to be used:

- measurement by counting
- measurement by scaling

(a) Some variables to be used in this study imply measurement by counting (e.g. utilization data or mortality data). Since in this part of the study no primary data collection is considered these measurements are to be extracted from existing reports or studies.

(b) Often detailed information concerning some aspects of the health system is either not available or difficult to quantify. Sometimes such information is available but interpretative judgements are considered useful. Consequently, scaling becomes necessary and two basic sequences are to be considered in this study. The first instance where a nominal scale is used as for example in task analysis of health professionals. Here to each task description a number is assigned and the question becomes which of the tasks innumeraed are performed by a given professional. In this kind of description clear definitions are essential.

The second situation to be found is where an ordinal scale is used to express preference or order of importance. This is frequently the case in assessing relative importance of certain types of policy or administrative practice (e.g. highly predominant, predominant or non predominant). Since this type of measurement poses important problems to cross country comparability, often these variables are analyzed over a period of time. In this way rather than focusing on a particular ordinal distribution in a certain point in time, the important element becomes the distributional changes over time.

Time trends are a major element of the study design and are going to be considered in a large number of selected variables.

(c) Scaling and scoring subjective probabilities as a measurement strategy is not considered feasible at least at this stage of the study.

Finally, the levels of aggregation or disaggregation of ascertainment needs to be considered. In this respect specific indications are going to be given for each concept to be described (Annex 1).

2. Methods of ascertainment

The sources of information to be used for this study are hereafter defined and information gathering procedures specified.

2.1 Sources of information: the sources of information concerning the variables defined in the study design are the following:

- (a) Documents available from official sources and studies published concerning the concepts and variables defined in the study protocol.
- (b) The national study groups.
- (c) Two expert panels (A and B). General rules for the constitution, operation and description of the panel of experts are established in Annex 2.

2.2 Information gathering procedures: the three members of each national group are to play the role of information collectors in relation to the sources ((a) and (c)) referred to above. A document: "guidelines for information gathering on the organization of primary health care in Southern Europe" (Annex 1) details these aspects.

3. Validity, reliability, testing and feasibility

3.1 Validity: in the context of this study, both the validity of the description frame (concepts and variables) and that of the cross national comparisons are to be assessed by how sound are the theoretical background, objectives and study design and their logical interrelationships and how well the ascertainment of the study variables is carried out. This can only be done by detailed recording of all stages of the study, planning, preparation and implementation and sequential evaluation of each stage. Validity issues are to be anticipated through the discussion and establishment of the study design (listing of validity issues and solutions proposed) and by strict adherence to the definitions, rules and procedures established in the study protocol. Discussions with the study coordinator of every possible ambiguity on doubt concerning the implementation of the study and detailed recording of all unavoidable deviations from the study protocol are important aspects in ensuring or assessing the validity of the study.

3.2 Reliability: testing the reliability of the entire information gathering procedure seems unfeasible and possibly unnecessary. Since it is assumed that the experts chosen to be part of these panels are considered to be the best possible sources of information concerning the study variables, the repetition of data collection procedures with a different set of panels is indeed expected to arrive at different results. However, two approaches may be introduced to test the reliability:

- (a) compare the results obtained from the panel with those to be collected from specific experts on certain descriptive items.
- (b) use the degree of agreement between panel members or between panels A and B on certain issues as a measure of reliability.

(c) panel's qualitative assessment of quantitative information.

3.3 Feasibility: the feasibility of this study protocol is to be established by assessing whether the different content requirements of the study protocol, the availability of the members of the national groups and the timetable constraints (the study is expected to be executed during 1983) are compatible. After consulting with the study group, some changes have been introduced on the original version in order to comply with some feasibility constraints.

4. Analysis and interpretation of results

The summarization and analysis of the information collected in this study will be based on the following principles:

- (a) Develop a set of hypotheses interrelating the different concepts studied and concerning the development of primary health care.
- (b) Within each country, see to what extent the observations made support the hypotheses formulated and make the necessary corrections.
- (c) In the context of cross-national comparisons, see to what extent the hypotheses generated and strengthened by the present observations within each country hold for the other countries.

SECTION 4:

Organization of the study

1. Study implementation (Part 1)

1.1 The panels indicated in the study design should be convened during May 1983. A copy of all information collected needs to be received by the study coordinator before 17 June 1983.

2. Analysis, interpretation and reporting of results

2.1 Each study group should prepare its own preliminary analysis for the Second Coordination meeting (Lisbon, 27-29 June 1983).

2.2 The study coordinator will prepare a preliminary cross-national analysis for the Lisbon meeting.

2.3 During the meeting, both national and cross-national analyses are going to be discussed in order to prepare a report to be included in the background material of the Conference on Primary Health Care in Industrialized Countries (Bordeaux, France, 14-18 November 1983) and to prepare the Second part of the study.

Table 1

Concepts relevant for the description of the organization of
primary health care in Southern Europe

<u>REFERENCE TO THE HEALTH SYSTEM</u>	<u>CONCEPTS</u>
1. <u>COMMUNITY SUBSYSTEM</u>	
Concept 1:	<u>The role of community organizations in the promotion of living conditions and healthier lifestyles</u>
Concept 2:	<u>Non-professional health care</u>
Concept 3:	<u>Selfcare</u>
Concept 4:	<u>Health problems and needs</u>
2. <u>SERVICE SUBSYSTEM</u>	
Concept 5:	<u>Sources of delivery of primary health care services</u>
Concept 6:	<u>Manpower structure in primary health care services</u>
Concept 7:	<u>Overlap on primary health care provision</u>
Concept 8:	<u>Activities performed by the primary health care services</u>
Concept 9:	<u>Horizontal integration of primary health care activities</u>
Concept 10:	<u>Integrative mechanisms for primary health care activities</u>
Concept 11:	<u>Support services and vertical integration of health care</u>
Concept 12:	<u>Collaboration between health services and other services</u>
3. <u>COMMUNITY/SERVICE INTERACTION</u>	
Concept 13:	<u>Community involvement in health services</u>
Concept 14:	<u>Accessibility to health services</u>
Concept 15:	<u>Utilization of health care services</u>
4. <u>HEALTH SYSTEM CONTROL</u>	
Concept 16:	<u>Health systems control</u>

References

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- Concept 1: The role of community organizations in the promotion of living conditions and healthier lifestyles
- Concept 2: Non-professional health care
- Concept 3: Selfcare
- Concept 4: Health problems and needs
- Concept 5: Sources of delivery of primary health care services
- Concept 6: Manpower structure in primary health care services
- Concept 7: Overlap on primary health care provision
- Concept 8: Activities performed by the primary health care services
- Concept 9: Horizontal integration of primary health care activities
- Concept 10: Integrative mechanisms for primary health care activities
- Concept 11: Support services and vertical integration of health care
- Concept 12: Collaboration between health services and other services
- Concept 13: Community involvement in health services
- Concept 14: Accessibility to health services
- Concept 15: Utilization of health care services
- Concept 16: Health systems control

Annex 1

Guidelines for information gathering on the organization of primary health care in Southern Europe

Introduction

This document is meant to define the qualitative and quantitative information items to be collected by each national study group.

As already indicated in the study design, some of the information items here indicated are to be collected from available documents or published studies by the national study group. Qualitative statements are made by the study group or by the panel. In some cases the panel is expected to comment on information prepared by the national study group.

A separate section of this annex was developed for each concept defined in Table 1. In each of these sections the following elements can be found:

- (a) a brief introduction as to what is expected from the description of the concept under consideration;
- (b) a reference to the time period and population or geographical unit to which the information pertains and to the level of the aggregation or disaggregation sought;
- (c) a description of the information to be collected with an indication as to the expected source of information:
 - existing documents for quantitative and qualitative information;
 - the study group and panels for qualitative information.

The general rules for collecting information from the panels are indicated in Annex 2. However, some specific information can be found under the relevant sections.

Whenever an item of information indicated in this protocol is not reported, one of the following observations should be noted:

- (a) information available in existing documents but not collected; or
- (b) information not available in existing documents.

SECTION 1

CONCEPT 1: The role of community organizations in the promotion of living conditions and healthier lifestyles

1.1 The importance of this concept is to focus on the role of community organizations in health care with special emphasis in the area of health promotion.

In this context the following definition of lifestyles is suggested: "lifestyles are patterns of choices made from alternatives that are available to people according to their socioeconomic circumstances and to the ease with which they are able to chose certain ones over others".

1.2 Time reference: 1982

Population reference:

country for Portugal and Greece

region for Catalunya and Veneto

Disaggregation level - if it is felt that there are important geographical variations within the population reference mentioned above, these should be noted as comments.

1.3 Question: How active are community organizations in promoting living conditions and healthier lifestyles?

Examples of formal community organizations: municipal institutions, labour unions, consumer/production groups and cooperatives, cultural and recreational groups and associations.

Examples of elements of living conditions and lifestyles: housing, water, air and noise pollution, diet, physical exercise, coping mechanisms, social and interpersonal relationships, smoking, alcoholism and dangerous driving.

1.4 The national study group is expected to:

(a) list activities in relation to the promotion of living conditions and lifestyles and for each of these activities mention the organization or organizations that have taken any initiative in that area (by decreasing order of importance);

(b) give a summary description of three examples of such concrete activities.

1.5 Panel A will act as an informal source of information (consultative body) for the study group on this item. Panel A should comment on the observations made by the national study group. These comments and suggestions will be noted and thereafter the national study group can use them in improving their previous observations. The panel can also make some suggestions as to recommendations to improve on the present situation on community involvement in the promotion of living conditions and healthy lifestyles.

The time to be allocated to Panel A for this item is 40 minutes.

CONCEPT 2: Non-professional health care

2.1 The structure of non-professional (lay) care in a community is an important indicator of some of its cultural characteristics. On the other hand the utilization of health services cannot be appropriately interpreted without considering non-professional care use.

In describing sources of non-professional health care other than considering health care provision by persons without a professional license (folk-healers as an example) professionals like pharmacists that provide health care services non-compatible with their professional profile (prescribing, for example) should also be included.

Self and family care are not included under this concept of non-professional care (please see concept 4).

2.2 Time and population references and levels of disaggregation are the same as for concept 1 for qualitative information.

For quantitative information:

Time reference: 1970, 1975, 1980, 1982

Population/geographical reference:

Country for Portugal and Greece

Region for Catalunya and Veneto

Level of aggregation/disaggregation:

country for Catalunya and Veneto

provinces for Greece, Veneto and Catalunya

"districts" for Portugal

2.3 Question: What are the more important sources for non-professional care in the country?

2.4 Quantitative information:

- (a) percent of deliveries that were supervised or assisted by trained attendants;
- (b) percent of drugs sold by pharmacists without medical prescription.

2.5 The study group is asked to briefly summarize studies or reports published in their country in this area.

Panel A is going to be asked to list the kinds of non-professional care believed to exist in the country by order of importance of each one of the categories of non-professional care listed.

Panel A is also going to be asked to state whether in general non-professional health care is increasing, decreasing or stationary over the last ten years.

For these items a consensus mechanism is required (please see Annex 2).

The time allocated to this panel exercise will be between 60 minutes.

CONCEPT 3: Selfcare

3.1 Selfcare is a basic component of community health care. It is important by itself as a source of care and as an indicator of selfreliance but is also a matter for consideration when studying professional care.

Care provided to oneself or to one's family can be of different kinds:

- (a) health promotion (e.g. physical exercise);
- (b) disease prevention (certain kinds of diets);
- (c) health monitoring (selfexamination: breast, blood pressure);
- (d) medication control (use of prescribed and "over the counter" drugs);
- (e) minor illness and injury control;
- (f) effective use of the professional system.

3.2 Time reference: 1982

Population reference:

Portugal and Greece - country

for Catalunya and Veneto - region

Disaggregation level: if it is felt that there are important geographical variations within the population reference mentioned above, these should be noted as comments.

3.3 To what extent selfcare has been studied in the country and what kind of selfcare reading material is available?

3.4 The study-group is asked to:

(a) list and briefly summarize studies that might have been carried out in the country or region concerning the practice of selfcare in the above referred categories over the last 10 years; and

(b) rank order the above selfcare category (by decreasing order of importance) according to the amount of books and other written material available to the general public.

Here again Panel A is to be used as an informal source of information or a consultative body expected to comment on the observations made by the study group and if possible make recommendations as to the improvement of the selfcare situation in the country or region. The time to be allocated to panel work for this concept is 40 minutes.

CONCEPT 4: Health problems and needs

4.1 This section is aiming at summarizing the main health problems and needs of the communities under study.

4.2 Time reference: 5 year trend from 1960-80.

Population/geographical reference:

for Portugal and Greece: country

for Veneto and Catalunya: region

Aggregation/dissegregation levels: Age (less than 15, 15-64 and +64) and Sex (male, female) distributions whenever indicated in each of the specific information items to be studied:

for Portugal and Greece: extreme values of provinces and districts

for Veneto and Catalunya: country and extreme values for provinces.

4.3 Question: what are the main health problems and needs of the country?

4.4 Quantitative information:

(a) mortality: cause specific mortality rates (10 most important causes of death by age and sex); infant mortality rate (neo-natal and post-neonatal); maternal mortality rate; diphtheria (cases and mortality rates);

(b) morbidity: diphtheria (cases and rates);

(c) demographic and socioeconomic context: population by age and sex, population of each of the five largest cities, crude birth rate, percent of population with piped drinking water, percent of formal illiteracy rate by age, percent of population by economic sector, gross national product per capita (US\$), percent of active population seeking employment (percent of the labour force).

4.5 Consider the following categories of health problems or needs: mortality, morbidity, disability, dependancy, dissatisfaction, selfreliance, physical, emotional and intellectual development.

For each of these categories of problems or needs, the study group will indicate one minimum and three maximum (decreasing order of importance) of specific problems existing in the country.

Panel A should again be used in this item as a consultative body. Time allocated: 40 minutes.

CONCEPT 5: Sources of delivery of primary health care services

5.1 Here a description of the diversity of primary health care providing institutions or agents in the country (or region for Italy and Spain) is sought. The expression "sources of care" refers both to the agent that delivers care as an independent provider paid directly by the patient or through private insurance arrangements and to the institutions that employ contract or pay providers for delivering services.

5.2 Time reference: the basic time reference will be 1980. For 1982 only major changes that have been observed since 1980 ought to be recorded. In the case of Italy where major changes were observed in 1978 a description for 1978 is also necessary.

Population/geographical reference:

for Portugal and Greece: the whole country
for Catalunya and Veneto: the region.

5.3 The following classification of providers of primary health care is suggested - two major classificatory groups. The first one is constituted by providers with no institutional affiliation (individual and group private practice) and the second group constituted by institutional providers. Among the institutional providers there are three subgroups - the first subgroup is constituted by profit oriented private health care delivery organizations, the second subgroup by nonprofit oriented private health care organizations (beneficiary as an example) and the third group public institutions. This third subgroup can then be subdivided into another three groups: municipal services, compulsory health insurance services and government services. (Please see Annex 1).

These sources of primary health care are to be described considering the attributes indicated in Table 1 of this annex.

Table 1Description matrix

		<u>Attributes</u>
Sources of primary health care	}	
1.1 <u>Sources of care</u>		
- Non institutionalized private (individually operating doctors)		
- Institutionalized profit (medical clinics) non profit		
- private: beneficiary/foundations		
- non private: municipal/social insurance/governments/consortia		
1.2 <u>Attributes</u> (for each source)		
1.2.1	<u>Manpower</u> (doctors, nurses and social workers) for each professional group	
1.2.1.1	<u>Workload</u>	
	How many with the following weekly workload	$\left\{ \begin{array}{l} \leq 12 \text{ H} \\ 13 - 24 \text{ H} \\ 25 - 36 \text{ H} \\ > 36 \text{ H} \end{array} \right.$
1.2.1.2	<u>Remuneration</u>	
	How many with the following remuneration schemes	$\left\{ \begin{array}{l} - \text{ unit of service (US)} \\ - \text{ capitation (CA)} \\ - \text{ salary (SA)} \\ - \text{ US + CA} \\ - \text{ US + SA} \\ - \text{ CA + SA} \\ - \text{ US + CA + SA} \end{array} \right.$
1.2.2	<u>Population coverage</u>	
1.2.3	<u>Financial support</u> (mechanisms)	
1.2.4	<u>Extension of facilities</u>	
	- number of units - number of consulting rooms (medical)	
1.2.5	<u>Ownership of facilities</u>	
1.2.6	<u>Weekly hours of attendance by the services</u>	
1.2.7	<u>Year of inception</u> (only for institutions)	

5.4 The study group is expected to provide the description to Panel B for comments. (Time allocated: 45 minutes).

CONCEPT 6: Manpower structure in primary health care services

6.1 The aim of this section is to describe the evolution of health manpower resources over the last 20 years.

6.2 Time reference: A time trend from 1960 to 1980 (5 year intervals) and a 1985 projection.

Population/geographic reference: rates per 10 000 population for the country and for the Catalunya and Veneto regions in Spain and Italy respectively. Rates for the highest and lowest provinces or districts within each country or region should be indicated.

Aggregation/dissegregation level:

(a) by services: national health service (non-hospital sector) for Italy after 1978 and for INAM and the public health sector before 1978. The public health sector and IKA for Greece. INSALUD and public health sector in Spain. SMS and public health sector in Portugal;

(b) dissegregation by specialties: medical (GPs, public health doctors, paediatricians, OBG, ear, nose and throat, psychiatrists, ophthalmologists, dentists, cardiologists, surgeons; nursing (non-specialized nurses and specialized nurses in paediatrics, obstetrics, mental health and public health); other professions (psychologists and sanitary workers).

6.3 This information is to be described by the study group and summarized to Panel B, for information purposes. (Time allocated: 5 minutes).

CONCEPT 7: Overlap on primary health care provision

7.1 Two types of overlap can be described under this concept:

(a) providers of primary health care working with more than one source of primary care;

(b) population covered by more than one source of primary health care.

7.2 Time reference: the basic time reference will be 1980. For 1982 only major changes that have been observed since 1980 ought to be recorded. In the case of Italy where major changes were observed in 1978 a description for 1978-9 is also necessary.

Population/geographical reference:

for Portugal and Greece: the whole country

for Catalunya and Veneto: the region.

7.3 For each of the categories of overlap indicated above a square matrix where sources of care indicated under concept 5 are to be described in both axes may be constructed and areas of overlap then noted and commented upon. This task is to be performed by the study group and commented on by Panel B (time allocated: 15 minutes).

7.4 Consider the following two statements:

Statement A: The existence of more than one source of primary health care for the same population is useful because it provides a range of choice for the users of health services and also an environment of emulation that upgrades quality of care.

Statement B: The existence of more than one source of primary health care for the same population results in the duplication of expensive social resources and is an obstacle for continuity and comprehensiveness of care.

Panel B is to assess the previous statements using the following scale:

- agree with A;
- agree more with A than with B;
- inbetween A and B;
- agree more with B than with A;
- agree with B.

The time allocated to Panel B for this exercise will be 30 minutes. No consensus exercise is required.

CONCEPT 8: Activities performed by the primary health care services

8.1 In this section the different activities performed within the primary health care setting by different professional staff are to be described.

8.2 Time reference: 1980 for Portugal, Greece and Catalunya and 1980 and 1978 for Veneto. (Major changes in 1982 should be indicated).

The activities to be described refer to the following sources:

- Portugal: SMS clinics and health centres;
- Catalunya: INSALUD and public health services;
- Veneto: district health team;
- Greece: IKA clinics and public health services.

8.3 Question: What are the activities performed by the primary health care services and by whom?

8.4 The activities to be described are to be considered in two categories:

- personal health care activities;
- environmental health care activities.

Under personal health care activities the following listing should be considered:

- (a) complaint response (according to age groups - children and adults; according to problems - gynaecological problems, for instance);
- (b) family planning (counselling, contraceptive support);
- (c) health monitoring, counselling and supportive action for special groups (preschool children, school children, adolescents, handicapped, aged, workers, addicts, alcoholics);
- (d) disease control activities (blood pressure control - blood pressure measurement and active support and followup of hypertensives; diabetes control - glucose assessment and active support and followup of diabetics; systematic screening for cervix cancer);

- (e) mental health activities (identification of individuals at risk of mental disorder; health monitoring, counselling and supportive action for the at risk groups; management of common and emotional conditions);
- (f) outreach activities (home support, school support, occupational support, health education and promotion initiatives for community groups);
- (g) health education/promotion activities (dental health, smoking, diet, physical activities, interpersonal and sexual development, dangerous driving).

Under environmental health care activities the following listing should be considered:

- (a) environmental monitoring (housing, food, air, water and noise);
- (b) environmental protection and promotion (information, education, community animation).

For each of these activities, the study group should indicate what professionals and from what institutional source (public health sector or social insurance sector) are carrying out these activities. For this purpose the listing of professionals involved in primary health care services provided under concept 6 should be used.

- 8.5 Question: What changes in the above distribution of activities is expected to exist 5 years from now assuming a policy of primary health care development?.

The study group should indicate the changes expected to occur following the reference scheme indicated above.

Panel B will be invited to comment on the study group's observations. The time allocated for this panel exercise will be 30 minutes.

CONCEPT 9: Horizontal integration of primary health care activities

- 9.1 Question: What is the level of horizontal integration of the primary health care activities?

9.2 The general references of this section are the same as for concept 8.

9.3 The following description is to be performed by the study group:

- (a) indicate what set of activities (described under concept 8) are to be performed by the same person within each professional category;
- (b) indicate what set of activities are to be performed through the same physical facility (health centre, medical clinic) - please indicate whether these physical facilities serve a defined population or a non-defined population in geographical terms;
- (c) indicate what set of activities are performed by the same health team (group of people that have defined common objectives, interchange values and develop interpersonal relationships, programme their activities taking into account each other's role and evaluate together the results of those activities) - please indicate whether such a team serves a defined population or a non-defined population in geographical terms;
- (d) indicate what activities are performed by a professional group under the same administrative authority (authority over health planning and resource allocation).

- 9.4 Question: What will be the level of integration considered desirable in five years time taking into account the manpower resources that then might exist and assuming a policy for primary health care development?

This question should be addressed by Panel B on the basis of the observations made by the study group on point 9.3. A consensus mechanism is required. Time allocated for this Panel B activity 60-75 minutes.

CONCEPT 10: Integrative mechanisms for primary health care activities

10.1 Under this section two kinds of integrative mechanisms are to be considered: control mechanisms and managerial activities.

10.2 The general references for this concept are the same as for concept 8.

10.3 Question: what are the control mechanisms operating in the primary health care services?

In this context the expression "control" is to be understood as the process whereby an observed situation is compared with an expected one and action is taken to comply with expectations. There are different mechanisms of control:

- (a) control through authority ("give orders");
- (b) control through negotiation, coordination or participation (by this mechanism the achievement of expectations is pursued either by negotiating with different agents involved or by coordinating their actions or by establishing a participatory environment where each agent is stimulated to contribute to the common objectives;
- (c) control through recommendations or provision of information (these even "softer" mechanisms of control are based on the expectation that the agents responsible for the provision of care will react to certain kinds of recommendations or will improve their decision-making patterns by having available appropriate information;
- (d) absence of management control. (the function of control relies here on education and training).

Now consider the following management activities:

- (a) identification of needs and definition of objectives;
- (b) identification or reevaluation of roles, activities and tasks of providers of care;
- (c) allocation of resources through time, space and productivity (human resources, facilities and equipment, financial resources and information resources).

The study group is asked to indicate what kind of mechanisms of control operate in the different primary health care management activities indicated above.

10.4 Panel B is to be asked to comment on the study group's observations. Time allocated 30 minutes.

10.5 Question: How are management tasks distributed within the primary health care services and who is responsible for those tasks?

The following tasks are to be considered:

- (a) identification of target populations;
- (b) identification and assessment of needs;
- (c) development of programme objectives and goals;
- (d) planning;
- (e) organizing resources (these include the organization of available resources and development of resources not available at present);
- (f) directing operations through executive action involving decision-making and communication of decisions;
- (g) motivating staff and creating conditions for job enrichment, career patterns and organizational developments;
- (h) developing appropriate incentives and disincentives aimed at the optimal use of available resources;
- (i) evaluating the attainment of goals and social impact;
- (j) mobilizing and maintaining community support (this task description has been extracted from bibliographic reference no 12).

The study group should indicate for each of the above tasks at what level of population aggregation are they performed (15 000, 30 000, 60 000, 120 000 and +120 000) and what is the professional profile of the person performing these tasks).

Panel B should repeat the exercise for the expected situation in five years time under the same assumptions indicated in concept 9. In both cases a consensus exercise is expected. Total time allocated 60 minutes.

CONCEPT 11: Support services and vertical integration of health care

11.1 This concept deals with the relationship between primary health care and specialized care and support services.

11.2 Time reference: 1980 (with 1982 changes).

Absolute numbers and rates for 10 000 population.

Aggregation/dissaggregation levels: by ownership (See concept 5).

11.3 Quantitative description of support services (to be performed by the study group):

- (a) transportation network (cars in ambulatory services and ambulances);
- (b) laboratories (public health laboratories, clinical laboratories, X-ray facilities, auto-analysis - automatic and semiautomatic and number of X-ray Mamp;
- (c) pharmacies;
- (d) hospital beds (total acute - general and psychiatric, long-term - general and psychiatric, maternity, percent of total beds in less than 30 bed hospitals; and percent of total beds in less than 60 bed hospitals;
- (e) occupancy rate and average of stay in hospitals (average figures for the hospitals referred above);
- (f) hospital support - hospital based primary health care (percentage of hospital emergency contacts followed by inpatient car; , percent of hospital admissions through outpatient departments, emergency departments or by direct access.

11.4 The study group should write a brief description (five line) about restrictions to direct access to hospital outpatient departments and to the present state of referral systems between hospitals and primary health care.

CONCEPT 12: Collaboration between health services and other services

12.1 Intersectorial collaboration is a central issue of the primary health care conceptual approach. The improvement of health status in the community does not depend only on the provision of health services per se but also on a long range of other services and community activities. The following services will be under consideration in this section: environmental protection services (air, water, noise, food); school and educational services; welfare services; housing services; agricultural services; industrial services.

12.2 The general references for this section are the same as for concept 9.

12.3 For each of the services mentioned above the study group should identify a counter part on the health services. Then the following aspects should be described:

- (a) the name of the department in the health services that act as counterpart;
- (b) its location (central, regional and local);
- (c) when was this department initiated (year);
- (d) what forms of intersectoral cooperation may exist between health services and the other services in this area. The following categories of cooperation should be considered: cooperation at the legislative level, cooperation at the planning and programming level, cooperation at the implementation level (case problem solving and referrals) and no cooperation.

CONCEPT 13: Community involvement in health services

13.1 Community involvement in health services should here be considered in both individual and collective levels as related to the planning and management levels of health services and to ad hoc problem solving.

13.2 Time reference: 1982

Health service reference: central, regional and local services.

13.3 Question: Are there any regulations concerning community involvement in the planning and management of health care?

Question: If YES, are these regulations successful in stimulating community involvement in health services?

Question: What are the main political, cultural and managerial obstacles in further developing community involvement in health services?

13.4 The study group should prepare a statement concerning the above questions and discuss it informally with Panel A. Both panels are to be considered therefore in this section as consultative bodies. Time allocated for panel consultation 45 minutes.

CONCEPT 14: Accessibility to health services

14.1 Accessibility to health care services can be considered from a geographical, administrative, financial or cultural point of view.

14.2 Time reference: December 1982

Service reference: primary health care services of the national health service or of the main social insurance institutes at the country level for Portugal and Greece and at the regional level for Veneto and Catalunya.

14.3 Quantitative assessment of accessibility:

(a) geographic: percentage of the population with good access to sources of primary health care; percentage of the population with reasonable access to sources of primary health care; and percentage of population with poor access to sources of primary health care;

(b) financial accessibility: payment per encounter (expressed in local currency), for non-hospital ambulatory consultations, for emergency or "permanent attendance" services and for hospital outpatient services, payment for drug prescription (percent of total cost), payment for X-ray examinations (percent of total cost), minimum busfare in Lisbon, Padua, Barcelona and Athens, train fare for 100 kilometres (second class), gasoline cost per litre.

Note: In order to have a standard to evaluate the expenditures referred above in local currency the three following suggestions are made: minimum national salary, minimum income for family of four, cost of a kilogram of bread.

(c) administrative aspects of accessibility, number of transfers requested from GP to GP (or doctors working in non-hospital ambulatory services) per 100 doctors - specific time reference 1982, number of granted requests in the same period per 100 doctors (also in 1982), average waiting time for non-emergency GPs and paediatric services in the largest social insurance or national health service clinic or health centre in the cities of Athens, Barcelona, Venice and Lisbon.

This information should be described by the study group and commented on by the panel.

14.4 Question: Panel A and B should rank order (by decreasing order of importance) the following constraints to accessibility of primary health care services: geographic constraints, administrative constraints, economic constraints and cultural constraints.

Note: By cultural constraints it is meant the obstacles in communication between provider and user of health care services due to different cultural frames of reference.

For Panel A a consensus exercise is required. Time allocated for Panel A activity: 60 minutes. Time allocated to Panel B: 30 minutes.

CONCEPT 15: Utilization of health care services

15.1 Time reference: 1970, 1975, 1980 and 1982 if available

Service reference: main social insurance institutes or national health non-hospital services expressed as rates for the total population and population covered by the social insurance institutes indicated

Geographical population reference: country for Portugal and Greece and regions for Veneto and Catalunya

Aggregation/dissaggregation level: geographical - provinces or districts, sex, type of provider, motive (medical including first and followup visits, for prescription or for administrative purposes), age (younger than 15, 15-64, 65 and over).

15.2 Quantitative description of utilization:

total consultations, disaggregated by the criteria indicated above;
 number of emergency or permanent attendance services by age;
 number of drug prescriptions by visit, by age;
 number of X-ray and number of persons with X-ray examinations;
 number of laboratory examinations;
 number of persons with laboratory examinations;
 number of school health examinations by age (specific reference for age 5-9, 10-14, 14-20 age groups);
 number of diphtheria vaccinations by age (specific age reference 0-4, 5-9, 10-14 age groups) and time reference (1960, 1965, 1970, 1975, 1980 and 1982);
 number of PAP tests.

15.3 The study group should present to Panel A and B a brief summary of the time trends observed in primary health care services utilization.

Panels A and B will rank order (by decreasing order of importance) the following explanatory factors for the time trends observed:

- (a) morbidity factors (change on morbidity patterns);
- (b) accessibility factors (change on the geographical, administrative, economic and cultural accessibility to health care services);
- (c) behavioural factors (different awareness and/or dependency towards health care services).

A consensus exercise is required. Total panel time required for this exercise is 60 minutes.

Panel B should also comment on the degree of reliability of information on utilization and indicate factors that might influence data reliability in their country's context.

CONCEPT 16: Health systems control

16.1 Although the main issues related to health systems control can be described systematically in their main components (cultural factors, political factors, management factors, legislative factors, educational factors and manpower development factors and international factors) in a clear cut way it is thought that this section should constitute an overview of the issues discussed in the previous sections.

16.2 A series of questions are suggested as an orientation to the study group in its consultation with the Panel A and B. An effort should be made to cross reference the following questions with the 15 primary health care related concepts first received in terms of their relevance. This consultation is expected to last 60 minutes.

QUESTIONS

1. Are there important cultural factors that interfere with the management/planning development of the health systems?
2. Within your "political culture" (set of values, beliefs, expectations and attitudes defining the relationship between the individual and the state) what is the expected role of the state in the provision of health care?
3. How predominant and desirable is "policy incrementalism" (a situation where policies are not reviewed as a whole but are based on previous policies and where attention is given only to a narrow range of increases and decreases) in your present environment?
4. What is the role of health administrations in relation to health policy:
 - (a) source of political initiative?
 - (b) provision of information and advice to policy-makers?
 - (c) implementation of policy?
5. What are the most prevalent planning types (problem solving for matters of current concern; allocation of resources to meet present trends; pursuit of desirable future) and main styles (laissez-faire, incrementalism; rational/comprehensive; rational/mixed scanning) in your planning system?
6. To what extent are the present legal, organizational and managerial characteristics of your public services considered to be appropriate for professional work?
7. Are health legislation and norms detailed and all-encompassing or are they general frames of reference setting the operational limits for management?
8. To what extent do professional and industrial interest groups influence health policy?
9. What is the degree of decentralization (central, regional, local) and the pattern of political/administrative distribution of the following responsibilities:
 - (a) setting overall objectives, policies and priorities?
 - (b) financing health care?
 - (c) allocating finance?
 - (d) planning, allocating and managing manpower resources?
 - (e) planning and managing informational resources?
 - (f) setting guidelines and standards?
 - (g) planning and organizing integrated health care services?
 - (h) planning and implementing training for health care personnel?
10. What is the present level and distribution of health expenditures?
Note: please give the following quantitative information:
 - (a) health expenditure as a proportion of the gross national product for 1970, 1975 and 1980 for the country and regions;
 - (b) health expenditure per head of population including percentage of health expenditure financed by government (central and local) social insurance (compulsory insurance), private insurance, private direct payment and others;

(c) within IKA, SMS, INSALUD (Catalunja), INAM (Veneto before 1978) and Veneto primary health care services breakdown expenditures in the following way (for 1970, 1975 and 1980): expenditures with own services (total with personnel, administrative costs, equipment, drugs and others) and with expenditures transferred to other sectors (support services like X-ray, labs and others and hospital care services).

11. What are the predominant cost-containment policies at present:
 - (a) decreasing accessibility to health services (user economic participation; administrative constraints)?
 - (b) decreasing benefits?
 - (c) establishing budget ceilings?
 - (d) establishing administrative restrictions upon the use of certain resource items and technologies?
 - (e) establishing provider incentives for cost-containment?
 - (f) implementing educational programmes for cost-containment?
 - (g) implementing more direct community financing and participation in planning and management of health care services?
 12. Are training programmes relevant to the need of health care development and do they stimulate teamwork?
 13. To what extent do models of health care developed in other countries influence your health policies?
- 16.3 The panel should be asked to rank order (by decreasing order of importance) three of the 13 issues indicated above in terms of their importance for the future development of primary health care within the national health care system. A consensus mechanism is required. Time allocated for this panel exercise is 30 minutes.

Annex 2Selection, preparation and operation of
the panels of experts1. Selection and composition of the panels

1.1. The following general criteria should be considered in selecting the panel members:

- (a) The members of the panel should have a global view of the health system and simultaneously have a good grasp of the specific situation in their particular area of expertise.
- (b) A reasonable age mix is expected to exist in the panels. In each of the panels at least two elements should be of the following age groups: equal or less than 40; 41 to 50; more than 50.
- (c) Members of the panel should not view their participation as representing a certain institution or cultural, political or interest group.

1.2. The following specific recommendations should be followed in setting up the panels:

Panel A

- (a) Number of members: 10
- (b) Distribution by different sectors or professional backgrounds: 3 from the service sector (to be chosen from health administrators and providers of health care), 7 from the community sector with the following distribution: 2 from the political sector, 2 from the media, 1 from cultural or recreational associations, 2 from labour unions.
- (c) Duration: one day (seven working hours)

Panel B

- (a) Number of members: 15
- (b) Distribution by different sectors or professional backgrounds:

Ten participants from the service sector distributed among the following areas - health administration (central, regional, local), providers of health care (physicians, nurses, social workers - one of these providers should have experience with mental health), teachers and researchers (medicine, nursing, public health). From the 10 participants allocated to the service sector, a minimum of 2 and a maximum of 4 should be allocated to each of the three categories indicated above.

Five participants from the community sector, distributed among the following categories: members from the political arena and from the media, labour unions and cultural or recreational associations. Among the five elements allocated to the community sector, at least 2 should be allocated to each one of the two categories above indicated.

- (c) Duration: one day (seven working hours)

2. Preparation of the panels

When invited, the members of the panel should be given material that explains the objectives and design of the study. Background material relevant to the issues to be presented to the panel should also be available for the members of the panel. If possible, the members of the panel should meet with the national study group one week before the panel session day to be briefed about the objectives, content and methodology of the study, and more specifically, about the operation of the panel.

3. Operation of the panels

In this study, Panels A and B are going to be used in three different capacities (please see Annex 1).

3.1. The panel as a formal source of information

(a) A question is formulated to the panel, the terms of reference of the question are briefly explained to the panel, the expected format of the answer is also presented (time allocated: 15 minutes)

(b) An exchange of views between the panel and the study group in order to clarify the concepts and methods presented is expected to take place (time allocated: 15 minutes)

(c) The panel members will write down the answers anonymously (time allocated: 5 minutes)

Note: Whenever a consensus exercise is required, the following steps are also necessary:

(d) The panel's answers are summarized (this summary should record the different patterns of response obtained and their frequency) and presented to the panel (time allocated: 10 minutes)

(e) The panel re-examines and discusses the terms of reference of the question without advocating any specific response pattern (time allocated: 15 minutes).

(f) The panel members write down once more their answers anonymously (time allocated: 5 minutes)

3.2. The panel has as an informal consultative body to the study group

The study group collects information and suggestions from the panels in relation to some aspects of the qualitative description. This is intended to be an informal mechanism and no specific rules of operation are going to be indicated. The time limits for this type of interaction are indicated for each concept in Annex 1.

3.3. The panel as a resource for information evaluation

In this capacity, the panel is expected to enumerate and weigh the reliability of the information presented.

TRANSLATION OF SPEECH GIVEN BY PORTUGUESE MINISTER OF HEALTH

I was pleased to initiate my program of public appearances by inaugurating this meeting, which is being held on the initiative of the WHO Regional Office for Europe, for two reasons.

The first reason is that it gives me a chance to state the utmost importance that I personally and the government to which I belong attribute to the principles and practice of primary health care as formulated by the international conference of Alma-Ata in 1978. Secondly, because it gives me the opportunity to visit the most important and well-known teaching institution of my Ministry, the National School of Public Health, and also the National Institute for Health, which is of strategic importance as a research institution.

I am probably the first Minister of Health to visit these two institutions and I am certain that the elevation of the Secretary of State for Health to the category of Ministry is not simply an operation of political prestige but it is mainly a confirmation of the priority that the government attributes to health issues.

The four countries which are represented in this meeting - Greece, Italy, Spain and Portugal - are not in fact a representative sample of all Europe or even of Western Europe. However, they are countries that share some important realities: geographical proximity, historical relationships, their cultures, their degree of socioeconomic development. Two of the four countries already belong to the EEC; the other two, from the Iberian peninsula, are now in the process of joining that organization. Three of the four countries represented here do have at the present moment socialist governments or socialist/socialdemocratic coalitions, as is the case with Portugal.

In the health field in all our countries there is a strong sector of social insurance that finances and even delivers primary health care and sometimes also hospital care. In all our countries we are under pressure from the present medical demography. In all of our countries we are concerned about the increase of expenditures with health, and we are all attempting to integrate in a unique system the previously dispersed institutions of primary medical care.

The Portuguese experience in health administration is rather rich, and I am sure that the same can be said concerning your countries. In the last twelve years we have gone through very important changes in our health care system, and I would like to emphasize the three following ones:

- (a) the decisive priority toward primary health care since 1971;
- (b) universal coverage to the entire Portuguese population by a National Health Service since 1978; and
- (c) the increased importance attributed to health as reflected by the increased public expenditure on health (1.9% of the gross domestic product in 1970 to 4.3% in 1980).

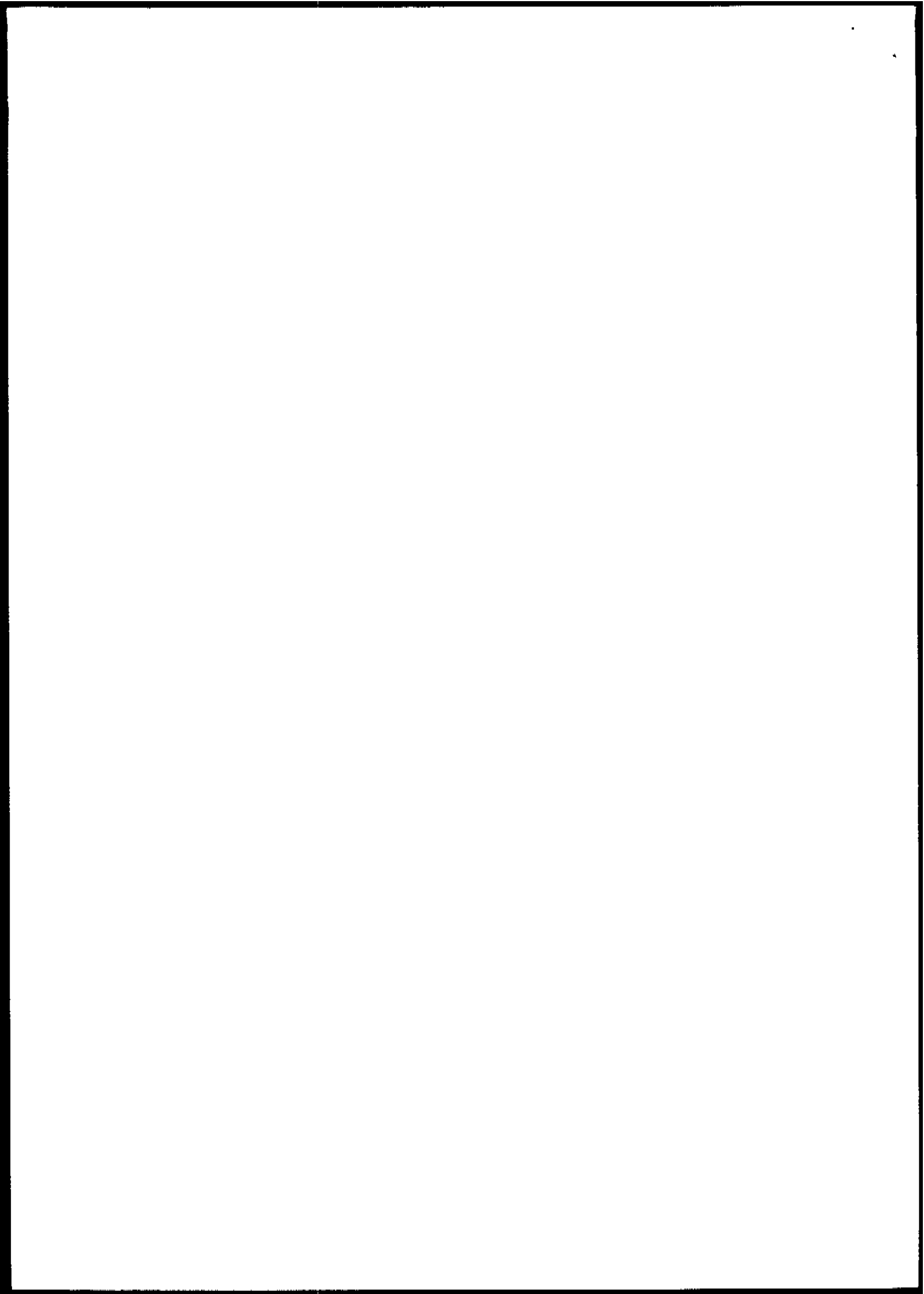
We are living an age of rapid transformations: in less than eight years our coverage by the social insurance schemes increased from 60% to 100%. The costs of this evolution, which took place in an era of government instability and growth of our democracy, are high, and this experience is worthwhile being studied. We have committed a few errors along this process, and we are more than willing to contribute to the prevention of the same errors by others.

The Ministry of Health is committed to transforming as soon as possible our primary medical care system, mainly responsive, curative, consumerist and depersonalized, into an integrated primary health care system characterized by continuity of care, humanization, coherently articulated with the hospital network. It is a difficult task, and we are counting on the conclusions of your study as a contribution to this task.

I know that your project is approximately half way and you are now proceeding to the establishment of a comparative description of the health care systems in our four countries. We are very interested in having immediate access to the results of the first part of your study, and our

Ministry is particularly interested in your final results. Because of this fact, I pledge the official support of this Ministry to the national study group.

I wish you all a good stay in my country and a fruitful meeting.





Second coordination meeting of the study on
the organization of primary health care
in southern Europe

Lisbon, Portugal, 27-29 June 1983

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ENGLISH ONLY

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ICP/PHC 013.5
4 July 1983

Lisbon, Portugal, 27-29 June 1983

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PROGRAMME OF WORK FOR THE SECOND SEMESTER OF 1983

	7	8	9	10	11	12	1
<u>Part I</u>							
Report 1st draft							
sent	X						
revised		X					
Report Final version			X				
<u>Part II</u>							
Protocol 1st draft							
sent		X					
revised			X				
Protocol Final version				X			
Study Implementation							
Study Results						X	
Final Meeting							X

• Answer from Greece

regarding venue of meeting

CS/vj

ADDITIONAL BRIEFING FOR SPAIN

Annex 5

1. I contacted informally Dr Henrique Nagera, Director General for Health in Spain in relation to the Spanish interest in the study on the organization of primary health care in southern Europe and the study on indicators for monitoring primary health care. He conveyed to me in Geneva and again through Dr Mercè Casas, his interest in these studies but I did not have a chance to discuss related issues in more detail.
2. Study on the organization of primary health care in southern Europe. Dr Alfonso Calvé representing the health administration of the Madrid region attended on his request the Second coordination meeting held in Lisbon, 27-29 June 1983.

Dr José Manuel Freira Campo, Director of Primary health care for the health administration of Andalucía, also attended the meeting as observer on his request.

It should be noted that the Spanish study group in this study is from Catalunya.

Since it has been announced in Spain that the central government is preparing a health care reform, one of our intentions in contacting Dr Nagera was to explore the possibility of having in this study an observer from the central government body that might be preparing the reform plans. However, this was never discussed and therefore I will follow Dr Nagera's request through Dr Casas and send him the study reports as they become available.

3. Study on indicators suitable for monitoring primary health care. It was decided to include in the study a representation from all European subregions. In relation to southern Europe, it was felt that since EDRO has an MTP with Portugal, a programme with Greece is being initiated and Italy is finding its way in the novel national health service, Spain should be considered as a most interesting candidate for inclusion in this study.

I took advantage of the presence of Dr Alfonso Calvé and Dr Freira, respectively from Madrid and Andalucía, in Lisbon, to discuss with them the possibility of including Madrid (urban region) and Andalucía (rural region) group in this study. Both welcomed the idea.

The first meeting related to this study was initially planned to take place in Copenhagen during the month of August. However, Professor Picard from Rennes suggested that we could take advantage of the presence in Lisbon for the ASPHER meeting (26-30 September 1983) of some of the participants of this study and organize our meeting in the first week of October in Lisbon.

Since Dr Freire and Dr Casas appeared very eager to have this organized in Sevilla, we are now considering this possibility (3-5 October 1983). It will be useful to have Madrid government's informal reaction to this possibility as soon as possible.

4. Both the Madrid regional government and the Andalucia regional government seem interested in implementing primary health care meetings in their regions with WHO/EURO participation. Andalucia was considering to hold a primary health care seminar 6-7 October 1983. Further details are expected from both health administrations.
5. As it can be noted by the developments described above, regional governments in Spain are becoming more and more active in attempting to stimulate primary health care developments in their regions. WHO will most likely be called upon to participate in this development. Some guidelines for dealing with these situations with the Madrid central government may be needed, both to avoid misunderstandings with the central government and also to avoid frustrating the regional health administration expectations towards WHO's capability of playing a leadership role in this area.

Constantino Sakellardes