

ANALYSIS OF THE  
FUNCTIONS OF PRIMARY  
HEALTH CARE IN TODAY'S  
EUROPE



WORLD HEALTH ORGANIZATION  
Regional Office for Europe  
COPENHAGEN

## TARGET 12

### REDUCING MENTAL DISORDERS AND SUICIDE

*By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.*

## TARGET 28

### PRIMARY HEALTH CARE

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

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# ANALYSIS OF THE FUNCTIONS OF PRIMARY HEALTH CARE IN TODAY'S EUROPE

Report on a WHO Consultation

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## ABSTRACT

As countries of the WHO European Region reform their health care systems, interest is growing in primary health care (PHC) as a means of securing better care at a lower cost. The WHO Regional Office for Europe convened a consultation of experts from widely differing countries of the Region to discuss the current and future functions of PHC. In addressing the question of how to reap the greatest health gain, the participants began by asking what functions PHC should deliver; the answer to this second question would point to the proper combinations of functions, providers and settings that would answer the first. The participants then identified a set of basic, additional and support functions for PHC. Their work was the first step towards developing a practical tool to identify the functions delivered in countries; this would permit international comparisons and the identification of needs for improvement.

### *Keywords*

PRIMARY HEALTH CARE – trends  
DELIVERY OF HEALTH CARE – trends  
EUROPE  
CCEE  
FINLAND  
GERMANY  
RUSSIA  
SPAIN  
PORTUGAL  
TURKEY  
UNITED KINGDOM

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## INTRODUCTION

The Consultation on a Functional Analysis of Primary Health Care in Today's Europe was held from 6 to 7 June 1994 at the WHO Regional Office for Europe in Copenhagen. The participants – experts from seven widely varying countries in the WHO European Region and staff of the Regional Office – were asked:

- to describe the current functions of primary health care (PHC) services in selected countries of the Region; and
- to list the broad health-related functions that PHC should fulfil in the Region by the turn of the century to meet both the current and anticipated changes in the health needs of the population.

The working papers and participants are listed in Annexes 1 and 2, respectively.

## THE FUNCTION APPROACH

Countries throughout the WHO European Region are working to reform their health services. While western countries are concerned about the rising costs of care and the extent of the benefits they bring, the eastern countries are transforming their health care systems in the midst of great social, political and economic change. PHC is the focus of change in these reforms, as a cheaper and more effective form of care.

The central question is how PHC services can contribute most to improving health. The search for answers often focuses on structure. This approach takes a narrow view of PHC as a segment of the health care sector, and it leads to problems as well as solutions. In addition, solutions tailored to one country's definition of PHC and system of care can rarely be shared with other countries.

As defined by the principles of the Declaration of Alma-Ata, however, PHC touches not only all parts of the health sector but also the other sectors that affect health. Policies on health and health care

determine the functions delivered in a particular situation, and health care can be defined as a combination of three elements – functions, providers and settings – to realize gains in health. This definition can be used to rephrase the central question; that is, what are the ideal functions needed to secure health gains, and by what providers and in what settings should they be delivered? Answering this question would secure health care based on the needs of the population and appropriate to the different circumstances in countries.

This approach could be used equally fruitfully on more detailed questions. For example, one could ask what combination of functions, providers and settings could be used to reach a health target (such as the reduction of pregnancy in teenagers), deal with a health problem (such as mental illness) or address the needs of a particular group (such as an ethnic minority). In addition, the approach sidesteps the problems of the structural approach, allowing countries to share their ideas and experience.

## DISCUSSION

Before listing the functions of PHC, the participants discussed systems of care in their countries. In addition, Regional Office staff representing the programmes on health promotion, nutrition, nursing, sexuality and family planning, training and research in public health and countrywide integrated noncommunicable disease intervention (CINDI) explained the relevance of PHC in their fields. Several suggested functions for PHC, which included: building alliances within and outside the health sector, advising and distributing information, conducting surveillance, and acting as leaders and advocates, particularly for intersectoral action.

## COUNTRY REPORTS

### Finland

In Finland, health care is the responsibility of the municipalities; the private sector makes up a small proportion of care in cities. Social health insurance covers the costs of pharmaceuticals, salaries and sick leave; the rest is financed by state and local taxes. Patients pay some nominal fees. The approximately 440 municipalities cooperate to run a network of about 200 health centres that covers the whole country. Each centre serves the population of a particular catchment area, with smaller units to cover the people in each locality. Each centre has a political board to make decisions and control financing, and a director, usually a general practitioner (GP), who takes charge of the centre and its activities. The local units and the hospital also have directors.

Health care teams, composed of a variety of professionals, deliver services; as well as being multiprofessional, more and more teams are becoming intersectoral, as municipalities begin to fuse the health and social services. The system is based on GPs, but the health centre team also includes a variety of nursing staff, speech therapists and physiotherapists, dental staff and some social staff. The team at a smaller unit usually comprises a GP, two nurses and two auxiliaries.

The functions of the health centre include: GP services (including emergency care), health education, well baby clinics, antenatal care, health care in schools, and community nursing. Each centre has a hospital, which serves mainly the old and chronically ill and handles support functions, such as radiology and laboratory services. Centres also provide veterinary and environmental health services. They do not function as outpatient clinics; patients come to see their own doctors, who refer them to specialists in secondary care if necessary. Mental health services are organized separately.

## Germany

Germany has primary medical care, rather than PHC. GPs provide most services, with the assistance of specialists such as gynaecologists, paediatricians and doctors of internal medicine. Nevertheless, the principles of PHC have become part of health policy with the support of the medical profession.

Three factors hindered the development of PHC. The structure of the social health insurance system stressed cost-containment and gave no room for PHC and health promotion. The medical profession was sceptical about WHO principles of PHC, and cooperation between health professions was lacking. The growth of ambulatory services, the promotion of general practice and doctors' growing interest in health promotion, however, worked in favour of PHC.

Both WHO strategies and national legislation on health care reform have increased the relevance of the principles of PHC. The principles of the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and a 1990 meeting in Bonn on health promotion as an investment in health became part of official policy in the reform act of 1989 and the health structure act of 1993. This legislation, with the third stage to follow in 1995/1996, stresses the importance of health promotion in care, with increased preventive and rehabilitation activities. Current policy includes the idea that primary medical care should be as ambulatory as possible and as stationary as necessary, and the promotion of general medicine and of GPs as a professional group. GPs used to make up only 40% of the medical profession. After 10 years of a state and professional policy whose target level was 60%, GPs now make up about 50% of the profession.

Further, the federal policy on the funding of health research stresses disease prevention and health promotion in the community, an idea taken up in many activities of municipalities. A resolution of a German health ministers' conference urged that public health services act as coordinators of health education. The concepts of the WHO Healthy Cities project have sparked many activities in communities, and become part of official health policy. In addition,

three major programmes of the medical profession show German doctors' interest in the principles of this policy:

- the further development of prevention and rehabilitation in the community in the context of health promotion;
- the development of a care system based on the family doctor;
- the promotion of citizen autonomy and involvement in the health care systems (including new fees for services);
- better cooperation between doctors and with other health professions; and
- intensified quality assurance to ensure more effective and efficient care.

Three important factors characterize the current situation. First, nongovernmental organizations and municipalities have established growing networks of PHC programmes and activities in the community. Second, health insurance companies and doctors' organizations are making greater efforts towards practice in groups and in the community. Third, these efforts include building new structures for medical cooperation in the third stage of health reform legislation.

## **Portugal**

A 1979 law created a state-controlled National Health Service in Portugal. Its objectives are to prevent disease, promote health, and provide treatment and clinical and social rehabilitation. The state contributes 90% of the costs of the National Health Service, and users of services pay some service fees, part of the cost of some diagnostic tests and specialized treatments, and the costs of drugs not included in the Portuguese national formulary.

PHC is delivered through about 360 health centres with nearly 1900 smaller units. Each municipality has one or more centres, and about 130 centres have a total of 2500 inpatient beds. PHC staff include about 8000 doctors, about 5900 of whom are GPs or family doctors and 400 are public health doctors. Other medical staff

include paediatricians, gynaecologists, stomatologists and ophthalmologists. GPs or family doctors make up only about 20% of the doctors in Portugal.

The coordinated work of GPs and public health doctors in health care centres is the core of the PHC system. Other members of the PHC team include nurses and social workers, who number only 6000 and 125, respectively.

All citizens must register with the GP of their choice. Each has about 1500 potential service users, but there is no real equity in access to or the use of services, or expenditure per head. Further, as employees of the National Health Service, GPs receive a fixed salary, regardless of the numbers of people on their lists or the services provided. While service users are required to see their GP before seeking specialized care, many are referred directly to, or directly approach specialized facilities.

A new, three-level career path was established for GPs in 1982, but most entered the National Health Service with little or no postgraduate education. Three institutes provide training, and the Lisbon School of Public Health offers courses in public health for GPs.

The traditional public health services are being integrated into more comprehensive health care programmes. Public health doctors are broadening their work to include disease prevention and health promotion, and partnership with other professionals and people in the community.

Several problems are hindering the development of more comprehensive PHC. First, decision-making is centralized, and national targets are not adapted to regional and local needs. In addition, the health sector makes decisions about care in isolation. Second, PHC lacks adequate funding from the state but is not allowed to seek alternative sources. Third, coordination between the three levels of services is poor, and there is no tradition of community participation. Finally, the functions of PHC focus almost entirely on classic preventive programmes. Health promotion, the management of the health of groups at risk, and care for chronic diseases and mental illness are weak or absent.

## Russian Federation

Health care in the Russian Federation varies widely in geographical terms and in structure and content. PHC is more common in rural areas, where GPs supply most care. Where GPs are lacking, feldshers and nurses deliver services.

In the big cities, PHC is delivered by area doctors, who work in outpatient clinics (or polyclinics) at the district level and are surrounded by specialists. The area doctor serves a catchment area that is half the size of that served by a specialist. A district may have several polyclinics, and clinics for special groups. District health authorities coordinate and finance the hospitals, which belong to the city health authorities.

The area doctor is the centre of PHC; such doctors treat minor problems, but refer many patients to specialists working on the PHC level. Each group of specialists deals with a particular topic, such as contagious diseases, cardiovascular diseases, cancer, diabetes, mental disorders, epidemiology, antenatal care, paediatric care and quality assurance. In addition, patients may bypass the area doctor and go straight to specialists. Each type of doctor thus works with a different part of the population, and coordination is difficult.

The training of the different health professions varies as much as the structure and content of care. There are about 60 training institutions for the various specialties and categories of personnel, each with its own PHC department and programme. Further, the Russian Federation, like some other countries, has too few GPs and too many specialists, largely owing to differences in pay. Encouraging general practice is a high priority for health services development, and needs pursuit at all levels of medical education.

The Russian Federation needs an adequate model for PHC, to clarify what services to deliver, how they should be structured and how care providers should be trained. This could help to close the gaps in services between rural and urban areas, and enable proper balances to be struck, and cooperation organized, between GPs and specialists and between GPs and other categories of personnel.

## Spain (Catalonia)

In Spain, the Autonomous Region of Catalonia launched a gradual process to reform PHC with Decree 84/85. The aim is that PHC provide health promotion, disease prevention, rehabilitation and psychosocial services, through cooperation between different health professions and with community involvement.

The new system is based on PHC teams, which work 36 hours per week and can include GPs, paediatricians, nurses and nursing assistants, dentists, social workers and administrative and clerical staff. Each team serves the population of a basic health area (5000–25 000 people). Such an area comprises several municipalities or parts of a city with similar characteristics. The size of the area determines the composition of the team. Teams in cities work out of PHC centres, although local surgeries take this role in rural areas.

The new network covers nearly half the population of Catalonia, and complete coverage is to be achieved by 1996. The new PHC teams work longer hours than the old units, which allows more time for consultation, and team members work together in new ways to deal with health problems. They offer more services of higher quality, and have a greater ability to handle health problems at the primary level. As a result, prescribing practices have improved, referrals to secondary care have fallen and the public is more satisfied with PHC services. Nevertheless, further improvements are needed to help PHC teams to provide disease prevention and health promotion services, as well as curative care. In addition, the various registers need to be used more consistently, and clinical practice needs evaluation. Both the new and the old networks have access to specialized support services, including rehabilitation, radiology and laboratory services, a network for mental health care, and centres for people dependent on drugs.

Both networks are under the authority of the Catalan Health Service, which was created in 1990. The Health Service is responsible for financing the health care system, while providers manage services, through contracts for PHC and hospital, social and mental health care. This system thus separates the purchasing from the management of services.

Catalonia has a health plan for 1993–1995 that should guide all public action for health. It focuses on the full integration of disease prevention and health promotion into health care, the improvement of the equity, efficiency and quality of health services, and the improvement of users' satisfaction with services. It sets targets and specifies measures for the achievement of these goals and for the assessment of and research on health problems, continuing education for health professionals and the consolidation of information systems.

## Turkey

PHC in Turkey is fragmented, as a result of the fragmented organization of health care as a whole. Public, private and some charitable organizations offer different systems of services: the most important of these are the Ministry of Health, the Social Insurance Organization (SSK) for labourers and their families, and faculties of medicine in universities. State economic enterprises and some ministries run systems of care for their employees and their families. These services, and those provided privately, mirror those provided under the Ministry of Health.

The PHC services organized by the Ministry are under tight central control, as mandated by a 1961 law. They are run mainly by the general directorates for PHC and for maternal and child health and family planning. The former organizes services to control malaria, tuberculosis and cancer. In the provinces, the provincial governors wield strong influence and there are provincial health directors. PHC is organized on the district level and delivered in a variety of facilities with similar functions.

Government facilities include:

- the health post, serving a rural population of 2000–2500, and staffed by a midwife;
- the health centre, serving a rural population of 10 000–20 000 or an urban population of 20 000–50 000, and staffed by at least one doctor, one public health nurse, a

midwife, a health technician, an environmental health technician and others;

- the maternal and child health care and family planning centre, which is very similar to the health centre, but includes a gynaecologist, paediatrician and dentist on the staff; and
- the hospital outpatient clinic, serving 5–6 health centres.

All four deliver the same eight functions: basic curative care, emergency care, immunization, maternal and child health care, family planning, nutrition and development services, and laboratory services. Other facilities – SSK dispensaries and hospitals, private surgeries and clinics, and university hospitals – deliver all or some of the same services. Health centres and outpatient clinics also provide preventive mental care, and maternal and child health care centres offer preventive dental care. While GPs are supposed to have a gatekeeping function of referring patients for secondary care, many people bypass them and approach hospitals and specialists directly.

The government pays 45% of the costs of health care, but more than 40% of the population (mainly farmers and the unemployed) have no health insurance cover. This fact and the duplication of services between different systems led to the recent proposal of health care reforms to change the financing, delivery and organization of health care in Turkey. First, general health insurance is to be established to cover the whole population. Second, the system is to be based on a new type of specialist, the family doctor. Graduates of medical school are called GPs; family doctors are to have four years of postgraduate training with a standard curriculum. Third, the control of government hospitals is to be decentralized and the organization of the Ministry of Health changed.

### **United Kingdom**

PHC in the United Kingdom encompasses many types of service: medical care, dental care, maternal and child care and some ophthalmic services. The system of PHC for mental illness was

discussed in particular. Such care should emphasize prevention, by targeting groups at risk.

Official health policy, set in 1991 and based on the WHO strategy for health for all, named mental health as one of five key areas. It set three targets for gains in mental health by the year 2000: improving the health and functioning of people with severe mental illness, reducing suicide in this group by 30% and reducing suicide in the general population by 15%.

PHC services are arranged around GPs. In 1991, England and Wales had 9000 general practices. These ranged from the 10% comprising a single GP to group practices with up to 10 GPs, working in health centres with a wide variety of staff. There were 9000 practice nurses, nearly 3800 community psychiatric nurses (who were recently renamed mental health nurses), and district nurses and health visitors working in the community. In addition, the PHC team may include psychiatric, occupational and speech therapists, physiotherapists, and, increasingly, specialists acting as consultants. Further, teams are forming alliances with the social services, and voluntary and self-help groups. On average, a practice has three GPs, one practice nurse, less than one district nurse, one health visitor and less than half a mental health nurse. There is one such nurse for every five GPs.

A GP serves about 2000 people; severe mental illness accounts for about 10% of the psychiatric morbidity seen, or about seven cases on his or her list, which are referred for secondary care. Depression and anxiety make up the remainder; they often pass unrecognized and almost all remain to be handled in PHC. The small number of mental health nurses means that each has to try to meet the great and different needs of about 35 people with severe mental illness; this leaves no time for coping with the bulk of psychiatric morbidity. This situation is one of the reasons for the growing popularity of counsellors in PHC. About half of GPs can offer patients access to counsellors, who advise people on personal problems, not necessarily dealing with depression and anxiety. These counsellors vary in professional background and training in mental health, and their functions are widely debated.

PHC in the United Kingdom is being reorganized. Under the former system, a family health services authority managed about 50 general practices; a district health authority, serving a population around 200 000, managed secondary care; and the Department of Health managed tertiary care. The new system permits GPs to become fundholders for the system, purchasing whatever services they wish, except in a few areas, such as severe mental illness. As not all GPs have chosen to take this role, the two systems run side by side.

The 1992 document *The health of the nation* strengthened PHC in the United Kingdom. It clearly emphasized the need for improved services, encompassing all aspects of care, at the local level. This philosophy has led to a change in the functions of PHC today. The basic functions, such as disease prevention and health promotion, have become a priority, while care and rehabilitation are rapidly moving from hospitals to PHC. Additional functions include informing and educating patients, acting as advocates for and empowering them, and making use of the contribution of community and voluntary groups in realizing health gains for local people.

Support functions enable the effective delivery of the basic functions. In the United Kingdom, support functions include administration, management, training and education for PHC staff, coordination between the primary and secondary levels of care, quality assurance and research.

Finally, the Department of Health is addressing the problems of primary mental illness care through a number of initiatives. These include schemes for GP training and continuing medical education, a public information strategy to remove the stigma of mental illness, and research on such topics as depression in GPs, the role of a mental health facilitator and the evaluation of a model practice.

## CONCLUSIONS

The participants agreed that PHC faces similar challenges throughout the European Region. These include the needs to

optimize the use of limited financial resources, to respond to changes in society and health care systems, and to shape services to the changing needs of the population. While circumstances and health care systems in countries vary widely, PHC has similar functions in all countries. The participants agreed to take a broad view of PHC and its role within and outside the health sector, and endorsed the function approach as the way to guide its development. They also agreed that functions are more specifically and concretely defined in relation to a health target or priority group than in general thinking about PHC as a whole. The functions of PHC ought to reflect the needs of the population, but they are a means to an end, not ends in themselves.

While definitions differed, the participants tended to divide functions into groups. At this stage of their discussions, the participants listed basic, additional and support functions (Table 1).

Table 1. Types of functions of PHC

Basic	Additional	Support
Health promotion	Advocacy	Administration and management
Disease prevention	Empowerment	Technical services
Care	Prioritizing the needs of the population	Training and continuing education
Rehabilitation	Catalyst for community groups	Research
	Information sharing	
	Coordination of care	
	Outreach to priority groups	

PHC has four basic functions: health promotion, disease prevention, care and rehabilitation. The balance between them is shifting. Prevention is growing stronger, although it should be shared with other health and social workers. Care is changing; many

types of care are moving from the hospital to PHC. In addition, the balance of responsibility between primary and secondary care is shifting. Secondary care is coming to be seen as a resource for PHC, not the other way round. This leads to a variety of improvements for both parties.

Several additional functions were suggested. For example, PHC can act as a catalyst to involve community groups in care. The information function includes distributing information within the health care system, sharing it with the users of services and providing it to the general public. Effective PHC requires coordination between different levels and types of professional; this in turn requires a strong information system. Another function is outreach to emerging priority groups in society, including ethnic minorities and migrants, children, the homeless, unemployed people, and those dependent on drugs or at risk of contracting AIDS. Advocacy is also an important function, and includes helping service users to speak for themselves about their needs and speaking for the health sector. All of these could be said to contribute to the function of empowerment: enabling people to take charge of their own health. Empowerment is a function of increasing importance, but requires knowledge in both the PHC team and service users to succeed. Finally, PHC could prioritize the needs of the population, which would help to determine the mix of functions to be delivered in a particular situation.

Support functions are those that enable the delivery of others. These include administrative functions and technical ones, such as radiology and laboratory services. One of the most important, however, is training and continuing education. These enable PHC staff to adapt to circumstances and needs, and to take on new roles and skills. In particular, PHC staff need training in leadership and management, so that they can lead PHC teams, work autonomously and flexibly together, and act as leaders and advocates in the community. The increasing decentralization of decision-making and financial responsibility in health care in many countries increases the importance of leadership and management skills for all categories of staff.

In view of the limited resources and the need for scientifically sound services, quality assurance (including both research and audit) is an important criterion by which to judge PHC functions. Research, however, is a function essential to the credibility of PHC.

Finally, the participants suggested ways to take the next steps in analysing the functions of PHC. These included:

- discussing the conclusions of the Consultation with the users of services and various providers of PHC, and professionals outside the health sector;
- analysing the functions both to compile a list of ideal functions and to specify what each should achieve (or even to set objectives for each);
- adapting the functions to differences between regions and countries;
- reviewing, improving and widely circulating the Consultation report; and
- continuing the discussion at a further meeting, which would be attended by the original participants and other interested parties.

*Annex I***WORKING PAPERS<sup>a</sup>**

*Development of primary health care in Germany,*  
by H. Kreuter

*East Surrey Health Authority and Surrey Family  
Health Services Authority: Mental health in  
primary care project, 1993–1995*

*General features of the Portuguese primary health  
care system,*  
by J. Sennfelt

*Primary health care in Catalonia,*  
by R. Vicente Ruiz

*Primary health care in Finland,*  
by P. Soveri

*Primary health care in Turkey,*  
by Z. Baser

*Primary health care in the United Kingdom,*  
by P. Jones

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<sup>a</sup> Copies can be obtained from the Primary Health Care unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark.

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