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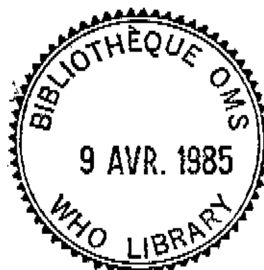
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Regional Health Development
Advisory Council



ICP/GPD 003
EUR/EXM/80.1
INTERNAL
2 March 1980

Reg. health plan ... for the Europe R.H.D.C

Report on a Planning Meeting

Copenhagen
28-29 February 1980

The purpose of this report is to record the main points emerging from the planning meeting. It is an internal report for the WHO Regional Office for Europe, the intention being that it should serve as a source of material for consideration by the Regional Director and his staff with regard to possible regional strategies for attaining the objective of health for all by the year 2000. The report is also intended to be an aid to the WHO secretariat when briefing the Regional Health Development Advisory Council.

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1. Introduction

Welcoming the participants, the Regional Director, Dr Leo A. Kaprio, stressed the importance of the WHO global initiative aimed at achieving health for all by the year 2000. He underlined the need for valid European regional strategies to be developed to follow through and capitalize on this initiative. In many ways this was a unique opportunity, not only to make a more significant impact on health in the Region but also to influence activity in other relevant and related sectors. The structure of the meeting was deliberately informal in order to maximize the opportunities for brainstorming and the generation of new ideas, and it did not pretend to be an exhaustive review of the issues involved.

Dr Asvall was appointed Chairman and Dr Pendreigh Rapporteur. A full list of participants is given in the Annex.

2. Scope and purpose

The World Health Organization has a long-term commitment to the attainment of health as a human right and a worldwide social goal, and considers it essential to the satisfaction of basic human needs and to the maintenance of the quality of life. Member States have reaffirmed that commitment on several occasions. In May 1977 the World Health Assembly stated that "the main social target for Governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". In September 1978, the WHO/UNICEF International Conference on Primary Health Care adopted the Declaration of Alma-Ata, which emphasized the importance of primary health care in attaining health for all by the year 2000 and called on all governments to formulate national policies, strategies, and plans of action to promote such care as part of a comprehensive national health system coordinated with other sectors. Then in May 1979 the Assembly adopted resolution WHA32.30 stating that the development of WHO's programmes and the allocation of its resources at global, regional and country levels should reflect the commitment of WHO to the overriding priority of achieving health for all by the year 2000. The proposals of the Executive Board contained in the document "Formulating strategies for health for all by the year 2000" were considered a sound basis for the development and refinement of such strategies, which should be formulated first and foremost by the countries themselves.

An important step towards achieving the goal of health by the year 2000 in all Member States will be the formulation of regional strategies for this purpose. Preliminary action in the European Region has included the adoption by the Regional Committee at its twenty-ninth session in Helsinki in September 1979 of a resolution (EUR/RC29/R6) requesting Member States "to review their health development in the light of the goal of health for all by the year 2000 and to promote an intersectoral approach to activities for the achievement of that goal". The Regional Director was requested to pursue the study at regional level in preparation for the discussions at the Committee's next session in Fez in October 1980, when progress would be reviewed and regional strategies formulated.

In this context, the Regional Director has decided to establish a Regional Health Development Advisory Council to advise him on the practical aspects of achieving health for all by the year 2000. It will deal with the assessment of priority health problems in the Region and the formulation of strategies for attaining health for all by the year 2000 through the establishment of national health development programmes in individual Member States and the appropriate orientation of the Regional Office programme.

A questionnaire on the subject was sent to all countries. On the basis of the Council's advice and the collated replies to this questionnaire, the Regional Director will submit a paper on proposed regional strategies to the thirtieth session of the Regional Committee in Fez in October 1980. In the light of the Committee's discussions, a report will subsequently be submitted to the Thirty-third World Health Assembly in 1981.

3. European health care problems - present and future issues

3.1 General

The group, in addressing this subject, first made the following general points.

There is a wide variation in conditions in the European Region, despite its being in many ways more homogeneous than other WHO regions.

Aims and goals must be dependent on the values and attitudes of the relevant societies and this is at present an area of much debate. Many old values are disappearing but have not yet been clearly replaced by others. Society now faces major choices: Should our complex medical and

health technology be developed further? Should dying with dignity be an objective? Should learning to handle one's own health problems be the proper aim?

The group noted that many current problems were dealt with in the Regional Director's report on the work of WHO in the European Region in 1978, which contained much excellent material. The report covered topics such as research in family health, the economics of health care, occupational health risks, road traffic accidents, health education, culturally induced diseases, etc.

3.2 Demographic trends

The participants then proceeded to discuss what they saw as a major group of problem areas which related to demographic variables, much of the material on this subject being introduced by Professor Cliquet. The following table summarizes the relationships noted by the group between population dynamics, health problems and the type of action which might be taken by the responsible authorities.

Table 1. Relationships between population dynamics, health problems and WHO actions

Demographic variables	Health variables	Areas of possible national & WHO action
I. Fertility exposure factors		
- premarital relations increasing and occurring at younger ages	- unwanted pregnancy - very young mothers	- development of education - health care facilities
- consensus unions increasing		
- marriage and remarriage becoming more and more dependent on personal instead of social control	- mental health problems	- development of education counselling
II. Fertility		
- actual fertility: both mean and variance decrease, leading to an increasing uniformity in family size	- family sibling size below 5 has favourable effects on maternal and child health	- development of education towards family size variations below threshold of 5
	- below replacement level	
	- genetic compositions change in the long term due to decreased opportunity of selection	- implications of possible reduced genemix
	- small minority of large families tend to concentrate in problem groups due to lack of ability, level of education, employment and poor social circumstances	
- fertility regulation (contraceptives)	- unwanted pregnancies; abortions	- education - services - counselling
- subfecundity, with replacement therapy (e.g., in diabetes) leading to increased fertility	- genetic composition of population changes in the long run due to selective relaxations	- education

Table 1 (contd) Relationships between population dynamics, health problems and WHO actions

Demographic variables	Health variables	Areas of possible national & WHO action
III. Mortality and morbidity		
- decreasing mortality induces increasing longevity	- increasing dependency, especially in those over 80 years	- development of new values, framework and service norms
- lengthening of the dying process	- increases in suffering	- education
- increasing morbidity and mortality due to effects of modern culture (environment and behaviour)	- increasing specific health problems of modern culture	- health care procedures - social organization
IV. Migration and mobility		
internal:		
- increase - assortment	- increased risk of contaminations - socially or geographically differentiated health problems	- education
international:		
- increase	- increased risk of contamination	- services
- assortment	- socially or geographically differentiated health problems	- social organization
V. Population growth and density		
- increasing crowding in particular circumstances	- increasing social pathology	- social organization

3.3 Epidemiological trends

The most reliable information on trends is still based on mortality data. Morbidity is much more difficult to measure, though there are reasonably accurate morbidity data relating to hospitalized patients. Much fewer data exist on primary care. A great deal needs to be done to develop data based on surveys of patients' own experiences and perceptions of morbidity. Disability is, of course, another biomedical parameter which could be measured.

The main trends in Europe in the next two decades was thought to be as follows.

(a) A continuing increase is expected in the number of elderly persons, especially those over 75 years. What has to be kept in mind, particularly, is the load on services which such a trend implies. However, despite the general aging process in the population there does not seem to be at individual level a parallel increase in dependency, as many people in the older age groups are now much fitter than their counterparts of previous generations. Nevertheless, the total social load will be great.

(b) There seems already to be some decrease in cardiovascular disease (CVD) in those countries with previously high CVD mortality rates, but in countries where mortality has so far been low the rates are expected to rise for some time yet.

(c) Following the pattern beginning to emerge in the United Kingdom, there could well be a decline in lung cancer in other countries of the Region also.

(d) Road accidents should probably level off in the future and then begin to decrease for a variety of reasons.

(e) In general, the infant mortality rate will decline and drop below 10 per 1000 over most of the Region. However, there will be a need for better prenatal identification of congenital defects. The effect of increasing the number of gene-affected diseases through the introduction of effective life-saving treatment for existing sufferers who will then be able to reproduce should be borne in mind.

(f) The use of health services in general is unlikely to decrease, but there may be a decrease in hospital utilization, the accent being instead on treatment by means of primary care. This trend is beginning to be observed in the Netherlands.

(g) Work absenteeism ostensibly due to illness may increase substantially, possibly even up to 50%.

3.4 Environmental health hazards

The group considered this to be an important area which was likely to give rise to many problems, both at present and in the future. The basic environmental hazards of the nineteenth century have, by and large, been solved, but it should be remembered that there are still significant geographical areas within Europe where there are basic problems of water purity and food hygiene. In general, Europeans attach high priority to a good physical environment.

The following points summarize the present and likely future situation.

(a) Atmospheric pollution. In general, this is decreasing, but there are still certain black-spots (e.g., Ankara).

(b) Industrial pollution. Gross pollution is diminishing, but much more subtle hazards are beginning to emerge. Between 200 and 1000 new chemicals are introduced into industry every year. Also, the importance of the indoor working environment, especially in northern Europe, is being increasingly stressed.

(c) Water pollution. Again, gross types of pollution are declining, but microchemical contaminants are increasingly being recognized as hazards, especially from the point of view of their possible carcinogenic and mutagenic effects.

(d) Noise pollution. Though noise hazards are increasing, the public is showing greater sensitivity to noise and is likely to demand more stringent control standards.

(e) Radiation. Nonionizing radiations are now being seen to have greater importance.

(f) General physical environment. There will be an increasing need for better designed housing and settlements, consideration being given to such factors as population density and transport facilities.

(g) Changing technology. Greater thought will be required in the siting of new industries and the reuse of materials, especially basic ones such as water. There is the continuing energy debate, including increasing use of nuclear energy. Microelectronics and its implications for employment and the environment generally have to be kept in mind. What are the hazards in biochemical production methods (e.g., use of enzymes)? The changing pattern of food production in favour of convenience foods has also to be properly assessed.

(h) Rural areas. The increasing use of pesticides will probably add to the problems of environmental toxicology.

(i) General aspects of human ecology. Factors to be debated are individual and community choices in patterns of behaviour, leisure and unemployment. The public has also to be made aware of the new health technologies being developed. An important factor emerging here is the international nature of many of the problems, such as river pollution (e.g., the Rhine), food transportation, aviation hygiene, migration and tourism.

In the discussion it became clear that health and the environment had to be clearly related to each other and also to other socioeconomic aspects such as energy. There seems to be a great need for a multidisciplinary approach and training. Also, critical manpower shortages which may act as a constraint on the evolution of good strategies have to be identified. Toxicologists, for instance, are in very short supply. Risk assessment with regard to environmental hazards has to be made much more sophisticated. For example, is it realistic to think of saccharin as a significant cancer hazard? Priorities in public policies, e.g., house insulation, accident prevention, decrease in the number of high-rise buildings, etc., have to be considered.

4. Implications arising from such issues

The main implications which the group regarded as arising from the problems and issues considered are summarized below.

There is clearly a need for better techniques of risk assessment. These should be developed.

A related but somewhat different point is that means should exist of making some form of impact assessment of new emerging factors, particularly with regard to environmental and behavioural aspects.

Epidemiology, in the nonworking as distinct from the working environment, does not yet seem to have the capacity to identify sufficiently quickly those trends indicating factors which have an adverse effect on health. The technology here also needs to be better developed.

There is a need for a more holistic and less *ad hoc* and incremental approach to many of the new problems. Significant multidisciplinary effort is necessary. Most of these problems are related to broad ecological and life-style factors which almost certainly require to be handled in a broad way across intersectoral boundaries.

Problems are now so complex and multifactorial in nature that modelling approaches should be tried.

Government structures often seem to be inapposite for dealing with complex intersectoral problems or for relating to other governments on common issues.

Many of the problems are of an intercountry nature and have to be resolved by groups of nations.

The effects of rapid environmental, social and behavioural change and the stress so induced have probably been underestimated and must be assessed.

There seems to be a continuing change in conventional values, and until these are clearly replaced by others it will probably be difficult to obtain a conceptual values framework within which the problems can be considered.

There is a lack of clarity as to how attitudes and relationships within a family affect attitudes to health.

A new phenomenon is clearly emerging, namely, of behavioural and other trends being liable to sudden distortion once identified and reported by the mass media. The appropriate use of communications media for education on health and life-style has yet to be clarified.

Health is increasingly seen as a valuable resource in itself. The health stock of many individuals is now being run down not so much by classical disease as by the pressure of society. The emergence of different types of dissatisfaction is also altering perceptions of health. Linked to this seems to be a general lowering of thresholds, so that people become more ill or more dissatisfied at lower levels than before.

The complex interrelationships in health services between resource utilization, patient behaviour and health professional behaviour are poorly understood and appreciated at present.

5. National strategies for attaining health for all by the year 2000

The group identified the following general points.

At present the planning and management of health services tends to be bureaucratic and technocratic in nature. Quite rightly, the theme of the rational, scientific approach is stressed, but what is scientific rationality? Does it derive from medical, biological, sociological or political sciences? In effect, all these elements have a contribution to make, but too often it is only

the biomedical or managerial model which prevails. A major exercise may be needed to gain insight into how decisions are really made at present, and this probably requires research initially and then education. It has to be appreciated that planning for health is a political and social process and not simply a technocratic one.

A major justification for having national plans and strategies is that they are a means of structuring political decisions and forcing them to be made at regular intervals.

It is not adequately understood what resources an individual in a national society requires at any given time to maintain his wellbeing, or how society exerts changing influences upon him. How should society accommodate to the changing needs of individuals with regard to health and well-being? It should be a major objective of national strategies to provide an answer to this question.

An important component of any national strategy should probably be to guide individuals towards participation and self-help in health matters rather than to provide services for them on a large scale.

Examples of existing national strategies for health were discussed. Inevitably, those cited were service-oriented and focused mainly on the health sector itself:

(a) improved care for the elderly, especially for those over 75 years old, with provision of psychogeriatric services; a switch to community care; better episodic care of old people who are acutely ill in acute hospitals;

(b) better programmes for the mentally ill, especially by increasing community care and support;

(c) better programmes for the relatively neglected groups with various forms of long-term handicap;

(d) increasingly tighter legislation to control the development of environmental hazards;

(e) the identification of underprivileged groups in national communities in socioeconomic, educational, health and employment terms, and the regearing of services to meet their needs more adequately;

(f) much greater emphasis on community and primary care as distinct from institutional and specialist care;

(g) deceleration of the growth of the acute hospital and specialist sector.

These strategies are invariably underpinned by the principles of equality of opportunity for all in the sphere of health, the services provided being available irrespective of the geographical location or socioeconomic position of the individual. These principles, in turn, have been leading increasingly to consideration of more equitable forms of resource allocation based on population structure, service utilization and morbidity (though mortality has often to be used as a substitute for this). Also, in order to have strategies effectively implemented, an increasing amount of work has been done in stratifying different planning functions into different planning levels from the national level downwards, with detailed working out of the relationships between these levels and the development of cyclical and iterative planning procedures. All this has had to be supported, of course, by better research, mainly in health services themselves, by increasing participation by both providers and users, and by the introduction of much better management techniques. Commendable as these types of strategy are, there is nevertheless considerable scope for developing much more broadly based strategies which take account of the main trends in society and are rooted in real intersectoral cooperation.

A cautionary note was sounded as to whether the goal of health for all by the year 2000 was a realistic one for Europe, given its already high standards of life and health. A more practical goal might be to maintain present standards of health. However, these could probably be maintained only by identifying emerging problems at an early stage and then initiating strategies for their containment and control by society.

6. Regional strategies for attaining health for all by the year 2000

The essential characteristics of most of the countries of the European Region at present were seen by the group as being:

(a) good standards of living;

(b) infectious disease less serious;

(c) societies based on clear concepts of democracy and equity;

(d) culturally creative societies.

However, Europe must soon make a choice between the course on which it is set, i.e., that of an increasingly sophisticated health and medical technology, and a more apposite, sensible set of strategies which lay stress on prevention, better health and life education in the broadest sense, and the introduction of a more self-caring and more independent approach to health on the part of the individual. Society must grapple in a more basic way than ever before with the behaviourally induced diseases related to alcohol, tobacco, drugs and stress in general, as well as the increasingly complex aspects of environmental pollution.

Many of the areas appropriate for the development of regional strategies naturally reflect present thinking with regard to national strategies, e.g.,

(a) the elderly, especially the over-75s,
(b) mental health,
(c) legislation for environmental control,
(d) family planning and abortion,
(e) long-term handicap,
(f) the underprivileged (for instance, those in the decaying inner city areas of many of the large industrial conurbations),

and, in particular, the whole aspect of primary health care.

In relation to these areas, however, a new values framework for society would seem to be needed. Only when this has been done can policies be formulated, objectives identified and quantified and, finally, strategies evolved which will secure these objectives.

An important point to keep in mind is the time horizon for any proposals or strategies. Clearly, there are many strategies which it might not be possible to implement fully by the year 2000 because of a basic lack of knowledge and expertise at present regarding the true dynamics of the problems and their possible solutions. Changes in patterns of social behaviour, for instance, might take much longer to achieve, but there are, of course, more immediate implementation measures which can be taken with regard to, say, better development of services for the elderly and the improvement of primary care services. Different types of objective will therefore need different time-scales for their attainment.

In considering how realistic and useful regional strategies might be promoted, the group pinpointed the following main areas:

(a) the identification of critical research areas. Work is obviously required on the following topics:

- valid, reliable health status indicators;
- the relationship between inputs and outcome in health;
- the relationship of health to other sectors, and ways of improving coordination and liaison;
- the field of policy analysis and how it might be made more sophisticated;
- the resolution of conflict between individuals, ideas and policies;
- research into attitudes and values, not only among the populations concerned, but also among the health and other professionals who serve them.

(b) the promotion of an interchange of views, information and activities. This was seen as being achieved both by the usual conventional means of information exchange, such as meetings, seminars and the distribution of literature, and by the establishment of networks of collaborating centres.

In the discussion it became evident that there could well be a case for thinking in terms of strategies for (a) the region as a whole; (b) particular subregions. Some problems do not relate to the whole Region. For instance, the countries in a subregion might wish to cooperate on questions such as river pollution. Also, the different political subgroupings in Europe could possibly be harnessed as frameworks within which cooperation on health might occur. Divisive factors such as differences in background culture, politico-administrative systems, economic structure and forms of health service organization have to be recognized but are not seen as presenting insuperable obstacles.

Following discussion of "content" problems in the Region, the group proceeded to identify what these meant in terms of functional or methodological type problems, as this was felt to be possibly a better approach from the point of view of identifying useful and practical actions which the Regional Office might take. The types of problem thus emerging are:

(a) insufficient understanding of the economic, planning and management aspects, and social implications, of health services, and indeed, of the exact relationships between activities and outcome in the health and other related services;

(b) insufficient knowledge of existing good practice and experience; much is happening that is useful and relevant, but not everybody knows about it;

(c) specific manpower shortages, e.g., of toxicologists and planners, are becoming evident;

(d) cross-boundary problems: these may be categorized into different types:

- physical, e.g., river pollution;
- cultural, where the import of factors such as drugs, alcohol, cars, or even ideas, has created problems;
- people: large-scale movements of migrant workers and tourists have created a whole new range of problems;

(d) the inadequacy of the health sector in influencing activity in other sectors;

(e) lack of a common legal basis for exerting control over aspects of the environment (though some subregional groups already have common measures);

(f) inadequate technological assessment procedures for new developments in health and health-related fields.

The planning group considered that in its brief two days of deliberations it had identified the major problems which were facing the WHO European Region, and that it had translated these into problems of a functional or methodological nature so that the Regional Office might perceive more clearly how it should grapple with them. The next step was to look at the appropriateness of the present WHO machinery for dealing with them and suggest mechanisms which might be applied. Central to any suggestions made would be the assumption that detailed analytical work would be carried out in the whole area in the future by expert technical groups.

7. Main repercussions on the Regional Office programme

In the light of the preceding discussions, the planning group felt that the following were the main areas in which there were likely to be repercussions for the Regional Office:

7.1 Development of information support

One particular issue is the completeness of the information at present gathered. All countries should be encouraged to be more comprehensive in the type of health and health-related information collected. This would provide a better basis for planning and evaluation activities, covering those parameters which are now thought to be important for more broadly based health development strategies. It might also be useful to use "spotter" or indicator countries to identify trends, etc. An objective of the Regional Office might be to help develop a model for national health information systems.

Some preliminary thought was given by the planning group to the structure of an information model. It was seen as having the following components:

(a) demographic

(b) cultural - attitudes, values, life-styles, etc.

(c) socioeconomic - social class, education, employment, family budget, housing, etc.

(d) health status - mortality, morbidity, disability, etc. (However, there is also a need for work to be done on developing other indicators of health status which would not necessarily have a purely biomedical orientation.)

(e) resources - finance, hospitals and beds, staff, utilization, organization, etc.

(f) environmental status - identification of various risk factors

(g) health technology

(h) policies.

An important part of the information system model would be to have feedback to the community as a whole and its different subgroupings, as well as to the health and other professionals involved. One of the main aims of this would be to stimulate dialogue.

What is necessary is to establish a list of centres not only those covering national aspects of health information in general, but possibly also those specializing in particular individual functions of health information collection and analysis.

An important issue is the existing use of available information. It is felt that much more should be done, both at national and at regional level, to produce analytical overviews of the present situation, past trends and, in particular, likely future developments. One of the most important ways in which the Regional Office could motivate countries to review their health care policies and rethink their strategies along the lines of more preventive action would be to produce at intervals comprehensive documents presenting forecasts of European trends for the coming decades in population growth, health status, health risk factors, health care technology, health care consumption, health resource production and similar factors. An important part of such forecasts would be an analysis of "scenarios" outlining possible alternative health care strategies. Such scenarios could show in an imaginative way different methods of preventing possible future problems in health or health care.

7.2 Research implications

The following seem to be the main research implications as far as the Regional Office is concerned.

(a) The Regional Office should encourage a better means of technological assessment of the new equipment being constantly introduced into health service systems. This function should mainly be at national level, but the Office clearly has a coordinating function and, if different centres were developed, they could specialize in different forms of equipment assessment. Apart from establishing initial assessment procedures there is also considerable scope for the development of some type of early warning system for incipient defects once equipment has been introduced into health services.

(b) WHO should also encourage and support the setting up of specific centres for the technological assessment of new medical and surgical procedures.

(c) The whole area of the relationship between different inputs and outcomes in health systems has to be explored.

(d) An area where more research should be initiated is that of perinatal problems. Investigations might follow the pattern of the studies already carried out in the United Kingdom. Morbidity in young children would be another fruitful research category.

(e) There is also great scope for research into the different types and combinations of services which might be used for the optimal care for the elderly.

A principal aim should be to switch the emphasis from biomedical research to health services research, while ensuring that much work is also being done on sociological research into attitudes and behaviour. A network of links between centres engaged in different aspects of such research might be established. An important corollary is to train researchers properly. A clear role for WHO is to identify research centres and appropriate individuals and to stimulate activity in this field. WHO might even initiate some health services research of its own.

There is a case for training generalist administrators and managers in order to give them an insight into the different types of health services research, but it will also be necessary to train a small elite band of full-time researchers. The difficulties involved in the relationshp of researchers and universities in general to service situations were considered. The advantages and disadvantages of independent research and research within the health service were also discussed. It was agreed that any research done should have the following characteristics:

(a) it should be of high quality;

(b) it should be independent;

(c) it should be problem-oriented;

(d) it should enjoy free access to health service systems and institutions.

The Regional Office should point out to governments that it is desirable for machinery to exist in each ministry of health for identifying new information on research findings and ensuring that it is made available to the appropriate policy-formulating services for analysis. Not only ministries, but also WHO, should develop better links with individual research comunities. Governments and ministries should also exploit international literature on research findings to a much greater degree. Indeed, the Regional Office should consider translating work done in "minority" languages into the Office's working languages. Conversely, WHO publications should occasionally be translated into these "minority" languages.

The group expressed interest in a joint study being developed by Belgium and Poland to explore ways of implementing the Declaration of Alma-Ata. The type of comparative work on primary care being done in EEC countries could possibly be replicated in CMEA countries. Studies are also clearly needed in the sphere of patient self-help. An implication of much of this discussion is that the Regional Office might enlist the services of a group of sociologists, especially medical sociologists, to advise it.

7.3 Possible WHO structures and initiatives

It will be seen that the areas of information, research and training have been underlined, and it is in these areas particularly that WHO should be promoting and stimulating activity. Another main activity is in the field of motivation and promotion. In this context it is suggested that WHO should aim for the production of some broadly-based European health charter to which most nations in the Region would feel able to subscribe. The level at which this should be agreed and discussed would probably be, eventually, that of minister of health.

The Regional Health Development Advisory Council is seen as the main body advising the Regional Director on the direction any such activities should take. However, a group of specialists and technical experts should be set up in the form of a steering group to identify and coordinate the studies and activities to be undertaken by WHO. This steering group would be supported by a series of technical groups covering specific areas, e.g., research, information.

Another subject discussed was the usefulness of the Regional Office convening seminars of Directors-General of Health or Chief Medical Officers of the Member States in order to secure their interest in such activities. These seminars should be informal and relaxed in nature, with the accent on brainstorming and creativity, and should focus on problems and strategies relating to the attainment of health for all by the year 2000.

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