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- either a set of guidelines specifying the objectives and stages in their attainment, and the measures to be taken, i.e. a document requiring one or two years to produce,
- or a much shorter charter,^a which would serve as a statement of principles and be submitted to countries of the Region for approval.

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EUR/RC30/8
page 39

ANNEX III

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

EUR/EXM/80.2

Report on a Meeting

Copenhagen
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CONTENTS

	<u>Page</u>
1. Introduction	1
2. Background and Aims of the "Health for All by the Year 2000" Movement .	1
3. Health Services in Europe: Current and Future Problems	1
Economic Background	1
Social Change	2
Demographic Trends	3
Needs of Different Age Groups	3
4. Strategies for Attainment of Health for All by the Year 2000	4
New Emphasis on Prevention and Education for Health	4
Health Care and Rehabilitation Services	5
Making the Most Effective Use of Resources	6
Health Manpower Development	6
Information Support	7
Evaluation	7
5. Role of the Regional Office	7
Appendix. List of Participants	9

1. Introduction

The Regional Director welcomed the participants and stressed the importance attached to this first meeting of the Regional Health Development Advisory Council (RHDAC).

He recalled that the purpose of the newly established RHDAC is to advise on regional strategies for the attainment of health for all by the year 2000. Accordingly, it comprises both the regular members of the Consultative Group on Programme Development and experts in fields such as political science, economics and sociology, thus allowing wider-ranging discussion of a more general nature.^a

As background material for the discussions, chaired by Professor B. Abel-Smith, the RHDAC received an internal document (EUR/EXM/80.1), drawn up a few weeks earlier by a small planning group, as well as a preliminary analysis of the replies of a number of countries^b to a 20-item questionnaire issued to all Member States in the European Region.

2. Background and Aims of the "Health for All by the Year 2000" Movement

The Director, Programme Management, recalled the different phases of the movement, which is based on provisions of the WHO Constitution and numerous resolutions adopted by the World Health Assembly since the founding of the Organization, but received its main impetus from resolution WHA30.43 adopted by the Thirtieth World Health Assembly in 1977. That resolution specified that the main social target of 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". The following year, in September 1978, the Declaration of Alma-Ata, adopted by the WHO/UNICEF International Conference on Primary Health Care, clearly identified primary health care as the key to attainment of the target. The Declaration was endorsed by the WHO Executive Board in January 1979 and, in May 1979, the World Health Assembly adopted resolution WHA32.30 setting out the technical, administrative and financial measures to be taken at different levels in the Organization, in accordance with guiding principles and a timetable of activities given in the Executive Board document "Formulating strategies for health for all by the year 2000" (A32/8).

Another important development was the adoption of resolution 34/58 on "health as an integral part of development" by the United Nations General Assembly, at its thirty-fourth session in November 1979. In turn, the matter was taken up by the WHO Executive Board which, in January 1980, adopted resolution EB65.R11 for submission to the Thirty-third World Health Assembly the following May.

The Regional Committee for Europe, at its twenty-ninth session, adopted resolution EUR/RC29/R6, urging Member States to review their health development in the light of the goal of health for all by the year 2000 and taking note of the Regional Director's intention to establish the RHDAC.

3. Health Services in Europe: Current and Future Problems

Economic Background

The RHDAC was of the opinion that the European Region is by world standards generously provided with health resources. Indeed, in some of the countries, spending on health services is not far below 10% of the gross national product. However, these resources are by no means evenly distributed, either between or within countries. Both in the north and in the south of the Region there are large numbers of persons without reasonable access to health care and even within some of the richer countries there are minority groups denied effective access by lack of health insurance coverage or by barriers of language or culture.

^a See list of participants attached.

^b At the time of the meeting, few countries had responded to the questionnaire, but by May, two months later, replies had been received from a total of 25 countries, and all are therefore reflected in the analysis given in Annex II.

Over the last 30 years spending on health care has multiplied in real terms. As countries have got richer they have allocated an increasing proportion of their resources for this purpose. It cannot be said, however, that the health gains have been commensurate with this vastly increased expenditure, despite the fact that pharmaceutical innovation has been greater than in the previous history of the world, surgical developments have been spectacular and a new high level of technology has been introduced into the modern hospital.

It is very unlikely that the rate of economic growth experienced in the previous three decades will return in the next two. This period will probably be one of slow economic growth and the possibility of no growth cannot be ruled out. Whether new ways will be found to allow a return to a high level of employment is uncertain. It would therefore be rash to assume that substantially increased resources can or will be devoted to health services in the next 20 years despite the capacity of health systems to generate new and useful jobs.

This does not mean, however, that health for all by the year 2000 is an aim which cannot be realized. To a considerable extent, the gaps in the provision of services will have to be filled and new needs met by generating greater efficiency in the existing systems, by redeploying resources in more effective ways, by reducing the unnecessary present load on services caused by inadequate attention to preventive action in the past, and by encouraging populations to take greater responsibility for their own health. Even if the economic outlook did not make it essential to move in these directions, a redeployment of resources would be justified in its own right as being the most cost-effective way of improving health.

Social Change

Health for all by the year 2000 is basically a socio-political issue, and the RHDAC agreed that the expected social changes in Europe would have a fundamental impact both on the nature of the health problems and, to a considerable extent, on their possible solution. The thrust towards participation, prevention and a greater element of self-care accords with social trends. The population of the Region is attaining constantly rising levels of education. Attitudes to work are changing. New lifestyles are developing. Long established patterns of authority are being challenged by the younger generation. A segment of the population feels alienated from society, dissatisfied with current social institutions and yet unsure precisely of what should be put in their place. New technology no longer goes unquestioned. There is a new consciousness of environmental hazards and a more suspicious approach to new chemical substances, whether food additives or pharmaceuticals. While the prestige of the medical profession remains high, it can no longer be assumed that medical advice will always be blindly followed. There is more questioning of the physician's authority and a greater wish to understand precisely what action he is taking and why he is taking it. With a more educated population has come a new health awareness upon which a new approach to health improvement can be built. Already there is a section of the population which wants to take greater responsibility for its own health.

On the other hand, greater geographical mobility caused by such factors as job opportunities and relocation on retirement is making communities less stable - particularly in the larger cities. The three or four generations no longer live near one another to the extent which was once the case.

The greater sense of sexual emancipation and the increase in divorce, separation and remarriage leave behind a trail of losers to be set against those who feel change has benefited them.

The trend for women to work outside the home is reducing the capacity of the family to provide care to the aged and disabled as was possible in earlier generations. On top of this, many of the housing developments of the past 30 years have not been conducive to the creation of a sense of community. In large tall blocks of flats people may have little contact with their neighbours. This is particularly true of the aged and the disabled, who sometimes live very isolated lives.

The work pattern has changed radically in the past two decades and this trend can be expected to continue in the next two, as old labour-intensive industries decline and the full impact of microelectronics is felt in industry and commerce. Major changes may also occur in agriculture. The health effects of the new patterns of work cannot be predicted. Indeed, too little is known about the effects of the existing patterns.

In general the RHDAC was acutely aware that the precise impact of the whole range of social change on health and particularly on mental health is not known. How far alienation, isolation and changes in family life account for the growth of alcoholism, drug abuse, suicide and parasuicide has not been established. However, taken together, these factors may well be of major importance for the health of the advanced industrial societies of Europe. How to recreate a sense of community and of social care in the face of the further social change which is likely to come in the 1980s and 1990s was seen by the RHDAC as a major challenge for those concerned with health in its widest

sense. While some of the young are creating new patterns of communal living, it is far from clear whether such patterns survive as the young grow older. The precise cause of the high incidence of symptoms of mental ill-health among the young and middle-aged is one of the critical areas for further research.

In a situation of growing disquiet in society, new challenges are posed and new forces are emerging. Between the "reds" (public authorities) and the "blues" (authorities in the private sector), with their conventional forms of organization, we can now see emerging the "greens" - pressure groups which are often unorganized as yet but are becoming increasingly numerous and influential.

The form of such developments varies, depending on the geographical area and political system concerned. However, they have a definite impact on health, and not only mental health, in a situation where the etiology of major groups of diseases (cardiovascular, cancer) remains unclear.

It should also be remembered that while it is fairly easy to work out strategies, it is much harder to apply and implement them and to overcome resistance. The social structures we have mentioned are far from uniform. Internal conflicts occur, including divisions and tensions between and within professions. There is competition between the public and private sectors and also among the different government services and private institutions; the "green" groups are highly diversified and in general not well coordinated, which is both a hindrance and an advantage for including them in a national health strategy.

However, whatever the differences, not only between the major zones in Europe but also within each country, it is important to emphasize the points of similarity and unity and, on the basis of national strategies, to draw up a detailed list of common strategies for regional application.

Demographic Trends

The first replies to the questionnaire sent to Member States show that, except in a few (especially developing) countries, the population in the European Region is expected to remain fairly stable and that the present trends will continue with regard to lowering of fertility and birth rates, increases in the expectation of life and numbers of the elderly, especially in the highest age groups, steady movement of populations towards urban areas, and the problems of migrant workers.

Needs of Different Age Groups

In his remarks on the issues to be faced in setting up national programmes to achieve health for all by the year 2000, the Regional Director suggested that it could be useful to examine the health problems of different age groups: the impact of the environment, lifestyle, social and economic conditions and their influence on health, and indicators to measure progress towards health for all. The RHDAC found this a very interesting approach, and made the following comments.

(1) Infants up to the Age of One

In the less developed parts of the Region emphasis will need to be placed on raising levels of nutrition and improving water supplies and sanitation to cut the high rate of infant mortality due to a combination of poor nutrition and low standards of hygiene. In the more developed areas the emphasis will be on all the factors which lead to low birth weights and to birth defects, since disability can now be detected before birth to an increasing extent.

(2) Children (aged 1-14)

In the less developed parts of the Region the emphasis will again be on standards of nutrition and of hygiene. In the more developed areas the emphasis will be on accidents, and the early detection of disability. All over the Region this is a vital period for health education.

(3) Adolescents and Young Adults (aged 15-24)

In this age group the provision of family planning services is of crucial importance. In the more developed countries attention needs to be concentrated on such problems as suicide, fatal motor accidents, other accidents, sexually transmitted diseases, and misuse of alcohol and drugs.

(4) Adults (aged 25-64)

In this age group the emphasis will be on the promotion of mental health and the reduction of disability from musculo-skeletal disorders and the prevention of cancer, heart disease, respiratory disease and stroke.

(5) Older Adults (aged 65 plus)

In this age group the aim must be not only to achieve further increases in longevity but also to improve the quality of life and reduce restrictions caused by those health problems which can be controlled.

By world standards, mortality rates in the first four of these age groups are low, but even a cursory examination of the data on causes of death indicates scope for a substantial further reduction by the year 2000. In the south of the Region there are still numerous deaths from communicable diseases which are readily preventable, with room for an appreciable fall in infant and maternal mortality through socioeconomic development and the improvement of maternal and child health services. Even in the wealthier countries of the Region with costly, well-developed services there are marked variations in both infant and maternal mortality. The challenge is for the higher rates to be brought down to the level of the lowest, and there is still room for further reduction even of these low rates. Throughout the Region, the annual toll of deaths by accidents in the home, and particularly on the roads, can be cut substantially.

A new generation brought up not to smoke, an increase in the proportion of nonsmokers among adults and a cut in the tar and nicotine content of cigarettes smoked by those who have failed to break the habit could result in a substantial drop in deaths from lung cancer, chronic respiratory diseases and cardiovascular disease. A decrease in alcohol consumption would reduce the deaths and disability caused by alcohol-related diseases.

4. Strategies for Attainment of Health for All by the Year 2000

Through the contribution of experts in sociology, political science and economics to its meeting, the RHDAC was able to obtain a better understanding of the conditions facing countries of the European Region and the trends up to the year 2000, and to work out broad strategies for action.

New Emphasis on Prevention and Education for Health

The RHDAC was of the opinion that the first priority must be given to prevention in its widest sense. The fundamental causes of ill-health in advanced industrial societies lie partly in the environment and partly in the lifestyles which have developed in affluent societies, and far too little effort has been directed to understanding the precise ways in which these factors interact. In the past, health research has been strongly biomedical in orientation, while studies in the behavioural sciences have been both undermanned and underfinanced. Thus the RHDAC noted a growing need for appropriate epidemiological research. For example, between 200 and 1000 new chemicals are introduced into industry each year without adequate testing of their possible impact on human health.

Much is written about the stress of modern society, but the effects of stress on health need further investigation. There is a lack of knowledge about how attitudes and relationships within the family affect attitudes to health. Nor do we know what patterns of housing and environment foster a greater sense of community, if indeed this can be stimulated by physical planning. There are many theories about the effects of elements in the modern diet upon human health but not enough hard evidence.

While we need to learn a great deal more, there is nevertheless much we do know which is not applied. Lives lost in the European Region due to smoking, alcohol and drug abuse, and reckless driving exceed a million a year, quite apart from the serious injury and disability created by these unhealthy features of lifestyle and the unnecessary and costly load they place on the Region's health resources. Such simple measures as the use of seat belts and the addition of fluoride to drinking-water are not yet widely applied because of the lack of a political consensus which depends upon public support and public education. The creation of such a consensus is not made easier by the massive expenditure of powerful industries in promoting the sales of products which are intrinsically harmful to health or are harmful when used inappropriately or in excess.

While in these and other fields there is no doubt about the messages which health educators need to get across, the most cost-effective method for the purpose is still unclear. Techniques of education for health are thus a further important area of research. What seems clear is that a didactic or authoritarian approach to such education is unlikely to be effective. This is one of the reasons why community participation is critical and must be built into the system of primary health care. Communities must choose their own health priorities and develop their own mechanisms of social control to enforce them. Special attention needs to be given to promotion of mental health, and to care of the aged and the disabled.

Education for health should start early in life and the role of schools is of crucial importance in this respect. Thus better coordination is needed at the national level between the ministries responsible for health and for education. Better coordination is also needed at the international level between WHO and UNESCO.

The RHDAC gave special attention to the problems of underprivileged groups who lack effective access to health services or do not use them to the extent to which their low health status would warrant. This is a problem to be found particularly in inner city areas. It was agreed that stronger planning measures are required to ensure that quality services are available where they are needed. Among the underusers are immigrants who come from countries where facilities are underdeveloped and do not know what use is intended to be made of services, e.g., for family planning, or do not appreciate the importance of early reporting of pregnancy, health checks and immunization for children. There are also language and cultural barriers to the use of services which may require a greater flexibility in their provision.

Within countries of Europe with highly developed services there are still major variations in the morbidity and mortality of different social groups. In at least one country there is evidence that the relative gap in health status has not narrowed at all in the past 30 years. New methods of communication may have to be developed to ensure that those who most need services use them to the extent they should.

While improved education for health is critical to the success of the new emphasis on prevention, it was stressed that traditional preventive measures should not be overlooked. Stronger measures are needed to prevent the misuse of toxic chemicals and tighter legislation is required to control environmental hazards. Such control depends on better techniques of risk assessment. The testing of products for health hazards needs to be strengthened and extended, not least in the field of food safety.

There are still black spots of atmospheric pollution and, while the grosser types of water pollution are declining, microchemical contaminants are increasingly being recognized as important health hazards. More attention needs to be given to the risks of radiation and to the problem of noise. Major emphasis may well have to be given to improvement of the water supply and sewage systems of large cities, which are becoming antiquated, difficult to repair and impossible to rebuild.

There are still parts of Europe which lack pure water, adequate sanitation and acceptable standards of food hygiene and housing. Provision of these essentials to sections of the population which lack them is an integral part of the health for all by the year 2000 movement. Similarly there are children in the Region to whom basic immunization services are not provided; this too must be remedied by the year 2000. There are also parts of the Region where the battle against the killer communicable diseases has still to be won. In these areas external aid to promote socioeconomic development will be essential to the health effort.

The battle against poverty is also part of the battle against ill-health, as poverty is at the root of so many problems of health and health care.

Health Care and Rehabilitation Services

Further reductions in mortality before the age of retirement would add to the present projected increase in the proportion of aged in the Region and to the number of deaths at advanced age from chronic and degenerative disease. In so far as fewer health resources will be needed for health care for those earlier in life, more can be used for the larger number of the aged to enable them to live the fullest possible lives, to provide support for the mentally and physically disabled among the aged, and to give dignified and appropriate care to the dying. The redeployment of resources from acute care to chronic care will require careful planning. The aim should be to enable as many old people as possible to stay in their own homes as long as possible through various means of support for daily living: home help, home nursing, adaptations to the home, day hospitals, day

centres. The further development of social as well as health services to promote wellbeing of the aged will be a major priority for the European Region within its programmes for health for all by the year 2000.

The problem of caring for the mentally and physically disabled is not confined to the aged. With the further development of life-saving treatment there is likely to be a higher proportion of people with chronic disability. This will represent a challenge to the rehabilitation services in enabling the disabled to live as economically and socially productive lives as possible. As in the case of the aged, a whole range of services will need to be developed to make this possible.

Making the Most Effective Use of Resources

Emphasis on prevention and the improvement of care and rehabilitation services was felt by the RHDAC to be among the highest priorities in attaining health for all by the year 2000 in the more developed countries of the Region. Prevention is no less important in the developing countries, but they must give the highest priority to the fight against poverty, communicable disease and low standards of hygiene. All this must not be read as implying that cure is unimportant or that opportunities should not be seized to incorporate into the health services of the Region further medical advances which are proved to be effective. In the industrial countries curative services are already of a high standard, which must be maintained, though in certain areas more cost-effective ways can be found of delivering them.

Because of the aging of the population of the Region, and particularly the rise in the proportion of those over 75, a steady increase in resources devoted to health care would be required just to provide the same standards of service as are presently available for each age and sex group within the population. Moreover, medical progress will not stand still, nor would we wish it to do so. Most advances in medical knowledge require extra resources for their application. If a concerted effort is made to improve services for the underprovided, to raise standards of care particularly for those with chronic physical or mental disability, to make a major investment in prevention, particularly through education for health, and to acquire knowledge of effective preventive measures, it will be essential to improve the cost-effectiveness of existing services. In view of the economic prospect, it is only in this way that resources are likely to be found for new developments.

The RHDAC pointed out that the key to cost-effectiveness in health services is to avoid using more costly technology than is appropriate to the particular task. Thus, it will be necessary:

- (a) to encourage the populations of the Region to take greater responsibility for their own health where this is appropriate;
- (b) to develop a wider range of services for care of people in their own homes (home nursing, home help, day centres, day hospitals);
- (c) to prevent the unnecessary use of secondary and tertiary services;
- (d) to evaluate new technology before it is introduced in a health care system on a routine basis (this would be a particularly fruitful field for systematic cooperation among countries).

To apply the first three of the above principles, it is essential to have a strong primary care system, characterized by:

- accessibility
- teamwork
- continuity
- participation.

There was wide agreement in the RHDAC that the strengthening of primary care is the single most important task for the Region in achieving health for all by the year 2000.

Health Manpower Development

The RHDAC identified a number of issues related to health manpower development, which can be grouped into four major categories.

- (a) There is a need for major investment in behavioural sciences research and environmental studies, to be undertaken in parallel with the continuing programme of biomedical research. The researchers would have to be independent, of high academic quality and problem-oriented, and have

free access to health services and institutions. There is at present in the Region a serious shortage of researchers of the requisite quality and experience. To attract investigators to this field behavioural scientists will have to be given equivalent status and job security to that enjoyed by biomedical research workers. A major initiative is needed to train more behavioural scientists, epidemiologists and environmental specialists to work with or parallel to health professionals in appropriately constituted multidisciplinary teams. There is a particular shortage of toxicologists which will have to be remedied in the near future. The training programmes should be based upon existing centres of excellence throughout the Region.

(b) A major investment in education for health is called for. The skills required for this task extend far beyond those possessed by health professionals. Specialized staff are needed to plan programmes of mass communication as well as to work with communities at the local level. This is a second area where substantial development of training programmes is necessary.

(c) A major redeployment of the health care effort and the introduction of more cost-effective ways of delivering appropriate services are called for, and these changes will need to be planned, managed and evaluated. The tasks will require a team approach by administrators, financial experts and health economists, as well as public health specialists, all of whom are in short supply in the Region. This is a third area where training programmes must be rapidly expanded.

(d) Strengthening of the system of primary health care is a basic requirement. This will involve the extension of postgraduate programmes for health professionals about to enter clinical practice, and the development of substantial reorientation programmes for those already engaged in professional practice - particularly in countries where the principles of teamwork, continuity of care and participation are not generally accepted.

Information Support

A sound information base will be needed to plan, monitor and evaluate national strategies for the attainment of health for all by the year 2000. At the same time it might provide insight into many of the new issues outlined above. The requirement is not only for provision of more data, but no less for better data synthesis and presentation, in order to reveal the real problems and new options in health care. It was felt that much more should be done, both at national and 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.

Evaluation

The RHDAC felt that an intensified, pragmatic effort was long overdue in this field. A uniform information base should be developed to monitor progress in the planned directions. A critical requirement for this purpose is the development of further indicators of health status which are not purely biomedical, but also cover sociopolitical and organizational aspects.

5. Role of the Regional Office

The RHDAC endorsed the recommendations of the Executive Board (document A32/8) and the report of the planning group convened earlier in Copenhagen (EUR/EXM/80.1).

Emphasis was placed on the Regional Office's role as catalyst and coordinator in all matters relating to exchanges of experience, knowledge and information, to training and to research, especially as regards prevention, education for health, behaviour and attitudes, cost-effectiveness of services, evaluation of new techniques and preparation of lists of basic drugs.

There is a need for a broader, distinctly interdisciplinary approach to the environment. In some countries there are still conflicts between health and environmental agencies. WHO has a key role to play in cooperation between ministries, European intergovernmental organizations, and other United Nations bodies such as UNEP which are active in the European Region.

The developing countries are in a special position in Europe and their "underdevelopment" is only relative. Nevertheless their situation would justify setting up primary health programmes similar to those in other regions. Moreover, it should be remembered that problems in this respect are encountered not only in the south of the Region (Algeria, Morocco, Turkey) but also in arctic zones in the north. Because it contains both highly industrialized and less developed countries or areas, the European Region might be an appropriate setting for studies on interrelationships with the Third World.

It was noted that a report summarizing the views expressed by the RHDAC and the data contained in the background documents for the meeting would be drawn up by the secretariat for submission to the Regional Committee at its thirtieth session in Fez. With regard to the presentation of the document, it was felt that there were two possible formats:

- either a set of guidelines specifying the objectives and stages in their attainment, and the measures to be taken, i.e. a document requiring one or two years to produce,
- or a much shorter charter,^a which would serve as a statement of principles and be submitted to countries of the Region for approval.

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^a Similar to the charter for the South-East Asia Region, which has been signed by several of the Member States concerned.

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^a Participation expenses not paid by WHO.

page 10
Appendix

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^a Other Regional Office staff, including directors of services, also took part in the meeting.