

HFA in Europe: post-Alma Ata response to the challenge of Primary Health Care

Keith Barnard

In March this year Kofi Annan, the UN Secretary General, presented his report on the Millennium Development Goals (MDGs). (See Box 3). The MDGs are important in securing "the economic and social advancement of all peoples" that the UN constitution states as a purpose of the Organization. The Report makes clear that health is a vital component of the whole UN agenda - peace and security, development and human rights. It also highlights the lack of systems for effective delivery, and of properly trained personnel - the right people in the right places.

The MDGs are clearly stated, readily understood and progress can be tracked. But they are selective, and although interconnected, do not truly constitute a new comprehensive strategy for the international community.

Yet I do not feel I am reading too much into Kofi Annan in thinking that he at least wants a rediscovery of the vision, idealism and shared sense of purpose of 1945. His report also presents proposals for reform of the United Nations Organization. Its title, 'In Larger Freedom', is a phrase consciously taken from the Preamble of the UN Constitution. He is reminding the international community that the purpose of the UN is not just to ensure peace and security in a purely military sense, but also to be the means, 'to promote social progress and better standards of life in larger freedom'. The whole UN family of agencies funds and programmes, including WHO, grew out of this commitment.

At this year's World Health Assembly, progress on MDGs was a major item on the agenda. But Lee, the Director-General, had nothing to say about WHO's vision of health for all, and nothing about Alma Ata and Primary Health Care (see Box 1), the means by which it could be pursued.

Why so? Have the vision and the means outlived their usefulness? Or is it realpolitik? The DG knows what is expected. Our demanding global bottom line culture means he must be seen to be working towards concrete measurable ends agreed by the world's heads of state and government. It's polio, SARS, avian influenza and the like that Member States look to WHO to deliver on. As to whether this is his whole agenda, the evidence is ambiguous. Is he more subtle than first appears? Not all countries are happy with the Alma Ata agenda, which exposes the health and equity consequences of their domestic economic and other policies. Yet Lee's most ambitious initiative, the Commission on Social Determinants of Health launched this year (see Box 4), could conceivably lead us back to an agenda that would closely resemble Alma Ata. (See: Richard Horton. Reflecting on health challenges: remarks for the official launch of the WHO Commission on Social Determinants of Health. Santiago Chile 18 March 2005 on WHO website). For the moment, we appear to be going backwards. A year and a half ago, when he presented the annual World Health Report, the newly elected Lee appeared to give proper recognition to the significance of PHC as a systems approach to health and community development. Now we appear to be returning to the technocratic approach of the first 20 years, when WHO initiated a variety of vertical disease campaign programmes.

1973, WHO's twenty-fifth anniversary, marked the change. The WHA elected Halfdan Mahler as Director-General. He was to become the driving force for a new approach. But the words of the retiring Director-General, Candau are significant, as they were to set the stage for Mahler. Much health improvement was due to economic and social change. Health services (where they existed) were often little used, were imposed on developing countries; and "unlikely to function properly in the conditions obtaining there." (WHO should) turn more directly to the consumer and the small communities, the smallest units, (in an effort to develop services that visibly) deal with the people's priorities, and not act as agents of outside forces however benevolent." Candau's farewell address was the first step. An evolution was in train. The focus of concern would move from disease to community to the individual in their socio-cultural context, with equal emphasis on the individual and the context.

The 1977 'health for all' resolution (WHA 30.43) called for action by WHO and its Member States, so that by the year 2000 all peoples would 'enjoy a level of health enabling them to lead socially and economically productive lives'. (The target year 2000 was not seriously seen as an end point. It was a device to harness the drama of the millennium, create a sense of urgency and focus on what could be attempted in the course of a generation.). The Declaration of Alma Ata, adopted by

the 1978 Conference on Primary Health Care (PHC), pronounced that PHC would be the means by which the goal of health for all could be achieved. The Declaration (see Box 1) presents fundamental ideas about health, strategies to protect promote and improve the population's health, and characteristics of an effective, responsive and sustainable health care system. It lays out an agenda for the local health sector, emphasising its need to develop links with other levels and other sectors, and with the community population. It was an early and unfortunately a sustained misconception, that PHC was just a synonym for first contact medical care. My friend and colleague Hannu Vuori, responsible for PHC in the European Regional Office post Alma Ata, later took on the task of elaborating and clarifying the concept of PHC for the benefit of the European professional academic, political and managerial communities (Vuori 1986 - see Box 2).

Vuori pointed out that PHC should be understood severally as: a set of activities; a level of care; a strategy for organizing care; and a philosophy permeating the entire health system. It is not a case of choosing between them. We have to understand and work with all of them. With hindsight we recognise the consequence of bundling so many crucial ideas into one term - the virtual impossibility of conveying this complex notion of PHC to everyone whose support we needed. Ask the public 'what's PHC', and, quite reasonably, the most you might get is, 'It's the GP, the community nurse or the health centre.' We were stuck with a label. It was difficult to get beyond terminology and definitions to the agenda for action that Alma Ata pointed to.

The significance of Alma Ata is in the challenges: securing equitable access for all to affordable socially acceptable essential health care, developing cost-effective technologies that are appropriate to the tasks to be performed, ensuring sustainable resources, reducing the health damaging consequences of inequities in societies, and developing strategies for social change. It's all in the Declaration.

How did Europe react in 1978? There were those who, perhaps wilfully, understood 'primary' to mean 'primitive'. And, because it was a drive to correct the gross disparity in health between the developed and developing worlds that had triggered the HFA/PHC initiative, it was queried whether it was really applicable to industrialised countries. We should remember that until 1992, the WHO European Region, despite its population of 800 Million, its vast geographic area, and its front line status in the cold war, was commonly regarded in a health perspective as an essentially homogeneous group of such "industrialized countries". After the dissolution of the USSR, a clearer picture of the region emerged. In terms of health and economic development, it was far from homogenous. As the region grew from 30 to 50 Member States, half were now found to require direct assistance of various kinds. It meant a revolution for the European Regional Office, in its ways of working and its relations with Member States. But at the time of Alma Ata, Geneva feared that, if developed countries of Europe did not take HFA/PHC seriously, developing countries might conclude that they shouldn't either. When Hannu Vuori became Regional Officer for Primary Health Care in 1980, the challenge was to advocate to all the various interest groups in the Region why PHC was relevant to them. Yet trends in western industrialised countries, with the emphasis on costly technology and specialist care, were already causing serious concern. In 1974 the Canadian Government's Lalonde Report had highlighted the high cost of 'hi-tech' health care and the consequences of assuming that the 'solution' to any problem was to spend more on health care. The cause of a problem, and hence the most appropriate point for an intervention, might be found outside health care in the physical and psychosocial environment or in people's lifestyles. In fact, Lalonde had already made the case for the relevance of PHC to developed countries. The Member States' commitment to Alma Ata first emerged at the 1979 Regional Committee. Their official statements put them into one of four broad groups (Vuori 1984). The socialist group claimed they had already implemented PHC. The second group (many central European countries) were reforming medical education; with a new generation of physicians they too would have PHC. The third group, including the Nordics, took PHC more seriously, and were worried. The distribution of their national budgets and personnel showed that they were still far from the goal. They would reorient their system, but they were not sure they could make it by the year 2000. The fourth group wondered: "Primary Health Care - what's that?"

In 1980 the formally supportive European Regional Committee adopted a Strategy that saw "an organized system of PHC as the key instrument for achieving HFA". In 1984 the Strategy was elaborated into a coherent interrelated set of specific objectives, referred to as 'HFA targets', which implicitly followed the Lalonde analysis of causes and appropriate interventions.

Target 26 proposed that: by 1990, ... all countries should have developed health care systems based on primary health care as outlined at the Alma-Ata Conference. Member States were offered an opportunity to test the relevance of PHC to their health policies and systems at the 1983 Conference on Primary Health Care in Industrialized Countries in Bordeaux (WHO 1985). The Soviet Union made clear that the Declaration did not necessitate any change in their health infrastructure:

health for all principles had always been the basis of Soviet health care. Other countries made different assertions but revealed a similar complacency. Undeterred, WHO went on to promote a "blueprint for change" (Vuori 1984). Put succinctly, it proposed a shift in focus from illness and cure to health, prevention and care; content from treatment, episodic care and specific problems to health promotion, prevention and care and a comprehensive concern; organization from physician specialists and single handed practice to GPs and other professions and to teams; and responsibility from professional dominance and the health sector to intersectoral collaboration, community participation and self-responsibility.

It made clear who and what needed to change. It was a powerful restatement of the Alma Ata agenda, with which the Regional Office persisted. But the situation was becoming complicated by the emergence of an activist lobby that believed in political and community action. Reacting against conservative mindsets in health care, contemptuous of 'old' Public Health, traditional technocratic disease prevention and control, it was advocating 'Health Promotion' as the principal strategy in what it chose to call a 'new public health.'

An observer might have concluded that the proponents of the 1986 Ottawa Charter on Health Promotion intended that it should replace Alma Ata as the new authoritative statement of the Organization's purpose. Mahler didn't see it quite that way. He used the conference to express his frustration at the lack of a strong response to Alma Ata. He said of the 'new public health'. It was recognition of the understanding of health in the sense of well being and not disease, and an understanding of public as a true involvement of people in shaping their own health. "That was the message of Alma Ata that has still not penetrated the thinking of many actors in the health field."

The Ottawa Charter was useful in appealing to actors outside the health sector, but in terms of its underlying principles and objectives, it was really a repackaging of Alma Ata. And whether driven by the Charter, Alma Ata or even Lalonde, the need to refocus countries' attention away from an exclusive concern with specialist health care services was a key strategic concern.

Hence such innovations as the Healthy Cities Project, the CINDI prevention programme, and a more modest initiative I remain involved with, the TTB Network (Tipping the balance towards primary health care). These initiatives have had a complementary character. Healthy Cities and later, Health Promoting Schools networks engaged local politicians, NGOs, and non-health professionals, and clearly took the message beyond the health sector. Likewise in recent years, the promotion of national and local environment and health action plans, a spin off from Agenda 21 adopted at the Rio conference on environment and development.

CINDI (Countrywide integrated non-communicable disease intervention programme) focused on the need for and impact of action on risk factors. This appealed inside the health sector to clinicians and epidemiologists interested in primary prevention.

TTB, focussing on local governance, management, the education of staff and users, provider-user relationships and service delivery, has appealed inside the health sector to 'front line' clinicians, local managers, and, to a lesser extent, politicians. It has the potential to address the region's biggest challenges: how to manage the chronic problems of an ageing population, and how to protect and promote the health of children and young persons. These are quintessential Alma Ata issues, with inter-professional, inter-sectoral and community involvement dimensions. The limitation of TTB has been that it has remained small scale and has only appealed in those countries with organised public sector health care systems.

With the possible exception of CINDI, none of these initiatives, despite their appeal, touched national governments. However, governments were to become unwitting protagonists in the 1990s, as new economic imperatives became a driver for reshaping the health sector with potential, if not consciously intended, benefit to PHC.

Historically, western European countries had either a public sector National Health Service or an Insurance funded system based on private practice. Soviet republics and other socialist countries had the Semashko model, state systems oriented towards specialist curative care. Western governments in the early 90s were bent on controlling and reducing public expenditure. Reforms included: encouragement of inter-professional team work; reassignment of tasks from physicians to others; providing in the community services previously performed at other levels, making first contact providers also purchasing or commissioning agents of secondary care; and restricting access to secondary and tertiary care without referral from a so-called gatekeeper.

So the medical aspects of PHC were promoted as a consequence of higher order economic policy. Some changes were better received and more successful than others, even becoming the new conventional wisdom. It proved easier to effect changes in NHS systems. In countries with the

physician-centred private practice cum health insurance systems, where GPs still work alone and often compete with specialists, the gate-keeping role is limited, especially when patients can go freely straight to specialists or hospital OPDs, without additional financial cost to themselves.

The Semashko systems faced the greatest pressure for change. Inadequately funded, with run-down facilities and de-motivated staff on low salaries, an alternative economically sustainable and socially acceptable model became a necessity. In the reforms initiated from the early 1990s onwards, the goal in most cases was to establish an insurance system based on family practice. In the former Soviet republics, change has been slow. In the relatively more prosperous countries of central and eastern Europe, leading clinicians became politicians. Seeing how colleagues in capitalist countries prospered, they wanted a similar model. The result was a rapid, not necessarily unproblematic, transition to a predominantly privatised, market-oriented system.

What have we learned from cost-control driven reform?

Many reforms reflected the idea in currency that a market where buyers and sellers of different social services meet would improve efficiency. It has since been argued that the evidence suggests that the conditions favouring the development of effective PHC are more likely to exist in an environment that emphasizes equity rather than efficiency. Contrary to assumption, privatisation and marketization don't diminish the role of state, and may make it more difficult. The negotiation and monitoring of contracts are more complicated and labour-intensive activities than allocating block grants from a state budget. Control through regulatory oversight can be more expensive than direct control. Health ministries are still responsible for formulating policy; monitoring the impact of health and other public policies; and providing guidance to the whole health system, both the public sector and the perhaps larger private sector. A focus on the economics of health care services diverts attention away from other essential PHC issues. Thus at a donors meeting in a former Soviet Central Asian Republic, presentations will stress financing, management, efficiency of services, and methods of physician remuneration. One can expect few references to health protection and promotion measures, or intersectoral mechanisms and strategies that could reduce use of health services for social reasons.

One cannot talk of the role of the state without also acknowledging the European Union (EU). Although at present the EU leaves health care provision to member states, in terms of the broad HFA/PHC agenda it is very much involved, with competence in matters that either have health as an 'objective' or equally, a positive or negative health impact as a 'consequence'. The French and Dutch referenda have created a new uncertainty about the future, but assuming the EU continues to function and expand, WHO/EU relations will necessarily be sensitive. Inevitably there is risk of tension between organizations with the same or overlapping membership but different mandates and ways of working, and where one has legal powers to act and direct, and the other can only persuade and exert moral authority.

What of the future? The quintessential Alma Ata challenge stands: what changes in health systems, in policy and action, will best achieve the highest attainable level of health for all? In 1998 the Regional Committee adopted HEALTH 21, taking HFA into the present century. This is an admirable policy document and essentially a renewal of the 1984 document. But its coupling of strategic objectives with rather detailed target setting and progress monitoring, first adopted in 1984, has perhaps obscured, and diminished the impact of, its basic messages. In contrast, MDGs are presented with a relatively simple set of targets and indicators.

HEALTH 21's Target 15 proposed that: By the year 2010, people should have much better access to family- and community-oriented primary health care.....The supporting text stated that a community health policy and programme should ensure the systematic involvement of various local sectors and nongovernmental organizations in promoting more healthy lifestyles, a healthier environment and an efficient health and social service system at local level. I read that as a reaffirmation of Alma Ata. I find the current situation confused, even contradictory. The espoused priority of the European Region, for WHO and Member States, is health systems development. That's fine. But there is no mention of PHC, the concept that would give meaning to it. Have they adopted a slogan - 'health systems' - without buying into the need for systems thinking? To paraphrase what one colleague put to me: "Why is there so little real interest in health systems design and functioning? This is what Health Ministers most need help with. Anyone who spends time in the east of the region sees that very quickly. League tables (as presented in World Health Report 2000) never helped at all, nothing in practical terms about how to improve things." The Regional Office in Copenhagen has had little to say on PHC, but initially Lee seemed to don Mahler's mantle and reclaim its development as the *raison d'être* of WHO's programme of work. For a while it seemed that the mechanistic or the analytic era of league tables was over.

Did we judge too soon? The picture I am getting is that there are those in the WHO secretariat

who are 'disease focused'; they do not believe that PHC/HFA is a useful framework. They say, " it didn't work ", but don't explain. It doesn't seem this faction will provide countries with a new paradigm, unless it's a new 'verticalism'. One understands their commitment to action, but PHC, as local public health, requires a combination of analysis and action. Analysis without action is pointless. Action without analysis is high risk, and risks being totally misguided. Some insiders say MDGs are the new development tool - implicitly, that MDGs have superseded HFA. My comment here is that we can welcome MDGs, but they are limited, selective and do not even attempt to match the scope of health for all.

Lastly, some say a better way of thinking is the analytical tool developed by Murray (a key adviser of the previous DG, Brundtland) - this simply breaks the system into 'functions' We should note here that 'systems thinking' is not simply analysing the parts, but keeping the whole PHC system in focus. 'Systems thinking' helps us to understand interrelationships and patterns as we respond in actions to the complex problems that we face. Although vertical programmes have made a comeback, ultimately "3 x 5", polio, TB and the others will need well functioning health systems in order to be effective and sustained. It's a key Alma Ata issue. It is also a powerful message in Kofi Annan's Report. It may yet be that more countries will come to see this for themselves and ask WHO for help in system development.

There is no interest in health system work per se among the donors involved in the high visibility vertical programmes. Their interest is in the outcome numbers. But they might yet be led to the conclusion that some part of their investment must go to health system capacity building if they are to get the results they are expecting.

All this suggests that those of us still committed to HFA and PHC are facing two major continuing challenges. First, there is the need for systems thinking and being ready to reflect on practice, asking how and why things happen. Secondly we need to learn how we can be more successful in collaboration (all forms of cross-boundary working) and in the integration and coordination of the whole range of actions that protect, improve and restore health.

This means inter alia we must continue working at crafting a shared vision, so that, within our Alma Ata concept of health and social and community development, we can accommodate a broad coalition of actors in the system, with their own interests, perceptions, and even specific objectives. A start has been made with initiatives like Healthy Cities and Health Promoting Schools. It will need sustained pressure on politicians and other key decision makers through sustained community mobilization. In short, it will need 'all for health' to achieve health for all.

Selected extracts from the Declaration of Alma-Ata, 1978

Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments should be the attainment by all peoples of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

Primary health care

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care and family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves health and all related sectors and aspects of national and community development;
5. requires and promotes community and individual self-reliance and participation in planning, organization, and operation of primary health care, making use of available resources; and develops through appropriate education the ability of communities to participate;
6. is sustained by integrated, mutually-supportive referral systems, leading to progressive improvement of comprehensive health care for all, giving priority to those most in need;
7. relies, at local and referral levels, on health workers trained socially and technically to work as a team and respond to health needs.

Box 1 (Declaration of Alma-Ata 1978)

Vuori's conceptualisation of PHC

PHC as a set of activities: is a down-to-earth understanding of PHC that has the advantages of simplicity and concreteness. Accordingly, one could say that a country has PHC if it covers the eight basic elements listed in the Alma-Ata Declaration.

Its major disadvantage is that although even the wealthiest countries have been unable to cover all basic elements satisfactorily, it easily gives rise to the claim that PHC is irrelevant for industrialized countries, allowing health authorities and professionals to claim: "We already have this; we have had it since the beginning of the 20th century."

Another disadvantage is that the elements can be organized in disregard for the principles implicit and explicit in the other understandings of PHC.

PHC as a level of care is also easy to grasp. PHC is that part of the health care system that people contact first they have a health problem. It has been popular in Western Europe and notably among general practitioners (GPs), since it seems to make them guardians of the concept. But although GPs are key players, their services lie primarily in the area of primary *medical* care. And besides, in the case of 80-90 % of 'medical' problems there is no contact with the formal system. Shouldn't the informal system also be seen as integral to PHC?

PHC as a strategy means that before one can speak of a country having PHC, there are certain strategic principles with which the system must conform. There must be accessible services that are relevant to population needs, functionally integrated, cost-effective, and use appropriate technology. PHC is based on based on community participation, multi sectoral action and intersectoral collaboration. Legislative reform, a redistribution of resources, and a reorientation through training and redeployment of health personnel may all be needed.

PHC as a philosophy may be far from the everyday realities of providers, planners and politicians; but is the most important understanding. A country can claim to have PHC in the most profound sense only if social justice and equity, self-responsibility, solidarity and acceptance of a broad concept of health and action for health characterize its health system.

Millennium Development Goals

In September 2000, the largest-ever gathering of Heads of State ushered in the new millennium by adopting the **UN Millennium Declaration**. The Declaration, endorsed by 189 countries, was then translated into a roadmap setting out **goals to be reached by 2015**.

The **eight Millennium Development Goals (MDGs)** build on agreements made at United Nations conferences in the 1990s and represent commitments to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

The **MDGs** are framed as a compact, which recognizes the contribution that developed countries can make through trade, development assistance, debt relief, access to essential medicines and technology transfer.

Improvements in health are essential if progress is to be made with the other MDGs. Three out of the eight goals, to reduce **child mortality**, to improve **maternal health**, to combat **HIV/AIDS**, malaria, and other *s* diseases, and eight of the 16 targets and 18 of the 48 indicators relate directly to health. Health is an important contributor to several other goals.

The significance of the **MDGs** lies in the linkages between them: they are a **mutually reinforcing framework to improve overall human development**. The **MDGs** provide a vision of development in which health and education are squarely at the centre. Since their adoption, no one has been able to say that development is just about economic growth.

More resources are needed, but money is only part of the picture. Progress will equally depend on getting policies right; making the institutions that implement them function effectively; building health systems that work well and treat people fairly and ensuring there are enough staff to do all the work.

The **MDGs** do not say everything that needs to be said about health and development. They say nothing about the importance of **effective health systems**, which are **essential to the achievement of all health goals**, or about reproductive health and **noncommunicable diseases**.

We therefore have to understand the **MDGs** as a form of shorthand for **some** of the most **important outcomes that development should achieve**: fewer women dying in childbirth; more children surviving the early years of life; dealing with the catastrophe of HIV/AIDS; making sure people have access to life saving drugs; and better health in all its forms making a major contribution to poverty reduction.

Faster progress towards the Millennium Development Goals (**MDGs**) is possible. It is a matter of political choice in the developed *and* developing world. We *can* dramatically transform the lives of millions of the world's poorest people.

Commission on Social determinants of health

Public health begins with recognition of the need for favourable social conditions, but the specific nature of those conditions, and the ways in which they can be improved, need to be more clearly and widely known. Knowledge of the social determinants of health, from national and international projects and research, is still too fragmentary. That knowledge needs to be more fully developed and widely shared so that it can be used. |

The launch of the Commission on Social Determinants of Health marks the start of a major effort to marshal knowledge for action. The Commission will work for the next 3 years on making practical recommendations about how to improve health by acting on its social determinants. Their findings and information on best practices will be drawn from involvement in national and community experience.

The outcome we are working for is a reorientation of public health action and policy towards more effective and sustainable approaches. The Commission's findings will take effect by interaction with knowledge networks, building communities of practice, and shaping policy for institutional change. The knowledge networks through which the Commission will work include: early child development, priority public health conditions, health systems, measurement, employment conditions, globalisation, urban settings, and social exclusion.

Some links between poverty and health seem obvious but in practice they can be complex and paradoxical. There are countries with a per-capita gross national product of US\$10 000 which have a higher average life expectancy than others with a gross national product of over \$30 000. When the specific causes of such anomalies are known, there is a strong basis for corrective action. Data on such action and its outcomes are clues to a vast area of neglected opportunity for health.

Lee Jong-wook Director-General WHO

Box 4 (See article in Lancet 19 March, 2005)

Reading:

1. Kaprio, Leo: Primary health care in Europe. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies No. 14)
2. Government of Canada. A New Perspective on the Health of Canadians (Lalonde Report) Ottawa 1975
3. Saltman, Richard B. and Josep Figueras: European health care reform: analysis of current strategies. Copenhagen, WHO regional publications. European series ; No. 72 (1997)
4. Saltman, Richard B., et al (ed.): Primary care in the driver's seat? Organizational reform in European primary care. European Observatory of Health Care Systems.
5. Saltman, Richard B, et al (eds.): Regulating entrepreneurial behaviour in European health care systems. European Observatory of Health Care Systems Series. Buckingham, Open University Press 2002
6. UN. In Larger Freedom: Towards Development Security and Human Rights for All www.un.org/largerfreedom
7. Vuori, Hannu: Primary health care in Europe: problems and solutions. Comm. Medicine (1984) 6,221-231
8. Vuori, Hannu: Health for all, primary health care and GPs . J.R.Coll. Gen.Practitioners (1986) 36, 398-402
9. World Health Organization. Primary HealthCare: Report of an International Conference. Geneva 1978
10. World Health Organization: Primary health care in industrialized countries. Report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1985 (EURO Reports and Studies 95)
11. World Health Organization: Targets for Health for All. Copenhagen, Regional Office for Europe, 1985
12. World Health Organization: Primary Health Care 21: "Everybody's Business": an international meeting to celebrate 20 years after Alma-Ata, Almaty, Kazakhstan, 27-28 November 1998. Geneva. 2000.
13. World Health Organization. HEALTH 21. European Health for All Series No 6 Copenhagen

1999.

Kontakt osoba:

Keith Barnard

Formerly Head, Nuffield Centre for Health Services Studies University of Leeds, UK

Formerly guest professor Nordic School of Public Health Göteborg Sweden

WHO consultant in policy and management and adviser to the TTB Network (Tipping the Balance towards Primary Health Care)

e-mail : keith.barnard@telia.com

phone +46 31 147101