WHO was founded in 1948 to improve the health for all peoples of the world. During the 1950s it fought the post-World War II misery and the large epidemics that ravaged developing countries. The 1960s was the belief that salvation lay in the breathtaking new medical scientific and technological breakthroughs, and in the newfound freedom of developing countries from centuries of colonial rule. However, by the middle of the 1970s it was becoming clear that none of these developments had led to any improvement for the big masses of people in the developing world, whose health and quality of life was, if any, worse than before.

Global HFA

Realizing this fundamental truth, the new visionary and charismatic leader of WHO, Halfdan Mahler, recognized that nothing short of fundamental change in the ways that countries and societies thought and acted in health development was required. Thus, for the first time, WHO developed at global policy for health development, using this as a wedge to move societies towards a better future. Starting with the 1977 WHA Health For All (HFA) Resolution, a crucial step followed in 1978 with the Alma Ata Primary Health Care (PHC) Conference – surely the most influential conference on health ever. In 1979 this world wide health policy movement gathered a decisive momentum when all countries and the 7 major elements of WHO (the global and the 6 regions) were all asked to develop their own, tailor-made HFA policy versions.

1980 version of the European Regional HFA

In the beginning the European Regional member States – overwhelmingly “developed” nations – felt that the HFA was of no interest to them.
In order to overcome this hurdle the Regional office asked the Director General, Dr Mahler, if he would accept a regional HFA where the main “vertical” pillars of the global HFA – PHC, multi-sectoral health action, community participation, appropriate technology for health etc. – became “horizontal” elements in the regional HFA. The “vertical entry points” would instead be those that the regional Member States themselves would recognize as relevant for their challenges. This Dr Mahler immediately agreed to.

The Regional Office decided that changing the mind of the European countries could only be done through facts relevant to them. EURO therefore undertook a major epidemiological review of the health developments of Europe from 1960 to 1980. This was a period characterized by huge improvements in health services technology and resources in the region. EURO could, however, demonstrate that, this development not withstanding, important health parameters had actually worsened during that period. The reason was a large increase in negative health determinants related to lifestyles and health; a problem area that no Member State at that time considered a health sector responsibility.

In 1980 the Regional Office presented to the Regional Committee the draft of a European HFA policy with 4 main elements: Lifestyles and Health; Health Care (where the main changes was PHC and Quality of Care); Environment and Health; and, finally, the Support (changes in health planning, health legislation, education of health personnel, in health technology etc) that would be needed in order to change the first 3 elements. The Regional Committee approved this policy in 1980, and in 1981 EURO reorganized its Programme Budget, created 7 new “HFA” programmes, and recruited different categories of staff to deal with them.


It was the practice at EURO to undertake, at the end of each biennium, an internal evaluation of all its programs, where all staff participated. When at the end of 1981 the question was asked: How are the countries moving with regard to HFA, the depressive answer was – not at all! Thus, a rethinking of strategies was required, and EURO decided to make the regional HFA sharper, more demanding, more transparent and easier to monitor and evaluate.
A large number of researchers and other experts from many disciplines and NGOs were organized into a substantial number of working groups, each getting one part of the 1980 HFA policy to analyze. Their mandate was: What was the true size of the problem that this part of the HFA policy addressed? What was the range of alternative methods available for improving the problem? What was the scientific evidence base for their effectiveness? If the best ones were applied throughout the European region, to what level of improvement could the region be taken by the year 2000?

On that basis a revised, targeted European HFA policy (with target specific strategic advice, over 200 target specific statistical indicators and a Regional Action plan) was developed and approved by the Regional Committee in 1984. Using the regional HFA indicators the progress was evaluated every 3 years. In line with the regional Action Plan the European HFA policy and its targets were updated in 1991 and again in 1998, based on the evaluations of the HFA indicators and on new scientific knowledge regarding the target specific strategies. This scientific knowledge the Regional Office program managers continuously collected as part of their daily work.

National, subnational and institutional HFA policies

A second decision taken at the internal evaluation in late 1981 was to find 2 member States that could be willing to be pioneers, formulating national HFA policies by using the European regional one as an inspirational framework and apply it to their own problems and possibilities. Finland and the Netherlands agreed to do this, in close cooperation with the Regional Office, and by 1986 these 2 were successfully finished. From then on the Regional office continuously pushed all other Member States to formulate their own national HFA policies and supported them in that work when they did. Some 2/3 of all Member States undertook such new national health policy developments, several more than once, using the same philosophy of evaluation and updating that characterized the European HFA.

In order to bring such policy formulation also down to sub-national levels, the Regional Office created a Regions for Health network, involving some 30 regions in many Member States. EURO also created a Healthy City network to stimulate similar developments at city level- a huge success as the network grew to some 1200 cities in Europe (and subsequently spreading to other WHO regions).
Finally, taking the movement all the way to local level (through the “settings” approach) EURO created the Health Promoting School, the Health Promoting Hospital and the Health in Prison networks that all used the European HFA policy as an inspirational tool for developing their own health policies and programs at institutional levels. Finally, in order to support health policy research and developments, a EURO led, multi-partner Health Policy centre was established in Brussels.

In addition to this health policy work, EURO undertook at major research, development and action program to improve the strategies that member States could use to tackle their problems regarding the major elements of the HFA policy, i.e. Lifestyles and Health, Health Care, Environment and Health, and Support.

Lifestyle and Health

As regards Lifestyle and Health an intensive development (actively supported by HQ funding and with a decentralized global management authority) started with 3 large international conferences (Ottawa, Adelaide, Sundswall) that developed a whole new concept as regards Health Promotion (e.g. the settings and life course approach and the above mentioned large networks). This development philosophy was then taken to the individual risk factors (tobacco, drugs, alcohol etc) where scientific state of the art reviews were taken to big regional conferences organized by EURO and followed up by systematic regional Action Plans. A EURO centre was created in Venice to look at Investment in Health, i.e. the multi-sectoral aspect of health promotion.

Health Care

In Health Care the Primary Health Care concept was first pushed through a large regional conference. As the settings approach took root a concept of a community health organization of public health structures, with organized links to the different local “settings networks”, took shape. That put the focus on the home as a key “setting” for health, and a new Family health Nurse concept was developed to give substance and structure to this “Home HFA setting”.
The second main European HFA thrust as regards Health Care took up the *Quality of Care* challenge. When this issue was included in the European HFA policy in 1980, the general belief was that quality of care was good in Europe; if problems appeared, the solution was to root out/fire the culprits – i.e. the “bad apple” theory. The new EURO program was launched in 1982 and as one of its first initiatives undertook a multi-centre study of quality of diabetes care in Member States from the North, East, South and West parts of the region.

That study, and other projects of the QCD program, led to 2 important findings. One was that there was indeed *a large problem with regard to quality of care throughout the region*, and that good quality was not necessarily synonymous with international or national institutional fame. The second finding was that a key to improving the situation was to *measure outcomes of care* and feed that information back to the clinical and managerial levels concerned, since such feedback provided a strong incentive for improvement.

In 1991 the Regional Committee decided to promote the introduction of the so-called *St Vincent* program as a pilot program in every Member State in order to demonstrate how to introduce the concept and practice of continuous *quality of care development* to the health services. The St Vincent model program for diabetes was developed through a cooperation between EURO and the European Branch of the International Diabetes Federation. Similar developments were subsequently undertaken by EURO in other health care areas, e.g. mental health, oral health, obstetrical care etc. EURO was also in this area of Quality of Care given global responsibility and resources (in the same way as for Health Promotion, see above).

In 1996 EURO organized a large regional Health Care Conference in Slovenia, taking these new health care concepts – as well as others (regionalization, privatization etc) – for debate. One result was the subsequent creation of the EURO led *Health Care Observatory*, a multi-partner health services research and information centre. Another initiative to strengthen these developments was the creation of a *EURO health Services centre* in Barcelona. A third, for Quality of Care, was in its final stage of planning when it was suddenly abandoned by the planned host country. EURO also had a strong *Care of the Elderly* program, and also in this area it was given global responsibility and resources.
Health professional networks

However, changing health care can not be done through government action alone. EURO therefore reached out to the major health professional organizations in Europe and created permanent cooperative networks with them. Thus, 3 major “joint Forae” of EURO and the leadership (Presidents and Secretaries General) of Europe’s national Medical Associations, Nursing Associations and Pharmaceutical Associations respectively were created. Through annual conferences of each of these Forae, and through permanent issue-specific joint working groups, the European HFA was introduced to these organizations, by and by adopted by them, and joint HFA project developments with EURO carried out 1.

Environment and Health

As regards the 3rd “leg” of the European HFA policy, i.e. Environment and Health, the EURO program initially dealt only with the production of technical guidance documents and UNDP financed projects in the developing countries of the region. An internal end-of-the biennium evaluation in 1985 drew attention to the lack of influence on the national policies and programs in the area. This led to a subsequent EURO initiative towards the ministries of health and of the environment, but this was rebuffed by the Member States, where the Ministries of health and the (newly created) Ministries of the Environment, were fighting over the same turf.

The 1987 Chernobyl disaster was, however, a wake-up call to the Member States. Thus, 2 years later, strongly supported by the Ministry of the Environment in Germany, EURO organized the first Ministerial Conference for Ministers of Health and the Environment. A tense meeting it nevertheless resulted in a joint European EH Charter, a decision to establish a EURO EH centre, and an agreement to organize a 2nd regional EH Conference in 1994. The EH centre was established with one leg in Italy, another in Holland and a third in France, giving EURO a substantial increase in its resources to deliver the EH program that the Regional Committee had approved 2.

1 E.g. joint development Quality of Care and Tobacco policies and actions for the medical Associations; the development of the Family Health nurse jointly with the Nursing Association; the partnership development of pharmacy based smoking withdrawal courses, needle exchange programs for drug addicts etc with the pharmacists
2 The French and Dutch ones were later replaced with a new one in Bonn, while the Italian one continued throughout the period.
By the time the second conference was organized in Helsinki in 1994 the mood had completely changed and cooperation between the 2 sectors of health and the environment was now strongly supported. A decision to develop *national Environment and Health Actions Plans* (NEHAPS) in every Member States was taken by the conference and subsequently followed up, with strong EURO support, in the large majority of Member States.

A EURO led *European Environment and Health Committee* with Regional Committee elected representatives from Member States and from selected European organizations (the EU Commission *et alia*) was by now giving added *gravitas* to the whole HFA/EH policy and program development. The 3rd EH conference in London in 1999 was a huge success, uniting some 75 Ministers (Health, Environment, Transport, Economy), adopting a Water Protocol and creating an intense interest from several delegations to enter the difficult policy field of Transport, Environment and Health.

*Disease prevention programs*

However, EURO did not forget the more classical public health concerns of disease prevention: Its *Road Traffic Accident* prevention program had a solid reputation and also in this area EURO was given global responsibility and resources.

A strong network - CINDI - run several large scale pilot projects regarding *Non-Communicable Diseases Prevention and Control*.

As regards *Communicable diseases*, WHO’s *vaccination programs* were pushed in all the country programs, but 3 diseases received particular attention:

In early 1983 the regional program manager for communicable diseases noticed a number of individual case descriptions of a similar, but strange pattern, in the international medical literature. The authors of the articles were therefore invited to a EURO working group in the autumn of 1983 in order to see whether this was just a coincidence or a new problem. The working group concluded that one probably was confronting a *new syndrome or a new disease entity*, of hitherto unknown origin.
On that basis EURO decided to establish, as from early 1984, a special European epidemiological surveillance centre in Paris, which from then on provided the region with systematic information on the epidemic. Late that spring EURO produced the first public health guidance document on AIDS, and started an intensive cooperation with interested Member States to develop national prevention programs. In the years to follow a large regional HIV/AIDS program was developed.

The second CD priority was Polio Eradication; a program carried out in close cooperation HQ and with WHO’s Eastern Mediterranean Office. The latter was done through the so-called MECACAR project, whereby over 60 million children in the 2 regions were vaccinated during the same week, several times during the life of the MECACAR. In 1999 the eradication of Polio was achieved in the European region.

The third CD priority concerned Diphtheria. When the Soviet Union collapsed, so did the vaccination programs for its citizens, and in 1992 diphtheria re-emerged as a public health problem. In 1993 EURO spearheaded a multi-partner project of vaccination in all the former Soviet Union countries. This was a successful project which, according to an epidemiological study, probably prevented more than 600 000 cases and 15 000 deaths from this disease.

**HFA and political and ethnic problems**

Finally, EURO used its “HFA umbrella” to help solve several serious problems in the region that were of a political or ethnic nature.

The development and adoption of a joint policy – the European HFA - among countries that at that time were bitterly divided by the cold war in all other sectors of society, opened up a unique avenue for exchange of experience and practical cooperation across the “iron curtain”. The reason for that was, no doubt, that the policy started with defining the final outcomes in terms of health of people and strategies for disease prevention – and on those the different fractions could agree.

Another example was EURO’s decision to enter the “hot wars” in the beginning of the 1990s in the Balkans and in Chechnya.
Being already a long time and close collaborating partner with all the warring fractions in the Balkans, EURO was able to get the confidence from all of them to establish operational offices in all areas and to organize 7 large scale assistance programs that operated continuously across the front lines.

A third example was the Bulgaria/Turkey conflict. In 1989 a serious problem suddenly emerged when hundreds of thousands of ethnic Turkish Bulgarians started to flee their country to seek refuge in Turkey, creating tremendous problems for both countries. EURO was asked to intervene, and did so in a carefully designed operation which solved the conflict and led to subsequent collaboration between the 2 countries.

Finally, an interethnic crisis in a very tense Macedonia in the first half of the 1990s (a sudden epidemic of unknown origin affecting a large number of children in the Tetovo region) was solved through EURO assistance, by using the same approach as in the Bulgaria/Turkey conflict.

**Conclusion**

What can be learned from the EURO experience during the 1980 – 2000 period? While there are many lessons that can be derived from the technical work, there is one fundamental issue that emerge. The development of a joint health policy uniting all the member states – very different as they are – was a major tool for WHO. With it EURO had no problems in getting access to the highest decision making levels in every Member State, because Ministers of Health, Prime Ministers and Presidents knew that the HFA was constructed carefully on the best available scientific evidence, not on a particular ideology.

The HFA – and behind it the EURO specialists and their partners throughout the region – had clear answers to most of the key challenges that faced decision makers at high levels in countries. Those decision makers would often question the impartiality of the advice they got from national experts with vested interests.

Of particular importance was the common framework for comparison among countries that the HFA indicators and evaluations provided.
Numerous are the examples of national policy makers that, faced with the cold facts of the HFA evaluations, went home to ponder afresh their own approaches as those of other Member States appeared to give better outcomes.

Last, but not least, the fact that HFA is not a one-off event, but a long term, science based, periodically evaluated and systematically updated policy, ensures that unique continuity of development which is so sorely lacking in most national and international developments. *Unfortunately, WHO itself seems now to have forgotten this crucial lesson* and has more or less abandoned the HFA.

It has thus deprived itself and the world of a major tool for sensibly and effectively mobilizing the huge potential for coordinated health development towards common goals that exist in society today. The tragedy is that WHO is, like no other, both mandated and uniquely suited for being the catalyst to mobilize that great potential.