Forty Years of WHO in Europe

World Health Organization
Regional Office for Europe
Copenhagen
The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible 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 WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 31 active Member States, and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of “health for all by the year 2000” the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

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a Albania, Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Spain, Sweden, Switzerland, Turkey, USSR, United Kingdom and Yugoslavia.
Forty Years of WHO in Europe

The development of a common health policy
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The development of a common health policy

Leo A. Kaprio
WHO Regional Director Emeritus
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1991 sees the completion of 40 years of work by the Regional Office in the WHO European Region. The idea of health for all has become familiar and is proving its worth in many and varied initiatives to improve health. Today, we are perhaps in danger of forgetting how remarkable and revolutionary are the idea of a common European health policy and, more, the work of implementing it. Further, this work has attracted new partners and a new generation has come to the fore in WHO and its traditional partners in Member States. For these people health for all is a fact of life, and the success of the idea perhaps obscures a part of its uniqueness and magnitude.

This book does more than highlight the work of WHO in the Region. It puts this work into perspective by describing one important part of it. This is the development of European cooperation for health and its expression through a common health policy, made with the Regional Office and in the forum of the Regional Committee for Europe, often called “the health parliament of Europe”.

This achievement is impressive, but gains added luster when it is seen against the length and difficulties of the journey towards it, and the tragic circumstances in which that journey began. Professor Leo A. Kaprio, WHO Regional Director Emeritus, is an excellent guide. Having served in the Second World War, which brought such devastation to Europe, he began his working life when WHO was born. He witnessed the birth of the Regional Office in the deepening winter of the cold war, and later played a remarkable role in both its scientific growth and its steadily increasing professional and political importance. In this account, he follows one thread of the work of WHO in Europe: how Member States
recognized the similarity of their problems in health and how, in spite of their political diversity and with rare vision and courage, they developed a common solution with a framework for action.

The last chapters of the story witness the arrival of a new generation, charged with the immense challenge of implementing this common solution. Writing in 1990, Professor Kaprio could describe only parts of the beginning of this dynamic process.

The scope of his account permitted him to mention only the most important events related to his theme and only a few of the thousands of people who have contributed to WHO's achievements in the Region. He could not, for example, dwell on the broad scope and large number of country activities. These dominated the work of the Regional Office in the early days and, history having come full circle, are resuming their old importance within the framework of the regional strategy for health for all. Their story, too, deserves telling.

These activities are particularly vital in tackling problems that were just coming to light when Professor Kaprio ended his account. By these I mean the severe health problems in countries in the central and eastern parts of the Region. They were revealed by the sweeping process of democratization that ended the decade of the 1980s and one of the chief facts of political life of WHO's first 40 years. At the same time, this political turnaround brought new opportunities for coping with the problems of these countries.

Today the basic principle of health for all and the subject of the first regional target — equity — has new importance. It is the raison d'être of the Regional Office's present priority work to help the countries of central and eastern Europe deal with their problems and build a healthier future. Professor Kaprio gives a history of health cooperation in the Region. Our current work to close the health gap between the central and eastern countries and their fellow Member States is part of the history of the future. Like the past, it poses many challenges. I firmly believe that today's partners in carrying out the regional strategy for health for all will show the vision, courage and energy that characterized the people who built the first 40 years Of WHO's success in Europe.

J.E. Asvall
WHO Regional Director for Europe
Preface

While writing this book in 1990, I have enjoyed the benefit of living in the beginnings of a new Europe. The story of WHO in Europe began in a far different setting: a continent that was in a shambles in 1945, at the end of the tragic Second World War, a continent that entered a cold war in 1946-1948, just when WHO formally began work. 1990, with the Paris meeting of the Conference on Security and Co-operation in Europe, saw the formal close of this era of confrontation. This old continent is on its way to a new type of unity. It is hoped that constructive political, economic and cultural cooperation can be built on the ruins of cold war and east-west tension.

In the field of health, WHO and its Regional Office for Europe have long been a forum for positive and practical international cooperation from the Atlantic Ocean to the Ural Mountains, and beyond. This cooperation was built, and has been maintained in the face of political realities that included the division of a majority of the Member States of the Region into two hostile military blocs.

From time to time, controversy impeded proposals for joint action that was useful and obvious from the public health point of view but politically unacceptable to one side or the other. As Regional Director, I was silent for obvious diplomatic reasons about some of the solved or neutralized conflicts; in the present open atmosphere, it is possible to discuss them. The achievements of WHO in Europe stand out more clearly against the periodic darkening of the political backdrop.

Europeans have contributed a great deal to the development of WHO as a global institution, but this account does not describe their role in the health development of the world as a whole. Instead, it concentrates on
how the Member States of the Region came together to build a common approach to health, how the Regional Office assisted them, and how both are working to realize their common goal.

This is only a part — although an extremely important one — of the tapestry of WHO work in the European Region. Following the threads that compose this story required that others be omitted or mentioned only in passing. In addition, this relatively brief account could mention only a fraction of the people and the activities that made and are making important contributions. Hundreds of documents and publications have been written to describe these in detail; a few are listed at the end of each chapter.

A detailed and complete history of the WHO Regional Office for Europe and all its activities would be encyclopaedic in size as well as in scope; this is not such a history. It is a subjective account of the development of the cooperation for health of the European Member States — with one another and with WHO. I describe this development as a person who has observed and taken part in it, in various national and international roles, since 1948. I wanted to tell how it happened that the Member States of a large and diverse Region, which was deeply divided by political and military hostility, were able to adopt a common approach to health and specific means to achieve it. The selection of facts and my comments on them are related to this theme.

This is the story of growing tolerance and intellectual courage in building international health cooperation. Much earlier than political leaders, the health authorities of the Region, under the umbrella of WHO and working in the forum of the Regional Committee for Europe, reached both an understanding of the similarity of their problems and a common solution. Accordingly, the Regional Committee agreed on a European strategy in 1980, and approved a common health policy in 1984: a blueprint to be applied independently in each country, but monitored and reported on jointly. During the recent rapid political changes in the Region, this joint policy, whose goal is health for all, has proved to be an extremely useful framework for further cooperation.

This account is mainly concerned with the methods and means of cooperation between countries. I regret that I could not give homage to each one of the real leaders: the people who have represented their countries on the Regional Committee since the first session in 1951. Their vision and their work for WHO at the global level, on the Regional Committee and in other regional activities, were vital to the new approach to health.
Until 1985, the story is in a sense a personal one. My involvement with WHO began in 1948, and I followed the developments, initiatives, negotiations and compromises very closely when I served from 1967 to 1985 as Regional Director for Europe, “the civil servant” of all European governments, east and west. The Regional Director, in fact, is the only official on the continent jointly elected by all the governments of Europe.

Today, however, a new generation is implementing the Region’s chosen policies. I am grateful to the present Regional Director, Dr J.E. Asvall, not only for encouraging me to write this story but also for his comments, which gave vital help in the writing of Chapter 5. Nevertheless, we both know that I have presented only some of the larger fragments of a dynamic process just getting started. New initiatives and networks of partners appear continually, focusing both on particular areas of the regional programme and on its overall principles of equity, citizen participation and intersectoral action. I hope that my overview of the history and beginning of this process hints to the reader of the hidden wealth of activities, experts and partners involved in the movement to realize health for all.

I also hope that the Regional Committee, whose resolutions and decisions through the years have created this new, health-promoting atmosphere in Europe, will continue to play its central role in European health policies.

Professor Jean-François Girard of France, Chairman of the thirty-ninth session of the Regional Committee, stated at the inaugural ceremony of the fortieth session, in 1990, that the Regional Committee:

has been privileged to be a pan-European organization from the outset and its work has thus been valued in all countries, regardless of their politics or their economic and social systems. It therefore has long and solid experience of cooperation in the various parts of our continent. A Europe of 32 countries already exists in the health field.

This account demonstrates that enlightened professional health leaders, working together in their own forum, have often acted in advance of political developments to benefit the health of the Region’s people. Perhaps we shall see a time when the Member States will use the Regional Office as the centre of cooperation for health in the new Europe.

Professor Leo A. Kaprio  
*WHO Regional Director Emeritus*
The beginning
From the WHO Interim Commission
to the regional organization for Europe
(1946–1951)

A World Health Organization

The reconstruction of Europe after the Second World War is well documented. Several excellent texts describe the contributions of the United Nations through such agencies as the United Nations Relief and Rehabilitation Administration (UNRRA) (1), the International Refugee Organization (IRO) (2), the United Nations Children’s Fund (UNICEF) (3) and the World Health Organization Interim Commission (4); this account therefore begins with a summation of the situation by Sir Robert Jackson (3):

Anyone who served in the Second World War and helped deal with its aftermath, witnessed death, destruction and suffering on a scale beyond human comprehension. Great cities were reduced to rubble, towns and villages were obliterated.

Millions of men and women were hurtled into concentration camps, tortured, used as living experiments, exterminated. Even more became hungry flotsam and jetsam scattered all over Europe by turbulent forces of an intensity never experienced in this world: ultimately they became known officially as “displaced persons” — homeless, hungry, bereft of hope.

Health systems had also suffered. In addition to the damage to services and infrastructures in the war-devastated countries, scientific and medical contacts were loosened or broken, the construction of hospitals and other health institutions was at a standstill, and Europe faced increased and serious health problems, including malnutrition and a number of communicable diseases (4).

In 1945, the United Nations Conference on International Organization, held in San Francisco, gave birth to the successor of the League of
Nations, the United Nations, and to a decision to establish an independent international health organization. The International Health Conference, which was held in New York in 1946 and to which all countries were invited, approved a name and a constitution (5) for the new organization: the World Health Organization (WHO). The Constitution established the World Health Assembly and the Executive Board as the governing bodies of WHO, and included the possibility of establishing regional organizations. It also gave a definition of health (5) that has become widely known:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

After the necessary ratifications by the member states of the United Nations, WHO was officially born on 7 April 1948. Between 1946 and 1948, before WHO officially started operation, work commenced through the WHO Interim Commission. WHO inherited the responsibilities for health services and some of the funds of UNRRA, so the Commission could operate, to a limited degree, in Europe and elsewhere until a budget for WHO could be approved in 1948. UNRRA funds similarly provided for UNICEF. This was the beginning of close cooperation between WHO and UNICEF.

During the period 1946–1948, the Interim Commission did its best to continue the work of UNRRA to serve the war-devastated countries of Europe. Among other activities, the Commission continued and further developed a very important fellowship programme. This later became an important activity of the WHO Regional Office for Europe.

WHO became fully operational after the First World Health Assembly was held in June 1948 in Geneva in the Palais des Nations, the site of the newly established WHO headquarters. The President was Professor Andrija Štampar of Yugoslavia, Chairman of the Interim Commission, and the Secretary-General of the Commission, Dr Brock Chisholm of Canada, was elected to the post of Director-General.

In accordance with Chapter II of the WHO Constitution, the Assembly delineated six geographical areas as a potential framework for regional organizations (resolution WHA1.72).

WHO needed regional organizations to allow for the integration of existing intergovernmental health organizations, such as the Pan American Sanitary Organization (now the Pan American Health Organization/WHO Regional Office for the Americas). The European Area comprised practically the whole continent of Europe. While approving organizations for some other regions, the Assembly instructed the Executive
Board, "as regards Europe, to establish, as soon as possible, a temporary special administrative office to deal with the health rehabilitation of war-devastated countries in that area".

A WHO REGIONAL ORGANIZATION

The six regions of WHO have an independence that is unique in the United Nations family of organizations. Each has the right to propose to the Executive Board a nominee for the post of regional director: de facto direct election. In addition, the right to recommend additional regional appropriations allows flexibility in budgetary matters.

Chapter XI — Regional Arrangements of the WHO Constitution (5) — describes the structures and functions of a regional organization. Article 44 stipulates that there shall be only one such organization in each area.

Each regional organization consists of a regional committee, composed of representatives of the Member States of the region, and a regional office, with an elected regional director and other staff. The functions of a regional committee are (5):

(a) to formulate policies governing matters of an exclusively regional character;

(b) to supervise the activities of the regional office;

(c) to suggest to the regional office the calling of technical conferences and such additional work or investigation in health matters as in the opinion of the regional committee would promote the objective of the Organization within the region;

(d) to co-operate with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;

(e) to tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;

(f) to recommend additional regional Appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions;

(g) such other functions as may be delegated to the regional committee by the Health Assembly, the Board or the Director-General.
A consultation of the war-devastated countries of Europe, held in November 1948, supported the proposed establishment of a small European office at WHO headquarters. The Special Office for Europe opened on 1 January 1949, with Dr Norman D. Begg of the United Kingdom as Director.

Withdrawals from participation
Unfortunately, a number of countries in the European Area withdrew from active participation in WHO shortly after the Organization began its work. The USSR had opposed the disestablishment of UNRRA, considering this an unfriendly action by the United States because UNRRA had given considerable assistance to the war-devastated areas of the western USSR. Thus, the USSR withdrew, early in 1949, from cooperation with WHO and UNICEF and demanded that the other socialist countries of the European area follow suit. Accordingly, Bulgaria, Romania, Albania, Czechoslovakia, Hungary and finally Poland also withdrew. Only Yugoslavia — relations with the USSR having been broken — remained an active member of both organizations.

The actions of Poland demonstrate the domination of the countries of central and eastern Europe by the USSR in the period after the Second World War. Poland was the last of these countries to withdraw from active participation. It withdrew from WHO in 1950, with a very violent attack against the United States to show loyalty to the USSR, and from UNICEF early in 1951. Poland quickly re-opened its doors to both organizations when this became possible.

At the time of the consultation of war-devastated countries in 1948, Czechoslovakia, Hungary and Poland were still participating. In fact, a participant from Czechoslovakia suggested the establishment of a full regional office in Prague. These hopes soon faded, however.

A Regional Organization for Europe
Nevertheless, the remaining countries of the European Area gradually recognized the need for a WHO regional programme for Europe. They had keen interest in some of WHO’s worldwide priorities; for example, tuberculosis was a problem in most countries, and malaria was prevalent in the southern part of the European Area. The improvement of maternal and child health was also a priority. Further, these countries realized that new health problems were emerging, following the reconstruction of their health services and the development of their economies and industries.
The Member States decided that a WHO regional organization for Europe could be a useful forum in which to exchange views and decide on joint action. During the January 1951 meeting of the Executive Board, Dr Begg introduced a document on the establishment of the regional organization for Europe based on consultation with the Member States in the European Area. Dr Begg presented three alternative proposals for which cost estimates had to be made for 1952:

- continuing the Special Office for Europe in Geneva
- establishing a European regional office in Geneva
- establishing a European regional office outside Geneva during the first year of activity.

Of course, the European members of the Executive Board led the discussion of the matter. Opposition from others was scarce, since the other five regional organizations had already been approved. Among the Europeans, however, Dr Axel Höjer of Sweden and Professor Stampar initially opposed any change for budgetary reasons. Dr Giovanni Canaperia of Italy, however, supported by the member from the Netherlands, said that he had always been in favour of establishing a regional committee; he thought such a body would be in a better position to discuss problems common to all the countries in a region.

As a compromise, the Executive Board recommended the convening of a Consultative Committee in May 1951 to discuss the question of a regional committee and to establish the European programme for 1952 and later years. This decision followed considerable lobbying by Dr Begg. Events thereafter moved quickly. The Consultative Committee — comprising representatives of the 18 active European Member States — met first in May and then in September 1951, establishing itself at the second meeting as the Regional Committee for Europe (Annex 1 lists the sessions of the Regional Committee, 1951-1990). It then decided that the Regional Office for Europe would be operational as of 1 February 1952, and nominated, for approval by the Executive Board in January 1952, Dr Begg as the first WHO Regional Director for Europe. The establishment of a regional organization for Europe created a framework that made possible cooperation extending throughout an important part of the globe, including the whole of geographical Europe.

Membership of the European Region

When the regional organization started work in 1952, the European Region differed in several respects from the European Area delineated by
the First World Health Assembly. The major change was that Greece and Turkey, which were originally placed in the eastern Mediterranean area, were active in Europe by 1951. They wished to join the European Region, because they felt that their health problems were similar to those of the other Member States of the Region.

The French territories in North Africa were also included, either as a part of France (Algeria) or as Associate Members (Tunisia and Morocco).

The unified Germany of today was occupied territory in 1948. The Federal Republic of Germany joined WHO on 29 May 1951, in time to start participating in the work of the Region. The admission of the German Democratic Republic became a thorny political issue, settled only in the 1970s.

The Byelorussian SSR and the Ukrainian SSR were original Member States, but withdrew when the USSR did so. Their membership required that they make contributions as Member States, and the USSR decided that the two union republics should remain inactive. Small disagreements subsequently arose with the central health authorities of the USSR when, for example, health experts from Kiev were described as Ukrainian nationals on lists of participants.

Malta and San Marino entered the Region in due course: Malta joined after it became independent in 1965, San Marino, an independent state for over 1000 years, eventually considered it useful to become a Member State, joining in 1980. Andorra and Liechtenstein never became members or associate members. The Holy See occasionally participates in Regional Committee sessions as an observer as it does at World Health Assemblies.

**DR NORMAN D. BEGG**

Norman D. Begg was born in 1906 in China. After completing his education in Scotland in 1933, Dr Begg worked for the London County Council in a communicable diseases hospital. In 1935, he was appointed epidemiologist and director of communicable diseases hospitals in Southend-on-Sea, returning in 1937 to London as Medical Superintendent for a large communicable diseases hospital. In 1946, he was lent to UNRRA for service in Warsaw, where he was first Epidemiologist and then Chief of the Health Division. Joining the staff of the WHO Interim Commission in 1947, he worked as a medical officer in Warsaw and Geneva, becoming a Deputy and then an Assistant Medical Director. The moving force behind the establishment of the WHO regional organization for Europe, he became the first Regional Director for Europe. He died in office in 1956.
Membership in the Region (Annex 2) continues to change with the health and political needs of countries. At present, the Region has 31 Member States, and the Regional Office is cooperating closely with Mauritius, a Member State of the African Region.

The First Phase: Reconstructing Health Services

As mentioned, the reconstruction of health services was WHO’s first task in Europe, and the global programme was pursued until the Region developed a programme of its own. Priority was given in this first phase to such issues as maternal and child health, malaria, tuberculosis, sexually transmitted diseases and environmental health problems such as food hygiene, housing, sanitation and water supply. Most activities were carried out as country programmes, jointly agreed by the countries and WHO, at the global or regional level.

WHO began in 1948 with a rather small budget and just over 50 Member States, those in Europe and North America dominating. Large parts of Asia and Africa were still under colonial administration, although this was beginning to change. WHO now has more than 165 Member States.

In the early years, Europe received a fairly large share of the WHO budget. The peak was in 1952 when funds from the United Nations Expanded Programme of Technical Assistance were still available for a number of war-devastated European countries or for Member States otherwise in economic difficulties. Technical Assistance funds were devoted to work for sanitation, the education of paramedical and auxiliary personnel, the development of basic health services and the control of communicable diseases.

The economic boom of the early 1950s facilitated the health reconstruction of Europe. Soon, many of the active Member States were on the way to being well-to-do contributors to WHO and other United Nations agencies. Others remained eligible for funds from the United Nations Expanded Programme of Technical Assistance and its successor, the United Nations Development Programme (UNDP). In addition, Algeria, Morocco and Turkey were considered to form a group needing continuous and material attention from the Regional Office.

UNICEF continued its activities in Europe but started gradually to move its focus to the developing world. Its International Children’s Centre, in Paris, continued to serve European students.
The Rockefeller Foundation, with its European Office in Paris, supported many important health activities in Europe. Some of the national projects created with Rockefeller Foundation assistance, carried out before and after the Second World War, became important foci for future WHO programmes. The Andrija Stampar School of Public Health in Zagreb, the Soissons rural health training project in France and a similar project in Uusimaa, Finland, for example, were operational when the Regional Office began work in 1952. Other examples of Rockefeller Foundation activities were a study of the reorganization of the Italian health services in 1948, the eradication of malaria from Sardinia, and the awarding of stipends to WHO staff, to support them during training in the United States.

The Regional Office for Europe, in cooperation with UNICEF and the Rockefeller Foundation, and with its regular and Technical Assistance budgets, devoted much attention to training or retraining large numbers of European health personnel and university teachers. As part of the reconstruction of health services, WHO fellowships were given to these professionals.

In Europe, the fellowships programme began with the WHO Interim Commission, and originally focused on war-devastated countries receiving aid from UNRRA. Fourteen countries were participating in 1949, and the programme’s subsequent expansion was rapid (6). The strength of the fellowships programme — first in securing education for European fellows and more recently in providing education in the Region to fellows from other regions — shows the abiding interest of the Regional Office in health personnel development and in linking countries through the exchange of experience.

Of the countries in central and eastern Europe, the USSR was not involved, for internal reasons, and only Czechoslovakia and Poland succeeded in obtaining a considerable number of fellowships before they withdrew from participation. Yugoslavia was the greatest beneficiary, as it represented to, for example, the United States, a “reasonable” socialist country. One consequence was that WHO has since had its share of well trained Yugoslav staff members all over the world. Yugoslavia later became a leading non-aligned country and, since the resumption of participation in WHO, has remained active, hosting many meetings on its Dalmatian coast or in the capitals of the republics.

Along with the travelling seminars discussed in Chapter 2, the early fellowship programme created tremendous good will for WHO in Europe and a “constituency” of thousands of public health, medical, sanitary
engineering and nursing experts, working mainly in national administrations or teaching institutions. The programme made WHO well known in the countries that became Member States of the European Region, and secured for the Regional Office invaluable partners in its development and work.

References

Learning to know one another
Growth of a European programme (1952–1967)

The period 1952–1967 saw the European Member States and the Regional Office taking their first steps together in developing the regional programme and cooperation for health. This naturally entailed both continuity and change, although the changes were mainly in emphasis. Success in the health reconstruction of Europe and in fighting communicable diseases led to new challenges, and the growth of the regional programme and of familiarity and cooperation between Member States caused a shift in methods. The Regional Office continued to work through advice, training and research. Direct assistance to countries in need of it was not neglected. As Member States discovered the similarity of many of their problems and needs through the exchange of information, however, they began to combine to address issues of common concern.

A European Programme

As described in Chapter 1, the second meeting of the Consultative Committee became the first session of the Regional Committee for Europe. It was held in Geneva in September 1951; owing to the withdrawal of the socialist countries, the Committee was composed of representatives of the 18 active Member States. The representatives included health leaders who also helped to direct global WHO policies in the World Health Assembly and on the Executive Board. Many of their advisers, staff and junior experts took part in the WHO fellowships

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"Austria, Belgium, Denmark, Finland, France, Greece, Iceland, Ireland, Italy, Luxembourg, Monaco, Netherlands, Norway, Portugal, Sweden, Switzerland, United Kingdom and Yugoslavia."
programme. Gradually these leaders and experts developed an identity as Europeans.

Until 1952, there was no European programme, although numerous WHO activities and projects responded to acute problems, mostly at the country level. This was the start of the Regional Office tradition of offering programmes fitted or adaptable to countries’ particular needs and circumstances. In addition to responding to countries’ separate and specific requests, the Regional Office began to hold meetings on health topics of common concern.

At the first meeting of the Consultative Committee, in May 1951, Europeans came together for the first time to discuss a joint programme, both its guiding principles and a proposed four-year programme of work. The detailed discussion of the proposal, and its content and conclusions were reasons for the establishment of the Regional Committee. At the second session of the Regional Committee, the representatives of the active Member States approved the four-year (1952-1955) European programme, which was included in the first specific global programme of work.

The Member States also endorsed the guiding principles of the European programme, noting that the broad principles for the WHO activities in the European Region thus far were based on the fact that Europe was an area of fairly uniform and high technical development, in which national health programmes were proceeding on the more specialized aspects of a very wide variety of subjects. The most important single role for WHO in Europe, therefore, was to stimulate activities designed to coordinate health policies on common problems and to exchange experience. WHO also had important work to do in studying different patterns of developed health services in Europe and in promoting professional and technical education and training. Further, the Member States approved various types of programme: work with other United Nations agencies, such as the United Nations Economic Commission for Europe (ECE), the International Labour Organisation (ILO), the Food and Agriculture Organization of the United Nations (FAO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) and joint programming with UNICEF, and programmes designed to strengthen national health administrations.

The Regional Committee urged that, in selecting programmes for direct sponsorship, the Regional Office:

— concentrate on the organizational aspects, rather than detailed techniques, of health services; and
— consider specialized services as part of the general health services of the countries of the Region.

The second principle remained important because some services, such as public health engineering or health services in industry, tended to develop in some isolation from the general public health services of a country.

European public health experts, in contrast to their colleagues in the United States, for example, disliked an narrow, separate-service or campaign approach. United States experts, however, long dominated WHO global programming patterns. Of course, Europeans participated in worldwide campaigns — particularly those concerned with topics important to them, such as tuberculosis, malaria, sexually transmitted diseases and the development of maternal and child health services. Nevertheless, they preferred a general approach, such as that of the National Health Service of the United Kingdom, and integrated preventive and curative services.

This holistic approach permeated the first WHO European programme and can be considered as a first milestone leading to the common health policy later adopted by all Member States. In fact, most of these principles became underlying themes of the work of the Regional Office. The road from this first milestone to the common health policy, however, was a long one. The first steps on the journey were taken through travelling seminars.

**Studying Public Health Administration in Europe: the Travelling Seminars**

In 1951, Dr Begg started to organize travelling study groups on the organization and administration of public health in various countries. These came to be called travelling seminars. They provided a practical way to study health services and exchange experience. Between 1951 and 1966, a total of 8 groups visited 16 countries, bringing together 162 leading health officials in groups of about 20 for an average of one month.

1951: Belgium, Sweden and United Kingdom (Scotland)
1952: France and Norway
1954: Federal Republic of Germany and Italy
1958: Portugal and United Kingdom
1959: USSR
1960: Bulgaria and France
1962: Greece and Yugoslavia
1966: Austria and Czechoslovakia
The organization of group studies was an excellent way of surveying the huge field of public health administration. The participants of these seminars, making their observations together, could study documentation prepared in advance and make supplementary visits to local health authorities and services on the spot. Through group discussions and an almost continuous exchange of views, they could also arrive at a better understanding and an objective evaluation of different systems. The first of these study groups is described in some detail, since it set a trend and subsequent travelling seminars were modified on the basis of the experience gained.

The first travelling seminar visited three European countries — Belgium, Sweden and the United Kingdom (Scotland) in September and October 1951. Experience showed the difficulty of trying to cover three countries, and almost all the other seminars confined their work to two countries, in order to make the most comprehensive reviews possible.

The first seminar visited Härnösand, Sundsvall, Linköping, Edinburgh, Glasgow, Inverness, the Shetland and Hebrides Islands, Hasselt, Namur and Bruges in its 37 days. Its successors were equally peripatetic. This established a pattern of direct contact with grassroots authorities and health services and of concrete demonstrations by the host countries of their successes and constraints in solving health problems.

I was one of the participants in the first seminar; my colleagues were senior public health administrators from 16 countries. Some later became directors-general of national health services or directors of schools of public health. Professor Andrija Štampar, who had introduced the idea of travelling seminars, was the leader of the group. He and several of the hosts in the countries visited represented the most senior level of European health expert.

During their 15 years, the travelling seminars, in addition to accomplishing their primary purpose, helped to build a new network of European health authorities and experts. With their vital work and support for WHO, these people gradually succeeded the WHO first generation, in leading positions in countries, at the World Health Assembly and on the Executive Board.

The documentation for the first study group was well prepared. Along with the material from the subsequent travelling seminars, it was later used to prepare the documentation for a conference on public health administration held in 1964. The documents were also used to inform experts outside the Region: the newly established public health administration panel at WHO headquarters.
On arrival in the host countries, the participants in the first seminar naturally received briefing and explanations of the documents at the central health agencies in Stockholm, Edinburgh and Brussels. They spent most of their time, however, on visiting, often in smaller groups, different types of health service and institution in different corners of the country. The participants also established a pattern of work. All the travelling seminars:

- noted the particular health problems of the countries visited;
- examined how these were tackled, against the background of the geographical, demographic, economic, political, social and cultural circumstances; and
- compared the methods and organizational systems used.

Much was learned in each seminar, and the participants and their colleagues in the host countries enjoyed a “continuous exchange of information, with the frankness, breadth of views and freedom to make constructive criticism which international meetings generally allow” (I).

Today the Regional Office is returning to the grassroots in a variety of initiatives: reaching out to European cities through the Healthy Cities project, for example, and working for integrated district health services.

**Working Together in Other Fields**

The first European programme included other work to mobilize joint thinking and solve problems in specific fields. Like the travelling seminars, these initiatives influenced priority-setting in future European WHO programmes.

For example, many continuing activities promoted the education and training of a variety of professional groups, including nurses, auxiliary health workers and physicians. The Regional Office collaborated closely with universities and other teaching institutions, and established a permanent link with schools of public health.

**Environmental health**

The systematic approach taken to these groups was also applied to a group whose connection to health was not as easy to see: sanitary engineers. The following discussion of work with this group demonstrates the principles and problems of intersectoral, cooperative action and of work on environmental hazards to health. Both of these increased in importance in the regional programme.
A series of activities strengthened the knowledge and skills of European engineers dealing with environmental problems, such as water supply and sanitation, the quality of housing, food hygiene and urban air pollution. In the United States, such people were called sanitary engineers, and considered to belong to a discrete public health specialty. In the United Kingdom, however, sanitary inspectors were usually responsible for environmental problems at the local level; in other European countries, this was the job of various groups of municipal engineers or hygienists with a medical background. Nevertheless, the idea of the sanitary engineer gradually gained acceptance.

Even before the Regional Office was established, WHO called together the professionals responsible for sanitation. European seminars for sanitary engineers were held in The Hague in 1950, Rome in 1951, London in 1952, Opatija in 1954 and Helsinki in 1956. In 1952, therefore, the new Regional Office was beginning to build a network of useful contacts to follow up on continuing activities, such as malaria control in southern Europe and water supply reconstruction in war-devastated areas, and on new work on such problems as air pollution.

Information on environmental health problems became available to WHO through ministries responsible for municipal engineering and networks of local sanitary inspectors, rather than ministries of health. Work on environmental health continues to require the Regional Office to work with authorities and allies outside the health sector. WHO experts and consultants in sanitary engineering made it possible for the Regional Office to work with many national agencies, and to become the executing agency for many important environmental projects in the following decades. These projects were sponsored by the United Nations Expanded Programme of Technical Assistance and, later, by UNDP.

Before the sanitary engineers started to tackle the problems of Europe’s industrial environmental hazards, they worked with malariologists to eradicate malaria from continental Europe.

Malaria

Malaria remains a serious problem on the global level. With WHO coordination, however, the European countries succeeded in eliminating the local transmission of malaria from the Region. Only Turkey suffered a return of the disease after a campaign in the 1950s and 1960s had reduced it to a few tens of cases. European malariologists also played an important part in the global WHO campaign against malaria. The history of malaria in Europe has been told by Bruce-Chwatt and de Zulueta (3). Great progress was also made against other communicable diseases.
Dr Alfred Eberwein of the Federal Republic of Germany was an early staff member of the Regional Office. He gives a vivid picture of the work and the staff of the Office in the 1950s.

The Regional Office was situated on the fourth floor of the Palais des Nations, surrounded by WHO headquarters, and the main endeavour was to give it a certain identity. Country programmes and projects were more important in that early time than intercountry activities. I soon realized how lucidly Dr Begg foresaw the necessity and importance of developing intercountry meetings in some areas. He submitted a plan to the Regional Committee of 1953 for an education and training programme, along with his ideas on the role of intercountry activities in discussing the programme with the government representatives. As a consequence, a staff project was developed to devise the strategy and the tactics of various types of intercountry meeting.

When I arrived, the staff consisted—apart from the top management, the Regional Director and his Deputy—of a public health administrator, a public health epidemiologist, a maternal and child health officer, a social and occupational health officer, a sanitary engineer and the administrative group.

Permanent staff were fairly few, but some men and women were employed as long-term consultants on such issues as mental health, nursing, medical libraries and health education. Slowly some of these consultant posts—such as those for mental health and for nursing—were converted into staff positions. The consultant librarian had a very special task, typical of the situation in Europe after the Second World War, namely, to help countries to re-establish or complete medical libraries as part of the country projects carried out with Technical Assistance funding. Naturally, more countries received such assistance at that time than today; for example, Austria and Finland were among those eligible.

It should be understood that all the socialist countries of eastern Europe were inactive at that time. The first new contact with them was a great event. The details of programmes were slowly negotiated and the first groups of fellowship applications, the first visible signs of active participation, were received in July and August 1957. In the mean time, some personnel had joined the Regional Office to work in the field, in countries such as Morocco.

Many fellows passed through the Regional Office "mill"; many are in high positions today, or already retired, and some of them—good friends today—never wrote a report! In addition, we had active and understanding collaboration with UNICEF, which was very active in Europe after the Second World War. WHO and UNICEF gave considerable help to countries in the rehabilitation of handicapped children.

The work and the atmosphere of the Office were stimulating. Dr Begg had a very personal style. Apart from meetings in which he informed the staff, he was a great listener. When talking, however, he gave a clear and precise summary of his thinking, leading to his opinion or his decision.
Mental health
The Regional Office began its involvement in large-scale mental health activities with a Scandinavian Seminar on Child Psychiatry and Child Guidance Work, held in Oslo in April 1952. WHO helped countries to prevent mental health problems in children, advocating that countries establish teaching posts in child psychiatry in universities, and develop and increase child guidance centres (4). Most of the Member States of the Region accepted and acted on these views. Mental health remains an important part of the regional programme, although approaches to the issue have changed.

Statistics
Vital and health statistics, too, are a topic of continuing and developing interest to WHO and the Member States. The duty of collecting information on morbidity and mortality was a legacy of WHO’s predecessors, and fell primarily on WHO headquarters. The Regional Office assisted in this global task by arranging meetings of experts to ensure that countries gave vital and health statistics in comparable forms. Interest later grew in the use of these statistics in national health planning and in planning and evaluation on the international level.

Dramatic Changes
Dr Begg served the first five sessions of the Regional Committee as Regional Director. He was able to convince the Regional Committee that an “independent” office, outside Geneva, would better serve the interests of the European Member States. A special session of the Regional Committee in 1954 selected Copenhagen from among five other candidate cities: Frankfurt, The Hague, Nice, Vienna and a city in Switzerland other than Geneva. The Danish Government agreed to start work on the reconstruction of the WHO Tuberculosis Research Office to accommodate the Regional Office. In addition, it was expected that the inactive Member States would soon resume participation. New, larger premises would provide better working conditions.

In 1955, Dr Begg proposed a second general programme of work for the Region, covering the period 1957–1960. He was a candidate for re-election in 1956, and was looking forward to moving the Regional Office from Geneva to Copenhagen. Unfortunately, Dr Begg died early in 1956. Another tragedy soon followed: the Deputy Director, Dr Gérard Montus
of France, died early in 1957. These losses created serious leadership difficulties.

Dr Paul J.J. van de Calseyde of Belgium became the second Regional Director for Europe, taking over from the acting Regional Director, Professor M. Gregorzewski of Poland (a director from WHO headquarters), on 1 February 1957. Dr Jack Cottrell of New Zealand, a former UNRRA colleague of Dr Begg, became Deputy Director.

Dr van de Calseyde moved the Regional Office to Copenhagen in June 1957, and welcomed the return of the inactive countries to participation. He now had the cooperation of almost all of the Member States of the Region, including the USSR. The Region now had the fully operational and independent Regional Office for which Dr Begg had fought.

Return of the socialist countries —
the beginning of new cooperation

In the 1990s, the east-west political divide is closing and great changes are expected both in countries and in their health service systems. The situation was very different in the late 1950s.

In 1954, under the leadership of the USSR, the socialist countries renewed contact with the WHO Director-General, Dr Marcolino G. Candau of Brazil. The stumbling block to their return was the question of the contributions unpaid during their absence. This was finally resolved through a compromise: that the countries would pay the arrears of their contributions up to the time of withdrawal and make a token

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**DR PAUL J.J. VAN DE CALSEYDE**

Paul J.J. van de Calseyde was born in Belgium in 1903. After completing his education, Dr van de Calseyde was appointed Medical Inspector of the Postal and Telegraph Ministry in 1930. In 1935, he joined the Ministry of Public Health and Family Welfare as head of the Department of Social Medicine. From 1945 to 1957 he served as Director-General of Public Health in the Ministry of Public Health and Family Welfare and was Secretary-General of the Higher Public Health Council. He was also active in international health affairs, as Secretary-General of the Anti-Venereal-Disease Commission of the Rhine, a member of the Health Committee of the West European Union and, from 1948 to 1956, a delegate to the World Health Assembly. Dr van de Calseyde served as Regional Director for Europe from 1957 until his retirement from WHO in 1967. Afterwards, he returned to the Belgian Ministry of Public Health and Family Welfare on a special mission. Dr van de Calseyde died in 1971.
payment of 5% of their contributions for the period of their inactivity. In 1957, Albania, Bulgaria, Poland, Romania and the USSR (the Byelorussian and Ukrainian SSRs remaining inactive) returned to active membership. Czechoslovakia followed in 1958 and Hungary, owing to internal problems, only in 1963. In addition, the German Democratic Republic began to seek membership in the early 1960s.

Following the programming pattern already accepted by the other Member States of the Region, the countries of central and eastern Europe soon participated in the travelling seminars and other meetings on specific topics, and were visited by groups of public health experts from western Europe.

Under the strong influence of the USSR, state medicine had become the rule in all socialist countries: medical care was provided free by the state. Countries retained some differences, for example, in medical education, but they all established systems of sanitary and epidemiological stations — sanepids — to control infectious diseases and environmental hazards. In such countries, one of the vice-ministers of health was a chief sanitary inspector. The health minister was always a physician, an active Communist Party member, and often a surgeon or a former military medical officer. The minister or a vice-minister of health represented the country on the Regional Committee.

Elsewhere in Europe, in contrast, the health minister was most often a politician, seldom a physician, and the highest national health authority, a secretary-general or director-general, represented the country on the Regional Committee.

People now know that centralized planning did not create viable economies in central and eastern Europe. Serious problems arose, such as economic stagnation, corruption and environmental health hazards caused by the brutal misuse of material resources. Naturally, these problems also affected health services.

Nevertheless, the health services were well staffed and had some early successes. Their first priority was to improve the health of children and workers. Many preventive programmes — such as those for immunization and those combating communicable diseases — ensured that health status rose from the level found immediately after the Second World War.

The participation of the USSR brought to the regional programme a stronger emphasis on planning. Planning and evaluation became accepted as important tools in all health services, including those of market economy countries. The United States, for example, accepted the importance of planning in the early 1960s, having previously objected to
it on ideological grounds. Socialist countries were called a planner’s paradise; when WHO turned its attention to long-term planning, at both the global and regional levels, they gave their full support.

The Regional Programme

How did Dr van de Calseyde apply the Regional Committee’s programme principles in his new environment? He inherited from Dr Begg the second specific programme of work, covering 1957–1960 and approved in 1955 by the Regional Committee. This programme accepted the importance of the guiding principles used in the first period, although modifying them in the light of experience.

Again, priority was given to stimulating activities designed to coordinate health policies on common problems, exchanging experience and promoting education and training programmes for medical and health personnel. Experience showed, according to the Regional Committee, that intercountry cooperation was particularly important in helping countries cope with the new responsibilities placed on the national health services.

In addition, the Regional Committee suggested that, in cooperation with WHO headquarters, the Regional Office could take a strong role in international work on the public health aspects of a group of chronic diseases, such as atherosclerosis, diabetes, cancer and rheumatism. The interest in cardiovascular diseases was remarkable; it arose at a time when research on the topic was proposed as a new priority for WHO at the global level.

As mentioned earlier, the return of the central and eastern European countries had a number of effects. For example, Russian joined English and French as a working language of the Regional Committee and the Regional Office. It came into full use in the Regional Committee in 1960 and, after the necessary budgetary and staffing arrangements were made, in the Regional Office in 1962. Documents could then be issued in Russian, and the Regional Office began to cooperate with the medical publishing house Medicina, in Moscow. This was an important step in improving communication between WHO and countries in central and eastern Europe. In addition, these countries began to take their turn in hosting the Regional Committee and travelling seminars.

In 1959, the USSR was the host country for a travelling seminar that gave some western European health administrators first-hand information on health services not only in Moscow, but also in several other parts of the country. This seminar, like the others, lived up to its name, covering 4500 km by air and rail in its 32 days (Fig. 1).
In addition to WHO staff, the participants included people for whom this activity was an introduction to European cooperation. In the 1960s, they would play important roles in the Regional Committee, the Regional Office and in their own countries. In this group were three future directors of health services in the Regional Office, future members of the Executive Board, future directors of institutes, health ministers and one future prime minister!

European Conference on Public Health Administration

By the early 1960s, the Regional Office had a large collection of new information on health development in Europe from the 14 countries visited by the seven travelling seminars (the eighth was held in 1966). All host countries had prepared documentation on their services, and the final reports of WHO staff and consultants included additional observations and analysis. In addition, a comprehensive questionnaire had been sent to the Member States; their responses formed the basis for the first report on the world health situation, produced by WHO headquarters for the Eleventh World Health Assembly in 1958, and were made available to Regional Office staff. Information was also available from Regional Office contact with countries and from activities such as training courses.
Clearly, the time was ripe — with the approval of the Regional Committee — to summarize what had been learned at a European Conference on Public Health Administration and to draw conclusions for future national and international health activities.

The European Conference on Public Health Administration was held in Zagreb, Yugoslavia in June 1964, at the Andrija Štampar School of Public Health. Professor Štampar, who had died in 1958, had led seminars in the Eastern Mediterranean Region during his last active years.

Participants from 27 countries attended the Conference. They reviewed the work of the seminars, the various systems of public health administration in industrialized countries, trends in health legislation and other areas, and planning for health and its place in overall planning for development. The participants noted that health services in industrialized countries had longstanding traditions, but had recently experienced a number of changes. Countries had reconstructed their health services after the devastation caused by the Second World War, and recognized both the successes of the past and emerging problems. For example, chronic diseases were growing in importance. Countries sought new approaches to meet the challenges of the future.

One of the participants at the Conference was Dr B. Kesic, Štampar’s successor, at the School of Public Health. He had already recognized two such approaches and their increasing importance in all systems of medical care and health protection (5):

(a) medicine is expected to become more active in promoting health, a tendency reflected in both medical theory and practice and in closer co-operation with those national forces capable of contributing to the promotion of health (education, agriculture, industry, veterinary medicine and various other economic and cultural activities);

(b) health services with an essentially curative character that are increasingly extending their activities to the preventive and sociomedical sphere, and, conversely, public health services that are taking over tasks which have also a curative character.

These views, reaffirming the holistic view of health services taken earlier by the Regional Committee, became the philosophy of the Zagreb Conference. In 1965, the Regional Office distributed to governments the final report of the Conference and its synthesis of health services in Europe (6). Updated editions were issued in 1975 and 1981 (7,8), and all three strongly influenced the development of health policy in the Region.
The preparatory work for these books improved the contact between the Regional Office and Member States, and the publication of the books helped to establish a pool of common information, facilitating the understanding of the major trends in health in the Region.

The Zagreb report was the second milestone in the work of the Regional Office. Its conclusions on health priorities in industrialized countries were accepted by future Regional Committees and applied in the Regional Office. These priorities included: national health planning (and epidemiology and statistics as the basis of such planning), psychiatric care and preventive mental health, cardiovascular diseases, the training of health personnel and environmental health. All were important in the next period of European health cooperation in the Region.

For the first time since the end of the Second World War, a single report gave detailed information on the organization of health services in each European Member State. The health community of Europe had a common basic document. It had taken 20 years to achieve.

Continuing Assistance to Three Countries

It is useful to remember that not all of the Member States were industrialized countries. Three countries still had many problems typical of the majority of the world’s nations.

The Zagreb Conference recognized that these countries needed special attention. Algeria, Morocco and Turkey therefore had the largest country programmes (including field staff), in a period in which these programmes comprised the majority of Regional Office activities.

When Tunisia gained its independence in 1956, it joined the Eastern Mediterranean Region as a full Member State of WHO. Morocco, also independent in 1956, decided to stay with the European Region, at least until the independence of Algeria. After a long period of war, Algeria became independent in 1962, needing special attention from WHO to reconstruct its health services and environmental systems, such as that for water supply.

Morocco became an active Member State, hosting meetings, conferences and two sessions of the Regional Committee in its beautiful cities. Sometimes, WHO staff — from headquarters and the Regional Office — were almost too eager to visit the country! Morocco also had special problems, however, in developing an infrastructure for health care in rural areas and eliminating malaria foci. The development and training of personnel of all kinds, from university teachers to field workers, were
other challenges. In addition, an early trachoma control programme was a success for WHO and the Government.

Turkey, one of the largest countries of the Region, had both modern cities, with pollution and industrial health problems, and large rural areas subject to malaria and other tropical diseases. In addition, the whole health infrastructure, including maternal and child health services, needed reorganization. The Regional Office began and continued close cooperation with Turkey on a variety of problems.

With WHO assistance, the Turkish Government carried out a malaria eradication programme culminating in 1960-1963, when indigenous transmission was practically stopped. The maintenance phase created a network of rural health services; unfortunately, this was not tight enough to catch all new cases in the southern part of the country. New malaria cases, mainly located in the Cukur Plain in southern Turkey, grew from 37 in 1968 to over 115,000 in 1977 in the country as a whole. Once the Government realized the danger, it worked with the Regional Office (and the generous assistance of other Member States) to control the problem after 1977.

Tuberculosis was also a problem in Algeria, Morocco and Turkey, as it had been in such war-devastated countries as Poland and Yugoslavia. In addition, a cholera pandemic touched the southern part of the Region at the end of the 1960s. This exposed the lack of safe water supply and the need to pay attention to sanitation in developed countries such as Portugal, Spain and the USSR.

**The Regional Committee and its Working Pattern**

From the beginning, the Regional Committee elected to hold its meetings in different parts of Europe. Even after the Regional Office moved to Copenhagen in 1957, the Regional Committee continued the tradition of accepting a Member State’s invitation to hold a session, usually in the capital city. The reasons were simple. At that time, the Regional Office lacked a conference hall and, as long as the budget was relatively small and decisions easy to make, the representatives of countries preferred to visit their fellow Member States. Another tradition was established and maintained: the Chairperson and one of the Vice-Chairpersons are nationals of the current and the next host country, respectively.

As activities multiplied, and budgets and management needs grew, the lack of access to the growing regional staff during a Committee session created problems. These were settled when the Regional Office
was enlarged and a conference hall built between 1968 and 1972. Even then it was difficult for the Regional Committee to reject friendly invitations and only since 1982 has the Regional Committee been regularly held in Copenhagen every second year.

With the assistance and financial contributions of the host country, the Regional Committee is able to meet outside the Regional Office, and has visited most Member States. This has definitely contributed to a pan-European spirit in the representatives.

The Regional Committee’s yearly session lasted five days, with the approval of the annual budget presented by the Regional Director as the main item of business. The whole Committee debated all matters.

The third session was the first to include technical discussions, held on one day or two half-days. These had two purposes. First, the participants (representatives of countries and nongovernmental organizations and invited experts) had the opportunity informally to discuss important medical or public health problems. The topic was decided two years in advance, to allow time to prepare background documents. The second purpose was to give WHO staff time to prepare the report of the session and translate resolutions, so that the report would be available in all working languages on the last day of the session. This allowed representatives to discuss and approve it, and to take copies home with them.

Annex 1 contains a list of the subjects of the technical discussions. Some, despite the informality of the discussions, were so topical that the Regional Committee added them to the agenda and approved resolutions advocating both national and international action. The Regional Office programme on the prevention of road traffic accidents started in this way in 1969.

The Regional Committee is a group of human beings. The representatives continue to be important parts of the growing network of health authorities and experts whose work is so important to the development of WHO. Dr van de Calseyde, for example, had been a very active participant at meetings and representative of Belgium. As Regional Director, he worked with a Regional Committee composed of long-time colleagues, a group that sometimes worked quite independently. This network cannot truly be described as an old boys network, in part because women have always been part of it too. More and more have made important contributions as experts, on the Regional Committee and as WHO staff.

As mentioned earlier, many leading European health experts were also WHO “global parliamentarians” at the World Health Assembly and
on the Executive Board. Some were winners of the Léon Bernard Foundation Medal and Prize, awarded by the World Health Assembly for outstanding work in social medicine (9). The European winners are listed in Annex 3.

Again, the programme budget was the major item of the early Regional Committees. The European Region receives about 5–7% of the WHO global regular budget, but the Regional Committee has the freedom to propose how it should be allocated. The subsequent World Health Assembly normally includes the recommended regional budget without change in the total WHO budget.

Fellowships are an item paid for by the regular budget funds for every Member State, rich or poor. Typical budget discussions concentrated on the balance between the major items of intercountry and country programmes. Details were scrutinized, but seldom finally challenged. The Regional Director was expected to have done his homework.

According to the WHO Constitution, the Regional Committee must discuss items referred to it by the World Health Assembly or Executive Board, and can comment on global questions on its own initiative. The Committee often made such comments, since the Region contributes nearly 50% of the WHO regular budget and makes voluntary contributions to particular programmes. Funds from one such programme, the Malaria Eradication Special Account, were available for Member States in the southern part of the Region. The Regional Committee concentrated on European matters, however, and tried to avoid spending too much time on global problems. The Region is well represented on the Executive Board, which discusses global problems.

This chapter ends with Dr van de Calseyde’s retirement in 1967, which coincided with growing pressure from the Regional Committee to focus the regional programme on a selected number of priorities. Countries recognized these issues as important from their own experience and Regionwide observation, including the major recommendations of the Zagreb Conference.

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Choosing new tools and topics
Long-term programmes and national health management (1968–1977)

The next steps towards a common health policy were taken through the growing involvement of the Regional Office in the planning, evaluation and management of national health services and in three technical programmes: those on cardiovascular diseases, mental health services and environmental health.

Naturally, the Regional Office continued its work in other areas and the regional programme (and the Regional Office) continued to grow. Within the limits of its budget and staff resources and with support from WHO headquarters and its other partners, the Regional Office addressed both familiar and emerging issues, including the education and training of health personnel, the control of communicable diseases, maternal and child health, and dental health services (1). Cooperation with WHO headquarters was a two-way street. Some activities were carried out as part of global work, and others developed into the core of global programmes. The Regional Office also continued to give, when requested, ad hoc support to individual Member States through specific projects.

European Member States increasingly turned to the Regional Office to address individual and shared problems. The expansion of the premises, and the budget and staff of the Regional Office (Table 1) reflects the growth of the regional programme. This expansion was remarkable; the old Special Office for Europe, in Geneva, began with a staff of two.

A New Direction

In three sessions (1966–1968), the Regional Committee extended European cooperation for health in two important ways. It chose both a new
Table 1. The regular budget and the staff of the Regional Office, 1951–1991

<table>
<thead>
<tr>
<th>Year</th>
<th>Regular budget expenditure (US $1000)</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>527</td>
<td>13</td>
</tr>
<tr>
<td>1961</td>
<td>1465</td>
<td>100</td>
</tr>
<tr>
<td>1971</td>
<td>4209</td>
<td>218</td>
</tr>
<tr>
<td>1981</td>
<td>14019</td>
<td>219</td>
</tr>
<tr>
<td>1990/1991&lt;sup&gt;a&lt;/sup&gt;</td>
<td>22227&lt;sup&gt;a&lt;/sup&gt;</td>
<td>248</td>
</tr>
</tbody>
</table>

<sup>a</sup> The Regional Office began biennial budgeting in the early 1980s; therefore, the figure given represents one half of the working allocation for the biennium at the time of writing.

Source: Data from the Budget and Finance and the Personnel units of the Regional Office.

...method of work on three important issues — long-term planning — and a new area for cooperation — national health planning. These achievements were the more impressive because they emerged from a political crisis that threatened the existence of health cooperation in the Region.

In 1966, the sixteenth session of the Regional Committee decided to reorganize the programme and budget to allow a more concentrated and technical approach. This meant that the Regional Office would use a more systematic and comprehensive approach, in contrast to the more ad hoc response of the past. The Regional Committee requested the Regional Director, after making the necessary budgetary changes, to take this new approach in planning a study on cardiovascular diseases to begin in 1968.

Taking up my new duties as Regional Director on 1 February 1967, I called together an advisory group in June 1967 to prepare a five-year plan for a programme on cardiovascular diseases for the period 1968–1972.

Interest in national health planning had grown, as shown at the Zagreb Conference. Such planning was a fact of life in a number of Member States, such as the USSR. In addition, the United Kingdom had its "planned" National Health Service, and France had long-term state investment plans that included medical facilities. Earlier ideological obstacles to national health planning had disappeared.

WHO now brought long-term planning to the international level. In the mid-1970s WHO headquarters moved gradually to what were called medium-term (five-year) plans; they were coordinated with the United Nations development decades and covered the whole range of the...
Organization's activities. Events moved faster in the European Region. In 1967, the Regional Committee first approved the proposed programme on cardiovascular diseases and then considered a report on long-term planning in the Region. It decided (Regional Committee resolution EUR/RC17/R6):

that long-term plans in the European Region, carried out in collaboration with national health authorities, WHO headquarters and other governmental, nongovernmental and intergovernmental organizations, are an important element of the future work of the Regional Office.

It also asked the Regional Director to submit long-term plans in several fields, with their budgetary implications, in 1968. This gave the Regional Director a clear mandate to propose specific long-term programmes with the principles approved in 1966.

The eighteenth session of the Regional Committee, held in Varna, Bulgaria, was remarkable in many ways. It was scheduled to be the setting for the European celebrations of the twentieth anniversary of the founding of WHO. The global celebrations were held at the World Health

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DR LEO A. KAPRIO

Leo A. Kaprio was born in Finland in 1918. His education was completed in 1955, having been interrupted by war, with periods of study in the United States, which led to a doctorate in public health. During the Second World War, he became a captain in the Finnish Army Medical Corps. Between 1944 and 1948, he held several hospital and university appointments in Finland. He then became Director of the Uusimaa Health Teaching and Demonstration Centre and Assistant Provincial Public Health Officer for Uusimaa Province. From 1952 to 1956, he was Chief of the Public Health Section of the National Board of Health, and took an active part in international health affairs. His first contact with WHO was as participant in the 1948 meeting that debated the establishment of the Regional Office for Europe. He participated in numerous meetings and represented Finland on the Regional Committee for Europe and at the World Health Assembly. He joined WHO in 1956, working in the regional offices for the Eastern Mediterranean and Europe, and as Director of the Division of Public Health Services at WHO headquarters. He served as Regional Director for Europe from 1967 to 1985, and was awarded the title of WHO Regional Director Emeritus on his retirement. He remained active at WHO headquarters, and began teaching international health in Helsinki in 1989.
Assembly in May 1968. This was also the time when a reformist government came to power in Czechoslovakia, and Professor Josef Charvát, a liberal Czech scientist, received the Léon Bernard Foundation Medal and Prize from the World Health Assembly.

Something happened before the Regional Committee met. On 22 August Warsaw Pact troops, including those of Bulgaria, entered Czechoslovakia. The Varna session suddenly became very unpopular. Several governments of western European countries asked whether it could be postponed, moved to Geneva or Copenhagen or even cancelled, but it was too late to change the time or location of the meeting.

After many telephone calls to and from the Regional Director's office, the French Foreign Ministry offered a solution to the hesitant western European countries. The session would be held in Varna, but only technical experts and permanent civil servants would represent western Member States; no politicians would attend. This satisfied most countries, and the eighteenth session of the Regional Committee was held as planned, with a minimum of political comments from either side. Instead of an additional east–west confrontation the session became a very technical meeting that saved cooperation in the health field.

A special ceremony was held to celebrate the WHO anniversary. The guest speaker, Sir Max Rosenheim of the United Kingdom, gave an address on health in the world of tomorrow, which was an excellent summary of the potential of medicine in the next 20 years (2).

We are thus entering upon an era in which total medical and social care is likely to be provided by teamwork, but though the practising doctor appears likely to lose his apparent omnipotence, he must always remain the friend and personal adviser of the individual patient. Patients are likely to feel increasingly lost in the modern world of science and computers, are likely to have increasing difficulty in adapting to the changing environment and to suffer increasingly from social maladjustment in the modern world. The doctor of tomorrow must be trained to recognize the individuality of his patient and his psychological as well as his physical troubles. While able to call, when necessary, upon the wonders of modern science, the doctor will still need to apply his own personality and understanding to help his patients to that complete physical, mental and social well-being that we call “health”.

The technical discussions on undergraduate medical education included an examination of the confusion resulting from the student upheavals and requests for radical reform that arose in many Member States during the early part of 1968.
The most important matter for the future development of the regional programme was the discussion of the Regional Director’s report on long-term planning and evaluation. A Regional Committee resolution (EUR/RC18/R5) stressed the importance of evaluating health services, recommended that health authorities take steps to ensure that their national health plans, priorities and goals were appropriately linked with the socioeconomic plans of their countries and requested the Regional Director:

(a) to continue the programme of the Regional Office in providing such technical assistance as governments may seek for the formulation of their own national programmes;

(b) to examine:

— the practicability of a greater concentration of effort on one or more special fields of interest to all Member States, on the lines now developing in cardiovascular diseases, but without limiting that programme;

— the desirability of such action in the field of mental health of young people or that of environmental pollution.

This was another milestone. From now on, support would be given to national health plans and therefore to all the various activities needed to make them, from vital and health statistics and epidemiology to managerial skills and evaluation. In addition, specific long-term programmes became priorities for the work of the European Office. It is time to return to them.

The Long-term Programmes

The three long-term programmes — on cardiovascular diseases, mental health and environmental health — began at about the same time and lasted for roughly a decade. They also set the course for future activities in these three areas. More interesting, however, are their shared characteristics and the spread of these to the regional programmes as a whole.

A WHO programme has been simply defined (3) as consisting of “two major elements: (a) the recognition and adequate description of a problem and (b) the sum of actions proposed to solve it, partly or wholly”. The three long-term programmes met this definition and shared a striking comprehensiveness of both structure and approach. Each replaced the short-term, uncoordinated activities of the past with a wide range of
projects intended to contribute to a central goal. In general, the activities
included gathering information on a problem and the services addressing
it, and applying the knowledge gained; this meant not only testing ways
to deal with the problem (and promoting a particular approach) but also
training the professionals involved.

In addition, each long-term programme addressed its subject in a new,
more comprehensive way. All three stressed prevention, in addition to
treatment, and included work to promote health. This required each
programme to work with larger and more varied groups of partners; many
of these links are still maintained. The programme on environmental
health moved furthest outside the health sector, while the two other
programmes extended their focus beyond the physician to include a
variety of other professionals. The Regional Office staff, as well as
national directors-general of health or equivalent authorities, had to learn
to communicate with new professional groups and to encourage clinicians
to cooperate with epidemiologists, statisticians, psychologists and com-
community health workers with different backgrounds.

The programmes naturally varied in the size and permanence of their
effects. Nevertheless, the views they espoused were accepted, although
unevenly applied. They broke new ground in cardiovascular diseases,
mental health and environmental health, and in the regional programme,
and extended European cooperation for health.

The human element
The duties of the Regional Director include guaranteeing high-quality
technical leadership for programmes. The Regional Office was lucky to
have regional officers who created a solid tradition of such leadership in
managing the long-term programmes. Of course, the success of all WHO
projects and programmes depends heavily on the personality of the
responsible staff members, in addition to their technical and scientific
knowledge and experience in the field concerned. Overcoming language
and cultural barriers to make the necessary contacts is a challenge to WHO
staff that the personnel of national health services or scientific institutions
do not have to face. WHO personnel and recruitment policies consider
such personal qualities a very important complement to the strict require-
ments for technical knowledge.

The activities of the long-term programmes penetrated to almost all
countries of the Region. They made WHO well known to medical and
university groups whose previous cooperation with the Regional Office
had been minimal. They also stimulated cooperation between such
groups. For example, the programme on cardiovascular diseases had an unexpected side effect: it established contact between politically concerned cardiologists who later organized a group, the International Physicians for Prevention of Nuclear War, whose activities earned it the Nobel Peace Prize. In addition, WHO contact with large groups of health and other professionals had a very useful influence on health policy development and assisted WHO in assuming leadership in this area.

A long-term programme on cancer?
Some members of the Regional Committee proposed a long-term programme on the prevention of and the quality of care for cancer. The establishment of an agency associated with WHO — the International Agency for Research on Cancer (IARC) — however, with its strong emphasis on cancer registers and epidemiology, was felt to meet current needs. In addition, professional and nongovernmental organizations were active and available to WHO at the global level. Nevertheless, the Regional Office maintained a programme on cancer that included activities analysing the organization of treatment (4).

Regional activities to prevent cancer started to grow in importance in 1969, when the Regional Committee took up the question of tobacco and health. The Regional Office started systematically to collect information on smoking habits in Member States. It also requested information on legislation restricting the advertising and use of tobacco in certain places, such as public premises. This work was done in cooperation with WHO headquarters and IARC, and made an important contribution to the health education programme.

Cardiovascular Diseases

In most European countries, cardiovascular diseases were considered an "individual" fate, to be dealt with by the patient and the physician. The idea of considering coronary heart disease as a mass phenomenon was alien to the vast majority of European cardiologists. It was also considered natural that heart disease would increase in a society with an aging population. During the 1950s, however, epidemiologists and statistical observers noticed an increase in acute myocardial infarction and a need to improve coronary care, as a growing group of relatively young middle-aged males were rushed to hospital after a "heart attack".

WHO had long been interested in cardiovascular diseases. In the European Region, the topic was raised at the Zagreb Conference and acted
on by the Regional Committee. WHO headquarters had already established a research programme. From the beginning of the regional cardiovascular disease programme, there was excellent cooperation with WHO headquarters. The worldwide problems of rheumatic heart disease, stroke and arterial hypertension were tackled from Geneva; coronary heart disease was the primary target of the European programme.

The aim of the long-term programme was to develop and test methods to control coronary heart disease. This required work in a number of areas, including:

- determining the true impact of acute myocardial infarction and the effectiveness of treatment services;
- testing whether changes in four risk factors would lower the incidence of coronary heart disease;
- examining the organization and problems of coronary care in various settings within and outside the hospital;
- fostering the trend towards more active rehabilitation of coronary patients, and testing its effects;
- developing programmes for the comprehensive control of cardiovascular diseases (such as the widely known North Karelia Project (5)); and
- related activities such as training, forging links with professional societies and national institutes, and “spreading the gospel”.

The achievements of the programme between 1968 and 1980 have been well described elsewhere (3), and numerous books focus on particular parts of the work and later developments arising from it (4–10).

The programme had the full participation and support of all Member States, and many positive effects. Much was learned about the epidemiology and natural history of cardiovascular diseases, and a firm, standard basis was laid for epidemiological studies of these diseases. The idea of preventing coronary heart disease by promoting changes in health-related behaviour gained wide acceptance, and WHO promoted the optimal use of, for example, intensive coronary care, bypass surgery and active rehabilitation in outpatient units and the community.

In addition, the ties between WHO and cardiology were strengthened; a firm partnership was established with the European Society of Cardiology. The programme also involved work with such professionals as sociologists and behavioural scientists.
The long-term programme helped to change the whole approach to cardiovascular diseases, and benefited all the ongoing important projects in this field, within and outside WHO. In return, the work of thousands of trainees, participants and experts in the programme was an important influence on the future work of the Regional Office.

Mental Health

The Regional Office began work on mental health in the 1950s, in the area of child psychiatry. Later, mental health was singled out at the Zagreb Conference as one of the major challenges for the health authorities of the Region; the report on the Conference emphasized the need to improve the quality of psychiatric care.

In Varna, the Regional Committee stressed the need for a programme on the mental health of youth. The abuse of drugs and alcohol and the social violence of 1968 greatly influenced the representatives. The first long-term plan, covering the period 1970–1975, listed the problem areas of European mental health services:

- the stigma of mental disorder
- traditional systems of care, based in the hospital
- large isolated mental hospitals
- outdated legislation
- few ambulatory alternatives to hospital
- a shortage of nonmedical staff
- a lack of adequate statistics
- a lack of coordination with other community services.

A comprehensive approach to mental health was the umbrella under which the various elements of an action programme were organized. This approach entailed involvement in the whole range of problems that could cause mental illness. It thus allowed the Regional Office to participate in the studies of alcohol problems carried out by WHO headquarters, and to be a partner in the youth programmes of the Council of Europe.

Like the programme on cardiovascular diseases, the mental health programme studied a particular problem and tested a new and broader approach to solving it. Mental health services were usually provided in special institutions and by physicians. The long-term programme
promoted a new model: comprehensive preventive, treatment and re-
habilitation services, delivered in the community by a multidisciplinary
team.

The objectives of the long-term programme were:

- to reduce the prevalence of mental disorders in communities;
- to strengthen national mental health services;
- to improve the range and quality of services;
- to improve coordination with other health and social services; and
- to train personnel.

Work to achieve these goals fell into four broad areas: the organiz-
aton and planning of services and personnel, education and training,
information on and classification of mental health problems and services,
and the problems of special groups, such as children and adolescents and
people dependent on drugs or alcohol.

In the early days of the programme considerable attention was paid to
the lack of adequate statistics, and WHO used considerable resources for
the training of personnel in countries. This made it possible to penetrate
the neglected area of mental health services, to know what really took
place in the large, half-forgotten psychiatric hospitals and asylums all
over Europe (11, 12).

The programme comprised dozens of activities in its four main areas
of work, and addressed a wide variety of services, personnel, and topics
such as suicide, deviant behaviour and the needs of the elderly and the
mentally handicapped, as well as those of youth (13). It generated dozens
of documents and publications, and directly involved thousands of people
in Member States who dealt in some capacity with mental health services.
An assessment of the programme (13) concluded that WHO succeeded in
promoting the community-oriented approach to services, and that major
developments in the Region were nearly always in line with the general
principles of the WHO programme.

Unfortunately, differences of approach prevented the full implemen-
tation of the regional mental health programme. The 16 Member States
that took part in the study on the current state of mental health services in
pilot areas (14), for example, included only two of the countries of central
and eastern Europe (Romania and Yugoslavia). In the late 1970s, the
question of political psychiatric patients brought the international psychi-
atriac community and the psychiatric systems of the USSR into conflict.
This conflict threatened to spill over into the Regional Committee in
1977, but the representatives refused to make any statement on the subject. While experts from central and eastern Europe continued to take part in the mental health programme, field projects remained “taboo” until the end of the study on services.

The long-term mental health programme became part of the global medium-term programme in 1978; since that time, the regional programme has remained active, continuing its efforts to improve the quality of mental health services in Europe. In addition, the Regional Committee gave a mandate to the Regional Director to start programmes on alcohol problems and drug abuse. This work took place in close cooperation with WHO headquarters. WHO alcohol programmes were often hampered by conflicts of viewpoint and sometimes farcical exchanges of accusations between Member States.

The dividing line was the definition of the problem. Was it the total use of alcohol in society or only the health problems of the individual alcoholic? The Nordic countries fought for an holistic approach that included the role of alcohol in traffic accidents and family and social problems; this view gradually gained strength. In other countries, alcohol had a role in society that people were reluctant to consider dangerous. In spite of these conflicts, WHO developed a global programme on alcohol and remains active in this area.

The comprehensive approach to mental health problems and services persists. It can be seen in the continuing interest in the statistical and administrative aspects of studies, the evaluation of mental health services, the prevention of suicide and the relationship of drug and alcohol abuse to mental disorder. As Regional Director, I considered establishing a division for mental health services, lifestyle-related preventable mental problems and neurological diseases, but a shortage of funds precluded the making of specific proposals to the Regional Committee. The lack of formal links, however, did not stop the development of increasingly close cooperation between the programme on mental health and those on the aged, drug abuse and alcohol abuse.

**Environmental Health**

The control of environmental health hazards has long been a public health concern. Work for housing control, safe water supplies, sewage treatment and food hygiene has a long history in the industrialized countries of the Region. From its beginning, WHO focused on these questions, which the devastation of the Second World War brought into new prominence. As
told in Chapter 1, early regional activities included the training of European sanitary engineers through the Rockefeller Foundation and WHO fellowships. Many of the people who became senior WHO staff members in the environmental field belonged to this group. In addition, the regular meetings organized by the Regional Office built a wide network of engineers responsible for environmental programmes within national health services. This background facilitated the preparation and implementation of the long-term programme.

Another important factor was close cooperation on environmental matters with the United Nations Expanded Programme of Technical Assistance and then with UNDP and, after the regional programme began, the United Nations Environment Programme (UNEP).

ILO was also an important partner in activities on industrial toxicology and chemical safety, and the Regional Office later assisted WHO headquarters in an important programme developed jointly by ILO, WHO and UNDP.

In 1970, the Regional Committee approved a long-term programme on environmental pollution control. It was to start in 1971 and continue until 1980. As it developed, the subject of the programme was more accurately described as environmental health. The main aim was to assist the Member States through a systematic and coordinated programme, in finding ways to prevent environmental hazards to health or to render them harmless.

The programme defined problems and developed and tested solutions in a variety of areas: water supply and sanitation, water and air pollution, the treatment and disposal of solid waste, chemical safety, food safety, radiation protection, the public health aspects of housing and occupational health. The programme took a comprehensive preventive approach that formed the basis for the wide range of methods employed: legislative, administrative and technical (15).

Country projects funded by UNDP were some of the most important of the programme’s activities. They offered a useful method of searching for solutions to environmental problems and had three advantages. The projects addressed urgent problems in the test areas, they had the cooperation of the governments concerned and they had abundant funding, with full-time project management. The projects provided experts, equipment and WHO fellowships and other training in some 11 Member States. Considerable research was also carried out. The projects addressed such topics as:

— water pollution in the River Danube and the Mediterranean Sea;
— the production of manuals to promote a harmonized approach to water and air pollution, solid waste management and nonionizing radiation protection;
— the building of centres for research and development and industrial toxicology in Poland;
— air and water pollution problems in Romania and Spain;
— a comprehensive programme for pollution control in Athens; and
— problems of water supply and sanitation in Algeria, Malta, Morocco, Turkey and Yugoslavia.

These UNDP-funded projects and the other activities of the environmental health programme generated many useful ideas and approaches. The Regional Office gained experience in planning and carrying out, in cooperation with Member States, cost-effective large-scale projects to control environmental pollution. More and more, such projects were designed to encourage broad national policies on environmental health, as part of overall economic and social development. The work also showed the need for international cooperation — through networks of institutions, for example — to tackle problems affecting more than one country.

These ideas spread beyond the people immediately involved in the projects. Through such means as workshops, study groups and editorial boards, the Regional Office mobilized hundreds of experts in each subject area covered during the decade of the long-term programme. These people and the other international and intergovernmental organizations involved proved valuable allies in future WHO work for environmental health.

The long-term programme broke new ground by urging a multisectoral, preventive approach and international cooperation on environmental health. Unfortunately, action on the knowledge gained and approaches tested was slow to follow. Countries accepted the ideas and methods but did not invest in implementing them, and political factors prevented the open exchange of information and the discussion of principles. As recently revealed, these problems were particularly severe in the countries of central and eastern Europe.

In tackling the thorny issue of environmental health, the regional programme provided lessons that would be important in the implementation of the Region's common health policy. Acting to improve the environment could be costly. All sectors of government are involved and the issue crosses national borders. Further, the days when environmental
health was the responsibility of health authorities had passed. When the long-term programme began, a single ministry was responsible for both health and the environment in only two Member States. Ten years later, only one country retained this combination of political responsibilities. Effective action for a healthy environment demanded the cooperation of governments and of the ministries and agencies within them. In addition, growing concern about the environment in the late 1970s and early 1980s brought numerous groups and authorities on stage. As only one of the international agencies involved, WHO worked to place health issues higher on the environmental agenda.

The regional programme on environmental health was one of the first to show the need for intersectoral action and to struggle with the problems of achieving it. It also helped create a network of experts on environmental health and in other sectors, and set the course for the future work on environmental health that became a large part of the work of the Regional Office.

The programme and its successors generated numerous publications to make results available for wider discussion and use (15–23). In addition, a series of documents was issued, whose first topic was chemical safety. The documents were intended to disseminate useful data from meetings, studies and training as quickly as possible. As its scope widened, the series was renamed the Environmental Health Series, and it numbers about 35 documents today.

The regional programme addressed a wide range of subjects. In the field of water supply and sanitation, for example, the Regional Office took part in the International Drinking Water Supply and Sanitation Decade (1980–1990) and in the Mediterranean Action Plan (24–26). The Regional Office continued its cooperation on environmental matters with partners within the United Nations system — ECE, UNEP, ILO, FAO, IARC and WHO headquarters (27) — and intergovernmental partners such as the Organisation for Economic Co-operation and Development (OECD), the Council for Mutual Economic Assistance (CMEA) and the Commission of the European Communities (CEC). It also took up new topics, including environmental accidents and disasters (28). Finally, the Regional Office continued to struggle with the problems that delayed the implementation of the principles established in the long-term programme. A consultation in Vienna in 1983 (see Chapter 4) took important steps towards the necessary international and intersectoral cooperation and a real breakthrough followed in 1989 at the First European Conference on Environment and Health (see Chapter 5).
National Health Planning

The Regional Committee resolution (EUR/RC18/R5) quoted earlier in this chapter urged Member States to use planning and evaluation in developing their health services to meet people's needs, and requested the Regional Office to advise and support countries in this task. This caused an important change in the relationship between the Regional Office and the Member States, and in the regional programming pattern. Planning and evaluation activities became an interesting two-way European experience, with a much greater role for the Regional Office as a common forum for improving the management of health services.

The Regional Committee decision was sponsored by a number of representatives who also initiated a more holistic approach to health services in the World Health Assembly and their own countries. This senior group included national health leaders such as Dr Franz Bauhofer of Austria, Professor Samuel Halter of Belgium, Professor Eugène Aujaleu of France, Professor Fritz Beske of the Federal Republic of Germany, Dr Arthur Engel and Professor Bror Rexed of Sweden, and Sir George Godber and Sir John Brotherston of the United Kingdom.

In addition, some European directors-general of health allowed their experts to take part in WHO interregional activities in the planning field. Some of these people eventually became frequently consulted advisers or WHO staff members. Two notable examples of the latter are Dr I. Sergiu Luculescu of Romania, now Director, Programme Management in the Regional Office, and Dr Jo E. Asvall of Norway, the present Regional Director for Europe. Such people linked national health services and WHO in one intellectually interactive group.

The new programme for the support of national health planning was supervised first by the Regional Director and then by Dr Lennart Hesselvik of Sweden. Dr Hesselvik succeeded the Deputy Director, Dr Cottrell, in 1964 under the new title of Director, Health Services. Dr Hesselvik was followed in 1968 by Dr Louis Lataillade of France, my old colleague from the Rockefeller Foundation programmes in Soissons and Uusimaa. At the time of his appointment, he was WHO representative in Turkey; in his new position, he soon established excellent relations with Algeria and Morocco. When Dr Lataillade retired in 1972, Dr Franz Bauhofer became Director, Health Services and enthusiastically took part in developing all the management-related programmes. It is interesting to note that all three men had taken part in the travelling seminars (see Chapter 2).
The programme was not structured as a long-term programme, but as a series of activities leading to a joint situation analysis, which was to be made at a conference on national health planning in 1974. The preparatory work included workshops and training courses. In addition, Member States requested increasing numbers of visits for the provision of advice and the exchange of information.

The holistic approach of the Regional Office was perhaps best described in the Regional Director’s report for 1968–1969 (28):

There is more and more need for central health administrations to ensure that modern medical science is applied effectively and economically for the benefit of the whole population. We are moving, in the application of health care, from a “handicraft” to an “industrial” approach involving large groups of health personnel working in teams. There is a growing need for long-term planning as well as better managerial leadership of the “medical service” which is, in economic terms, one of the major employers in modern industrialized society. Central health administrations should be able, usually within their own structure and through their normal contacts, to handle the technical and planning aspects of hospital, extra-mural and preventive care. They have, however, to co-operate with many other services, and administrations must be able to prevent psychological and behavioural disorders and promote a positive atmosphere in the community. To this end, a physically pleasant and safe environment must be ensured, not only in factory and workplace, but also in the home, the street and recreational amenities. Not only is co-operation necessary at home: to study and solve serious health problems, international co-operation is essential.

This broad approach to health underlay a number of activities. As a first step, the programme for the support of national health planning summed up the results of a series of nine training courses held in the period 1958–1967. The courses dealt with planning and evaluation at the local level, and some provided background information for the Zagreb Conference in 1964. The experience gained from all nine, however, was examined at a seminar on public health practice, held in Sofia in September 1970, whose participants recognized the value of planning at the local level. Two workshops followed, and built on this base.

The workshops focused on health planning and national development, and the evaluation of public health programmes. They provided a setting in which senior health administrators and decision-makers on socioeconomic and health plans could exchange and analyse the latest available information on planning and evaluation. Meanwhile, the Regional Office asked several health planners in Member States to write...
a collection of articles on health planning and the organization of medical care (29). Part of the aim was to attract the interest of hospital planners and health economists to the new WHO programme.

The Regional Office started a new series of training courses on health planning in 1972. An improved version followed in 1974; it included a nine-month period spent in preparing a plan for a particular sector of the health services in a particular country (such as health education in Spain) before presenting the plan at a meeting for analysis and criticism.

It is important to note that “economic culture” was growing in importance in all sectors, including health (30):

The scope of the health services has become so large, individual coverage so complete and the expenditure involved so huge that an ever-increasing amount of scientific forecasting and practical planning will be needed both for preventive and for curative medicine. In other words, we can no longer be contented with rough estimates and generalities, but must assess accurately what is to be expected of medical research in terms of innovation and of society in terms of manpower and money. Economic culture — the *sine qua non* of civilization as one sociologist has put it — is now indispensable to the public health administrator as to anybody these days holding a position of responsibility. “Determining priorities”, “cost/benefit analysis”, techniques such as the “planning, programming, budgeting system” (PPBS) or, in French “rationalisation des choix budgétaires” (RCB), “operational research” and “forecasting methods”, not to mention “futurology” — are among the expressions which crop up frequently today in studies and reports from different European countries whatever the philosophical systems they acknowledge.

These facts and the WHO activities already discussed formed the backdrop for the European Conference on National Health Planning, which was held in Bucharest in 1974. The participants comprised government-nominated representatives, WHO staff and large numbers of experts, most of whom had participated in the preparatory activities.

In discussion, the participants fully supported planning as a tool for health services. They made no dogmatic recommendations on the subjects or levels of planning, however; the structure of health services varied too much between countries to allow this. For example, some countries had a private medical sector; state health authorities could not make plans for such a sector but could consider or guide its wishes and economic needs.

The Conference participants also debated ways to include national health plans in a country’s overall socioeconomic plans. This was done in socialist countries, but in a way that did not allow for flexibility in
implementation. In contrast, health planning in market economy countries was originally less common, but developed gradually to include alternatives or targets for achievement, and took epidemiological factors into consideration. These activities in countries, supported by the Regional Office, created the group of experts who became involved in work on the common health policy for the Region in the early 1980s.

The recommendations made at the Conference did not attempt to impose any fixed ideology on the Regional Office, which thus maintained a free hand to continue both the exchange of experience and the training courses on various topics. The Conference participants also supported both academic studies and planning exercises in local government. One such exercise focused on planning health services at the subnational level and emphasized intersectoral cooperation. It made a detailed analysis of systems in eight countries with widely different practices (31).

Information for Action

As mentioned in Chapter 2, the collection of mortality and morbidity information had always been one of WHO's main duties. WHO headquarters remained responsible for reports on the health situation worldwide and analyses of health conditions and resources (such as available health personnel in Member States). It also regularly prepared reports to the United Nations to be included in reports on the world social situation.

The Regional Office assisted in this global task by arranging meetings and seminars for experts on vital and health statistics. Countries' increasing interest in and need for information led to the development of other regional information activities. These became much more prominent as the Regional Office became involved in technology for planning and management.

The first attempts to use computers in health administration were made in the United States. With the assistance of experts from the United States and with the cooperation of ECE, whose responsibilities included the collection of economic, trade and demographic data, the Regional Office arranged a series of meetings to analyse the use of computerized data processing in public health, vital statistics, hospital administration systems and health care. British and Swedish experts provided information, and French experts rapidly became leaders in some applications.

As mentioned, the premises of the Regional Office were rebuilt and expanded between 1968 and 1972. With new, larger facilities and the
interest of senior staff, the Regional Office became a centre for WHO experimentation on the use of computers in health administration. The Regional Office worked in close cooperation with the International Computing Centre (ICC) of the United Nations, which was housed in WHO headquarters. This work enabled the Regional Office to offer increasing support to Member States as a technology adviser on research and data processing in health services, and to carry out studies on its own or with such partners as the International Institute for Applied Systems Analysis (IIASA), universities and nongovernmental organizations.

Health services in Europe
The first report on health services in Europe in 1965, describing each country's health service structure and main problems, greatly influenced the Regional Committee's policy decisions of 1966–1969. A second edition was issued in 1975 (32). Programme officers at the Regional Office wrote the first part, linking trends in health administration in the Region with the progress made through Regional Office and country work on the prevention of disease, the organization of health care and the training of personnel. The second part described services in each Member State and the third comprised statistics on health and health services, along with vital statistics and some economic and social data. This widely distributed document was later used as part of a book on health services worldwide. The year 1975 also saw the publication of another useful tool in easing and widening communication: a glossary of some 350 health care terms (33).

Further, a study group examined the role of central institutes of public health and hygiene. A symposium followed, describing the existing networks used to make the information generated by central technical institutes, research laboratories and universities available to health decision-makers. Such decision-makers often needed technical and scientific knowledge to defend health priorities against economic considerations or other political options.

The need of health authorities for information for planning and management caused the 1975 Regional Committee to request a technical discussion on information systems for health services. As usual, the Regional Office made careful preparations for the discussion, sending a questionnaire to the (then) 32 Member States; 25 replied. Each country was asked:

- how it defined a national health information system;
- whether it had made an overall development plan for its system;
— the procedures used to make information available to users and to respond to changes in their needs;

— aspects of the system that were not satisfactory and the type of improvements required, particularly those that justified greater attention at the regional level.

The Regional Office analysed the replies and provided other technological background papers for the discussion, which took place during the twenty-seventh session of the Regional Committee in 1977.

The analysis of the replies to the questionnaire yielded the following definition of a national health information system (34):

An organization of people, facilities, and methods interacting together as a subsystem of the national socioeconomic information system to provide the necessary data and information on the health situation of a nation and the factors (social, economic, geographic, etc.) influencing it, on the deployment of the health resources available, and on the utilization of those resources in support of the planning and management of health services.

Interest in national health information systems has remained high in the Region and the Regional Office.

Changes in Global Policies and their Impact

Changes of leadership and thus policy and practices at WHO headquarters naturally affect the work of the Regional Office. In 1973, Dr Halfdan Mahler of Denmark succeeded Dr Candau as Director-General of WHO. Dr Mahler had considerable experience in tuberculosis control and field research in developing countries. As an Assistant Director-General, he had developed a programme on systems analysis. As Director-General, he was a keen advocate of improving the social condition of developing countries. He also wished to improve the coordination of work between WHO headquarters and the regions and to delegate more WHO action to the regional, and particularly to the country, level.

Dr Mahler established a WHO Global Programme Committee, which met in Geneva and included both the assistant directors-general and the regional directors. A subgroup of the Committee, a Programme Development Working Group brought the directors of health services (later directors, programme management) of the regions together at regular meetings. This group met in each of the six regional offices in turn, and its members thus became familiar with the problems of regions other than their own.

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This coordination led to a new medium-term programming pattern, covering five-year periods and all major programme areas, including the strengthening of health services, health personnel development, and the control of both communicable and noncommunicable diseases. Regional programmes now had to take their places in the global medium-term programmes, and sometimes had to be adjusted to avoid overlap. In the European Region, this meant the merging of the long-term programmes into the global system in the late 1970s and early 1980s. As each of the regional directors chaired the Global Programme Committee in turn, potential conflicts were ironed out.

The Director-General also delegated certain responsibilities to the regions. In 1976, the Regional Office for Europe started two new programmes, on health protection of the elderly and traffic accident prevention. These two — and, later, a programme on appropriate technology and an interregional project on health promotion — became responsible for WHO global activities on the same topics. This decentralization to the regional level by the Director-General was a very interesting experience, which deserves its own historical analysis. Clearly, the arrangement had both pros and cons, and in 1989 the new Director-General, Dr Hiroshi Nakajima of Japan, on taking up his duties, returned the coordination of these global programmes to Geneva.

Dr Mahler also decided to decentralize the planning, performance and coordination of research, allowing the regions to develop their own research programmes. It was hoped that this would encourage research, particularly on health services, and speed up the establishment of research centres in developing countries that would deal with the particular problems of such countries. In the European Region, this decision gave the Regional Office an opportunity to build direct links to the very large and diverse European research community. One such link was the Regional Advisory Committee for Medical Research (EACMR), established in 1976. The Committee had a central role in the preparation and implementation of the common health policy of the Region.

World political trends also continued to influence the Region. In 1973, both the German Democratic Republic and the Federal Republic of Germany became members of the United Nations, and the former officially took part, for the first time, in the Regional Committee. As soon as budgetary arrangements allowed, German became the fourth working language of the Regional Office. This move greatly improved communication (through public information and publications) and scientific cooperation.
New Opportunities for European Health Leaders to Participate

Growing numbers of experts and health decision-makers and administrators became involved in the daily work of the Regional Office by participating in the steering committees and technical advisory groups of the long-term programmes and the programme on national health planning. In these groups, senior health leaders gave their time to evaluate important programmes and thus provide information on which the Regional Committee could base important decisions.

An outstanding example was the meeting of a consultative group in 1975 to evaluate the programme on cardiovascular diseases. The participants were prominent, regular participants in the Regional Committee, representing a range of Member States: France, the German Democratic Republic, the Federal Republic of Germany, the United Kingdom and the USSR. The members of the evaluation group were all decision-makers with long experience in both the health services of their countries and the international health community.

The positive experience with this group encouraged me, as Regional Director, to create a similar arrangement for the regional programme as a whole; it seemed a productive way to handle the expanding programme and the resulting rise in management needs. Some current representatives on the Regional Committee therefore began to meet each year as a Consultative Group on Programme Development (CGPD). It soon became necessary to convene a special smaller group called the Consultative Group on Budgetary Questions (CGBQ). The CGPD remains important in guiding the development of the regional programme.

The CGBQ comprised representatives from the “big contributors” of the Region and the host country, Denmark. The group gave the Regional Director advice and support on difficult or controversial questions in budget allocation.

The CGPD gives advice on the regional programme and evaluates particular programmes. The Regional Director nominates its members; the Regional Committee did not wish to use an election procedure, but insisted that the membership and chairman be changed at reasonable intervals, to allow all Member States to participate. This decision demonstrated considerable trust in the impartiality of the leadership of the Regional Office.
Conclusion

The end of the period covered in this chapter saw increasingly close cooperation between the Regional Office and the Member States. Every country took advantage of the WHO services that were considered useful and many participated actively in selected long-term programmes. Cooperation with WHO headquarters and various international partners also proved productive. Country programmes continued, and Algeria, Morocco and Turkey made considerable improvements in such areas as infectious diseases and maternal and child health. The first family planning programmes were attempted. Further, programmes on such issues as aging, accident prevention, and the education and training of health personnel (including physicians, nurses and dental workers) promoted intersectoral cooperation between many European agencies and the Regional Office.

Much was achieved: the establishment of cooperation and the acceptance of both a comprehensive approach to health problems, and national health planning as a tool in health development. The next step was to apply all three to the whole field of health by establishing a common health policy. This required impetus from the global level.

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The Regional Office in 1958

1951

Dr Norman D. Begg
Regional Director 1952–1956

Dr Paul J.J. van de Calseyde
Regional Director 1957–1967
Participants in the RHDAC, meeting in April 1984. From left to right: Dr J.E. Asvall (EURO), Professor P. Recht (BEL), Dr B. Nizetic (EURO), Dr A. Marques Vicente (SPA), Dr Z. Brzezinski (EURO), Dr G. Martin-Bouyer (FRA), Dr P.O. Petersson (EURO), Sir Henry Yellowlees (UNK), Professor P.F. Hjort (NOR), Dr R. Müller (DDR), Professor M.T. Alaoui (MOR), Dr J.H. Walsh (IRE), Dr A. Grech (MAT), Professor F. Baro (BEL), Mrs C. de la Cuesta (SPA), Mr J.M. van Gindeaetel (EURO), Dr P. de Schouver (BEL), Dr K. Leppo (FIN), Professor M. Sokolowska (POL), Dr J.-P. Jardel (EURO), Mr A. Grimsson (ICE), Ms S. Haxthausen (DEN), Mr P. Lamarche (EURO), Dr H. Hellberg (WHO/HQ), Professor D. Jakovljevic (YUG), Dr B. Westerholm (SWE), Dr A. Wojtczak (EURO), Professor B. Abel-Smith (UNK), Professor M. Benhassine (ALG), Dr C.O. Pannenborg (NET), Dr L.A. Kaprio (EURO), Mr E. Westenberger (EURO), Dr E. Leparski (EURO), Professor M. Steinbach (DEU), Dr D.A. Orlov (SSR), Professor M. Kunze (AUT), Dr A. Weber (EURO) and Dr T. Mork (NOR).
Participants in the fortieth session of the Regional Committee for Europe, gathered outside the Regional Office.
Dr Leo A. Kaprio
Regional Director 1967-1985

The Regional Office in 1990

Dr Jo E. Asvall
Regional Director 1985-
Making a common health policy

Health for all in the European Region (1977-1985)

A New Movement on the Global Level

1977 was a remarkable year in WHO history. What could be called the Organization’s disease campaign period ended with a great victory: the eradication of smallpox (1). 1977 was also the beginning of a new period in international health cooperation involving not only WHO but also UNICEF, the United Nations itself, and the group of agencies and individuals that I call the international health community. Documents such as the United Nations Declaration of Human Rights and the WHO Constitution have lofty goals; in this new period, the Member States of the United Nations and WHO worked to realize them.

In the middle of the 1970s, the WHO Director-General and the Executive Board were forced to admit that health conditions in large parts of the least developed countries were deteriorating and that progress was very slow in building what were then called basic health services. UNICEF’s governing bodies felt similar anxiety about the health of the world’s mothers and children.

Experts started to speak of the need for broader, socially oriented primary health care and of people’s active participation: “health by the people”. A new start was necessary. In May 1977, the World Health Assembly passed an often quoted resolution (WHA30.43) choosing as the main social target of governments and WHO in the coming decades “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”. This was the beginning of the worldwide movement for health for all.
European reaction
In the European Region, in contrast, it was business as usual for the Regional Committee and the Regional Office in 1977. The Regional Committee, for example, gave guidance on future activities in nursing, cancer and health care of the elderly. The EACMR became more involved in providing expertise, culled from the European research community, for the research elements of various regional programmes. The rising incidence of malaria prompted the Government of Turkey to ask for special assistance from WHO. As described in Chapter 2, the Regional Office and the Member States responded quickly and generously. With the Regional Office, the Member States also focused on planning new, specific medium-term programmes, using the experience gained from the long-term programmes, and on the analysis of and possible solutions to such problems as traffic accidents, toxicological risks and drug utilization patterns.

The industrialized countries of the Region took seriously the global resolution on health for all. They believed, however, that it had no relevance to them, except as the new approach required them to provide more assistance to the third world.

International Conference on Primary Health Care
Soon after becoming WHO Director-General, Dr Mahler expressed concern about basic health services in developing countries. He felt these services were modelled too much on the medical care pattern of industrialized countries, which was not easily applied or acceptable to the large rural populations of developing countries. Aware of the Chinese “bare-foot” doctors, he wished to encourage similar approaches to ensure the participation of the people in building their own health.

WHO and UNICEF had launched studies on existing and experimental developments that successfully encouraged such participation. To summarize all the experimentation and the experience gained, WHO and UNICEF jointly organized the International Conference on Primary Health Care, which was held in September 1978 in Alma-Ata, Kazakh SSR. The resulting Declaration of Alma-Ata and the report of the Conference (2) carefully defined primary health care and named it the key to attaining health for all.

European report on primary health care
As background papers for the Conference, all six WHO regional directors prepared reports on primary health care in the regions. I wrote my report
with the assistance of four experts. This summary document was well accepted and edited, updated and published after the Alma-Ata Conference (3).

Many European governments and associations of health professionals thought that good primary care was already available in the Region. This was actually primary medical care, delivered in socialist countries with controlled economies through systematically planned state services and in countries with free market economies mainly through public and/or private services, supported by sickness insurance.

My report argued for the relevance of health for all and primary health care in the Region. It explained the potential of the broader primary health care approach to reach underserved or vulnerable groups in the population — such as the old, the young, the unemployed and the disabled. This would require an intersectoral approach and the cooperation of communities. All this is now well known, if not yet well applied.

I argued that several principles of the Declaration of Alma-Ata were as relevant for developed as for developing countries (3):

(a) health care should be related to the needs of the population;

(b) consumers should participate, individually and collectively, in the planning and implementation of health care;

(c) the fullest use must be made of available resources; and

(d) primary health care is not an isolated approach but the most local part of a comprehensive health system.

The report discussed these principles and showed their applicability in the local community, in various elements of health care, and in the interaction of care with other health promoting services — educational, social and environmental.

A European Strategy

Several government representatives at the 1978 Regional Committee came directly from Alma-Ata to London for the session. As members of the Regional Committee, they noted the importance of the success of the Conference and requested the Regional Director to follow up the issue in 1979, when the worldwide guidelines for the preparation of a strategy for health for all would be available.

The twenty-eighth session of the Regional Committee marked the thirtieth anniversaries of both the National Health Service of the United
Kingdom and WHO. His Royal Highness the Prince of Wales honoured
the session by speaking at the opening ceremony, joking that, as he too
was 30 years old, he had been invited to attend as an example of
achievements in health during the period. His Royal Highness went on
to say that WHO’s global vision had changed the lay person’s view of
health.

Professor Samuel Halter traced the growing impact of WHO on the
European health scene. Professor Halter concluded by stating:

For many peoples, WHO has been a symbol of health development and the
generation of wellbeing, and the Regional Office for Europe, which WHO
headquarters often assigns particular tasks to, has been called on to develop
certain activities with an impact that should be felt far beyond the Region;
in this connection the Regional Office, its Director and its staff, amply
deserve the marks of respect and praise they receive on every hand. Maybe
the Regional Office could also play a role in trying to diminish the chaos
that develops in Europe in the health field due to uncontrolled and
uncoordinated explosive development of initiatives in the various European
organizations.

The European strategy for health for all gave the Regional Office an
opportunity to control this “chaos”.

The Member States of the Region, however, still thought that neither
the global strategy for health for all nor primary health care had much to
offer them, as industrialized countries with well developed health ser-
VICES. Nevertheless, discussions between senior WHO staff — the
Regional Director, the Director, Programme Management and later the
Director-General — led to a decision to pursue both in the European
Region. There were two reasons for this. First, on the global level, the
limiting of the health for all movement to developing countries would
cause them to reject it as second-rate.

Second, in the European Region, Dr Asvall and I recognized the
usefulness of a health for all strategy to developed countries, not least as
an opportunity for reform. (Dr Asvall had acted for Dr Bauhofer during
his illness in 1978 and succeeded him, under the new title of Director,
Programme Management, in 1979, after Dr Bauhofer’s death. This
brought him in on the ground floor of the movement whose implemen-
tation he now guides.) Thus, the Regional Office started to work to
overcome the hesitation of Member States. The work was done in phases;
the first step was to demonstrate the advantages of the health for all
approach. If this was successful, the Regional Office could next propose
a strategy and then means to act on it.
The preparation for the European strategy started at the twenty-ninth session of the Regional Committee, using some already relevant programme proposals as points of departure. One was a medium-term programme for family health, the result of six years of study, consultation, meetings and planning. It had specific objectives in five areas:

- the place of women in health and development
- the perinatal period
- nutrition
- chronic diseases in children
- new problems of children and adolescents.

This programme eventually supplied important background information for the development of the strategy and targets for health for all.

The other programme proposal focused on the application of the principles of Alma-Ata through primary health care as part of comprehensive health services. The proposal introduced the points that the regional programme on primary health care would emphasize, such as: the promotion of self-care, the improvement of the cost-benefit ratio of health services by providing care at the lowest effective level, the use of secondary- and tertiary-level specialized staff to support primary health care, the promotion of health education, the strengthening of research capabilities, the promotion of attitudes favourable to primary health care and the establishment of an information system. It is interesting to note that the proposal was discussed at a session of the Regional Committee held in Finland, which was a pioneer in shifting the emphasis from hospital-oriented care to community services.

The Regional Committee approved a plan to hold a conference on primary health care in industrialized countries in 1983. The conference would take stock of the current trends in primary health care and of progress since Alma-Ata, and is discussed later in this chapter. Other important topics included the programme on chemical safety, a global programme in which UNDP, ILO and WHO were partners. The main point for this story, however, is that the Regional Committee clearly began its involvement in health for all and primary health care in 1979.

Earlier in the year, the World Health Assembly had requested WHO to start preparing the global and regional strategies and action plans necessary to act on the conclusions of the Alma-Ata Conference. In response, the Regional Committee approved a suggestion made by the Global Programme Committee, and established a Regional Health
Development Advisory Council (RHDAC). This was the first such regional body to be set up.

The new RHDAC was to meet in March 1980. The Regional Office staff had to prepare its agenda and thus offer ideas for the Council’s consideration. A questionnaire asking for the opinions of national authorities was sent out in autumn 1979. A small steering group under the leadership of Dr Asvall analysed the 25 replies and made them available to the RHDAC.

The steering group also found the rationale for a specific European approach. The group studied epidemiological developments in the Region in recent decades. Its analysis noted countries’ considerable achievements. Generally high expenditure on health personnel, facilities and technology had resulted in high standards of care, considerable improvement in health and the virtual conquest of the major infectious killing diseases. Countries had also failed in important ways, however, and these failures held ominous consequences for the future. At a time of economic difficulty, costs continued to increase while showing decreasing health returns. Important differences in health remained, between countries and groups within countries, and services were unevenly distributed. Finally, treatment and cure (and specialized care) were overemphasized, at the expense of disease prevention and health promotion (and primary health care).

A new direction was needed for countries’ health priorities, resources and services. A strategy for health for all could provide this new direction and solve the two biggest problems for the future: the optimal return on health investment and the removal of inequalities in health and health services. The steering group prepared a list of the major problems to be tackled by a European strategy, summarizing them under three headings: lifestyles and health, the social and physical environment, and appropriate care.

The RHDAC comprised several members of the CGPD and the EACMR, as well as experts in social policy and economics and the health professions. The group was to ensure the soundness of the Regional Director’s proposals, which were submitted to it for endorsement, to the Regional Committee for a strategy and action plan for health for all. Professor Brian Abel-Smith chaired the RHDAC from its establishment until 1984. A leading expert on social policy and health economics, and a long-standing adviser to WHO, he could balance the views and proposals of the large and growing number of experts involved. He could be called, if not the ideological father, the midwife of health for all in the Region!
As Chairman of the RHDAC, Professor Abel-Smith introduced a regional strategy for attaining health for all by the year 2000 at the thirtieth session of the Regional Committee. He described it as a comprehensive, coherent and consistent long-term strategy for the Region as a whole.

The first part of the document summarized the strategy for policy-makers, and gave general statements on past progress, present problems and future trends, and an outline of the main areas for action. Objectives and programmes were suggested for the national and regional levels, as well as the support measures for implementation and methods for monitoring and evaluating the success of the strategy. These main objectives and programmes were presented under three headings that soon became well known:

- healthy lifestyles
- the reduction of preventable conditions
- the provision of adequate and accessible health care for all.

The section on lifestyles related to both individual and community lifestyles conducive to health. It spoke of intersectoral approaches and dealt with self-imposed risks. The section on the reduction of preventable conditions covered major classical health programmes typical of current European society. The third section, on the provision of adequate and accessible health care for all, stressed the need for primary health care, accessible to all and supported by secondary and tertiary care. It spoke of the redistribution of resources and urged that underserved and high-risk groups should benefit from special services integrated into the current health system and linked with social networks. Early diagnosis and rehabilitation and the identification of risk factors were the tools suggested to fight chronic diseases.

The second part of the strategy document specified activities in the three areas in greater detail. It also discussed support measures, collaborative mechanisms, monitoring and evaluation, the role of WHO and finally a tentative plan for implementation. A list of suggested indicators was attached.

Fully discussing the document in plenary session would have been a formidable task for the Regional Committee, so a Regional Committee Working Group was established to study the regional strategy (and a related topic, the WHO Seventh General Programme of Work). The Working Group examined the strategy proposals in detail, made several modifications and clarifications and added a stronger social dimension:
“to reduce poverty”. This evolved into the primary principle and goal of the strategy: equity. (Several members of the Working Group were involved in the further development of the strategy; they included Dr Nils Rosdahl of Denmark, Dr Håkan Hellberg of Finland, Dr Méropi Violaki-Paraskeva of Greece, Dr D.A. Orlov of the USSR and Professor John Reid of the United Kingdom.)

In resolution EUR/RC30/R8, the Regional Committee approved the strategy document, with the changes made by the Working Group (4). The resolution urged Member States:

bearing in mind the Declaration of Alma-Ata and the indispensability of an intersectoral approach to health promotion, to determine national objectives, outline plans for achieving them, work towards national targets and submit information on national experience in these fields to the Regional Director.

The Regional Committee also approved a tentative action plan for the Regional Office and requested the Regional Director to prepare a draft regional plan of action with detailed targets for achievement.

This was another milestone in European cooperation for health in the forum of WHO. The first was the exchange of experience and information among Member States, and the second was the development of a common description of the Region's health services, as a result of the Zagreb Conference. The third was the adoption of a long-term joint approach to specific problems and the improvement of the management of national health services. The agreement on a common strategy was the fourth.

**European Targets**

WHO headquarters gave general instructions on the development of the global strategy for health for all and on the regional strategies as contributions to it (5). These instructions, of course, had been available to the RHDAC at its first meeting in 1980. The members of the Council knew that very general, rather sweeping targets would be established for the world as a whole. The main purpose of the global targets was to close the gap in health conditions between the industrialized countries and the third world: the north-south divide. This type of target, however, would present no challenge to the Member States of the European Region if they wished to improve the health of their populations by reorganizing their health programmes in the health for all spirit.

The World Health Assembly approved the global strategy for health for all in 1981 (6). As expected, most of the targets proposed (such as the
reduction of the infant mortality rate to less than 50 per thousand live births and the extension of life expectancy beyond 60 years) had already been achieved in Europe. The Region needed its own targets. These would be applicable to the Region as a whole and offer four important advantages. They would:

- act as a mirror in which countries could see the trends in health and the consequences of failing to act;
- highlight a limited number of the most important areas for development;
- give practical examples of the meaning of the strategy, making it more easily understandable to authorities, special interest groups and the public; and
- by defining indicators and including an evaluation process, enable countries to measure and compare their progress.

The first need: information
There was no political unity or even political cooperation across the Region. The Conference on Security and Cooperation in Europe (CSCE) had no permanent secretariat; some important WHO Member States long considered CSCE of very minor value, although its role is now rapidly changing. The Council of Europe covered only part of Europe and relied on WHO for technical information on health matters.

The Regional Committee had requested the Regional Office to tackle specific health hazards and organizational questions. The work of the Regional Office had broadened decade by decade, as cooperation with the Member States’ health authorities increased. Nevertheless, the Regional Office worked with specific problems, not as an overall health agency.

Now the Regional Office needed information on all types of health problem as the basis for regional targets, what Professor Abel-Smith called “a comprehensive health policy”. The Regional Office sought assistance in this task from many sources.

WHO itself created some sources of information. WHO headquarters collected statistics worldwide; of somewhat limited value, particularly as regards morbidity, they gave useful information on mortality in Europe. Most Member States had complete and reliable registration systems. Further, the Regional Office regularly organized meetings of the government officials responsible for vital and health statistics. These people and their networks were now ready and willing to help.
The Regional Office staff concerned with statistics and epidemiology benefited from contact with three institutions that for decades had organized WHO-supported statistical and epidemiological courses. The London School of Hygiene and Tropical Medicine (through Professor Donald Reid), the Free University of Brussels (through Dr Léopold J. Martin), and the Postgraduate Medical Institute of Bratislava (through Professor Jurij Cervenka) established a tradition of WHO training courses in English, French and Russian respectively. Through former students, the courses helped greatly to improve statistics and epidemiology in the Region. Numerous other epidemiological and statistical experts gave vital support to the Regional Office in creating the regional targets for health for all.

The Regional Office also had strong links with the International Epidemiological Association (IEA), sponsoring workshops during the triennial IEA scientific conferences that were held in Europe. Joint ventures included publications, (7,8) and studies.

In addition, the work of the EACMR on the coordination of research established valuable links between the Regional Office and professionals such as sociologists and economists.

The Regional Office itself gathered considerable information on health service structures, health economics, health personnel and the control of environmental health hazards. This was published in the third edition of Health services in Europe (9,10). Like the 1975 edition, it gave both a general analysis of trends in Europe and information on each country in the Region. The book is still useful reading.

Volume I provided the only comprehensive analysis of the major trends in health services available in 1981, and included suggestions for future development. The contributors to Volume I were a group of European health authorities, well aware of international trends, in addition to the special problems of their countries and the Region.

Despite the experience, partners and publications of the Regional Office, much information was still needed. It was particularly important to learn more about the influence of lifestyles on health and how individual and community lifestyles could be changed.

A new challenge
Having approved the regional strategy for health for all in 1980, the Regional Committee expected to have a new version, with targets, available for its thirty-second session in 1982, according to a plan prepared by the Regional Director. In fact, another year was needed to
prepare meaningful targets for the Region, and a second version was presented in 1984. A tremendous amount of work was done in this hectic period. Hundreds of outside experts were involved, and the task required contributions from almost all the staff of the Regional Office (in addition to their duties in carrying out the rest of the regional programme).

The Regional Office had a new challenge: proposing targets for concrete and measurable improvements in the health of the people of the Region. The targets were to be organized under the agreed broad headings of healthy lifestyles, the reduction of preventable conditions in the environment and the provision of adequate and accessible health care for all, and to include the principle of equity. The Regional Office started to act on three fronts:

- drawing on its staff and its experience in the fields in which it had been active;
- with the assistance of many Member States, building additional networks of people and institutions with the information needed; and
- starting a campaign to publicize to citizens and politicians alike the health problems needing urgent action and the regional strategy as the means of tackling them.

Public information campaign

As mentioned, most Europeans had little interest in health for all in 1977 and 1978. Members of certain groups of health professionals ridiculed the global strategy (6) as utopian. People who became familiar with the global targets understood that these had little practical importance for the European Region as a whole or industrialized countries in general. In the early 1980s, public health experts already familiar with the European strategy, however, awaited the proposals of the Regional Office. In the meantime, some of them started to develop their own national targets (as in Finland) or extended existing ones (as in Sweden).

To secure support from both politicians and the public, the Regional Office had to dramatize the need for health for all in the Region. It took the unusual step of hiring a journalist, Mr Peter O’Neill, to prepare a lively book on the health problems of the Region, based on the European strategy document. Appearing in 1982, the book was intended to enable a larger audience to participate in the dialogue as to what the real issues were, to stimulate the public debate and political decisions necessary to attaining health for all.
This direct approach to the public succeeded. The book became very popular; a second edition (11) was published in the United Kingdom in 1983, with a foreword from the Rt. Hon. Dr David Owen, MP, and a press conference in the House of Commons. The Green Party in the Federal Republic of Germany translated the book into German and distributed it along with the Party’s political proposals for health improvement from an ecological point of view. A Russian version also appeared, although there were difficulties with the book’s discussion of drinking habits. In short, *Health crisis 2000* took the European strategy into the media and the politics of several countries, and supported the technical work of producing targets and indicators in a form that all Member States would approve.

**Obtaining information and drafting targets**

Some general principles were followed from the beginning. Perhaps the most important was the requirement that the targets be realistic. The goals to be achieved by the year 2000, then less than 20 years ahead, must already have been achieved by some country or by some population group. Negative trends (such as an inevitable increase in the numbers of women with lung cancer, owing to increased smoking) were to be identified and slowed down.

In December 1980, the regional strategy, with the corrections and suggestions of the Regional Committee, was sent to governments for information purposes and national follow-up. In March 1981, a planning group met in Copenhagen. Its members included five outside experts — Mr Ron Draper of Canada, Dr Håkan Hellberg, Dr Mårten Lagergren of Sweden, Dr David M. Pendreigh of the United Kingdom and Professor Magdelena Sokolowska of Poland — who were experienced in the handling of lifestyle issues. The WHO staff in the group, starting with Dr Asvall, represented the other areas of the strategy, such as health policy, health economics, health planning, the environment, and maternal and child health.

A particularly difficult question was: what should the targets be? There were as many answers as participants in the debate. Finally, one statement brought consensus: “The targets should be a blend of today’s reality and tomorrow’s dreams”. This view required the targets to have a firm scientific basis, derived from the answers to some difficult questions, such as:

- How large is the problem?
- What are the past trends in its development?
• What will be the size and nature of the problem at the target date if nothing is done?
• How effective will the proposed action be on the problem?
• What will therefore be the situation at the target date if this action is carried out as proposed?

The planning group reported to the RHDAC meeting held at the end of March. The RHDAC approved the proposals made and asked the planning group to continue as a steering group for the preparation of the target document. The Council also supported the establishment by the Regional Director of ad hoc working groups to draft targets in selected areas.

The steering group was then supposed to finalize the document, referred to as the second version of the strategy, for presentation to the Regional Committee in September 1982. Again, this timetable was too tight for such a complex task. The Regional Committee sessions in 1981 and 1982 approved the postponement and received progress reports.

Five working groups were set up to draft targets on: healthy lifestyles, reduced environmental risks, adequate care, equity and support measures. Each worked in one area, screening and analysing the information amassed by 15 expert groups composed of about 250 scientists from 25 disciplines. Each group comprised both outside experts, the most senior of whom acted as coordinator, and the Regional Office staff member most experienced in the field, acting as focal point. In June 1982, the Regional Office gave the working groups a compilation of targets already set elsewhere (6,12–14), and detailed advice on their task. Each of the regional targets was to be:

- directed at a significant problem
- reliable (expressing a reduction of the identified problem)
- realistic
- simply and clearly expressed
- quantified as far as possible (thus making progress measurable)
- relevant to the regional strategy for health for all
- politically acceptable
- meaningful and attractive to the public, politicians, administrators and professionals.

In late 1982 and early 1983 the Regional Office staff was under continuous pressure to serve the target-setting groups, in addition to doing
their usual work. The groups met and made reports but left some questions open. To resolve these, staff had to arrange special smaller consultations or ask for expert advice from relevant institutions. A Regional Office task force was established in March 1982 to ensure the coordination of all material. Dr Asvall was Chairman, and the Programme Policy Officer, Ms Celia Celinder of the United Kingdom, served as Secretary. Dr Paul Lamarche of Canada watched over the unity of the proposals. Two outside experts, Dr Sharon Levine of Canada and Dr Kay Dean of the United States, did most of the technical editing.

The target on research posed a difficult problem. The EACMR hesitated to approve the proposals, and offered to work out a compromise. This eventually became a target on appropriate technology.

At the beginning of the process, many hundreds of targets were proposed; every expert had strong personal opinions. After the working groups reached consensus, the task force did its best to reduce the targets proposed to a manageable number. The task force scrutinized and checked the targets, working to avoid excessive detail. Former Regional Office epidemiologist Dr Zbigniew Brzeziński of Poland assisted with the collection and analysis of epidemiological data for target setting.

The First Draft

After review by the RHDAC, 82 targets in support of the regional strategy for health for all were presented to the thirty-third session of the Regional Committee. For the first time the representatives of the Member States had the promised new version before them in all four working languages. The draft provoked a lively discussion and a generally positive reaction. Criticism focused on the number of targets, their scope and how they would be applied in countries. Some countries, such as Finland, however, used the 1983 draft to continue the preparation of their long-term national plans and modified the proposed regional target structures to meet their health problems.

A Regional Committee resolution (EUR/RC33/R4) urged Member States to continue to develop or update their strategies for health for all, including the setting of targets, and gave the Regional Office instructions for the next phase, requesting the Regional Director:

(a) to continue the present analytical studies in order to arrive at final proposals for regional targets;
(b) to submit the draft proposals for regional targets (EUR/RC33/9),
together with the comments of the Regional Committee, to Member
States and to seek their written comments;

(c) to involve the regional advisory bodies, particularly the European
Advisory Committee for Medical Research and the Regional Health
Development Advisory Council, in the further development of re-
gional targets;

(d) to submit a final version of the regional target document to the
thirty-fourth session of the Regional Committee, together with a plan
of action and a list of indicators for monitoring progress towards
achieving the targets in the Region;

(e) to continue to support Member States in the formulation of their
strategies for health for all and the implementation of the strategies;

(f) to assist in intensifying dialogue between countries and groups of
countries relative to the formulation of strategies for health for all and
to facilitate the exchange of experiences and information;

(g) to inform the Director-General of the outcome of the discussions.

The Regional Office had a full year of hard work to do to meet these
requests.

The most important need was to secure the comments of the govern-
ments of the Member States. The first draft, revised in accordance with
the comments of the Regional Committee, was immediately sent to them.
The draft also required editing, the checking of epidemiological facts and
a new target on research. All of this had to be done in time for the text to
be reviewed by the RHDAC and the CGPD. Only then could it be
presented to the 1984 Regional Committee.

The consultation with governments became an important dialogue
between the drafters of the target document and the decision-makers who
could approve it for implementation in their countries. The work of the
experts was under scrutiny by the people who would put it into practice.
These included not only ministries of health and other ministries and
agencies but also subnational, independent health authorities (such as the
Länder in the Federal Republic of Germany and the cantons of Switzer-
land) and nongovernmental organizations at the national level.

In this connection, WHO documents in the German language were
especially useful in explaining the purpose of the health for all movement
in Europe to authorities in the Länder of the Federal Republic of
Germany. In fact, the movement met the greatest hesitation in this very liberal country; central planning was not accepted and health for all was felt to impose too “uniform” a pattern.

To help secure the approval of the Regional Committee for the second version of the targets, I sought advisers and potential allies. A small group met with Regional Office staff late in 1983 and early in 1984. It began with three members: Dr Enrique Najera of Spain, a critic of several aspects of the first target document; Professor D. Jakovljevic of Yugoslavia, who became the Chairman of the 1984 Regional Committee; and Professor Abel-Smith. Their suggestions were so useful that the exercise was repeated early in 1984 with an additional two “key personalities”: Professor John Reid (now Sir John Reid) of the United Kingdom and Dr Felix E. Vartanian of the USSR.

Meanwhile, the rewriting of the document continued. This simplified account refers to only two drafts of the targets: those presented to the Regional Committee. In fact, the text went through a couple of dozen versions.

In the rewriting done in the hectic year before the 1984 session of the Regional Committee, the main task was to respond to the three major criticisms of the 1983 session. First, the representatives had said that there were too many targets. Second, representatives of a group of countries, led by those of France, argued that some targets (those on the prerequisites for health, such as sufficient work, shelter, food and water for all and freedom from the fear of war) lay outside the bailiwick of WHO. Third, how were Member States to act on the targets, once approved? Implementation seemed a particularly thorny problem in federated countries (often called pluralist countries), in which responsibility for health was not located at the central or national level.

The third problem was finally solved by the 1984 Regional Committee, but the writers and rewriters of the targets largely settled the other two. The number of targets was cut from 82 to 38. The targets on the prerequisites for health were dropped, although traces of them reappeared elsewhere. Reducing the number also meant combining some targets, and turning others into goals within targets (with optimal indicators). In a sense, this made the approach more general, but it also sharpened the focus on the issues of highest priority and impact.

In addition, experts rewrote the so-called soft targets on lifestyle and worked on approaches to the problems of children and youth.

The EACMR formulated the research target as a single open-ended statement which became a starting point for a later analysis of the research
needs of the whole strategy. The target emphasized health services and behavioural sciences research. Gaps in knowledge mentioned throughout the target document, however, were recognized as areas for future study. The members of the EACMR, including the Chairman, Professor Teodor Fliedner of the Federal Republic of Germany, played an important role in keeping the door open for a broad approach and avoiding future conflict with the research community, particularly biomedical researchers. Professor Walter W. Holland of the United Kingdom (Chairman of IEA when this account was written) analysed the information requirements for the targets and indicators, and checked the validity of final text from an epidemiological standpoint. In addition, the text was edited for style.

Of course, the final proposal needed the approval of the Regional Director. I read it through, line by line, during free-time intervals at the World Health Assembly in May 1984. I tried to eliminate some politically touchy words, and to ensure that the text was balanced. For example, it was important to stress the role of the family in health promotion, which had been rather neglected in the emphasis on social networks. After making such small changes, I gave the document the go-ahead.

The next step was to finalize the document in English, French, German and Russian. Word processors enabled this to be done in the short time remaining before the Regional Committee session. The targets spelled out the meaning of the European strategy in practical terms. Would Member States approve them?

Political Change and Technical Developments

A review of some earlier developments in Europe would help to provide a backdrop to the deliberations of the thirty-fourth session of the Regional Committee.

Political and membership changes
The present rapid changes in most of the countries of central and eastern Europe make it easy to forget the dramatic series of political changes in southern Europe in the middle of the 1970s. The ending of the totalitarian rightist regimes of Portugal and Spain and the return to democracy of Greece, after a spell of military dictatorship, were still very recent history in 1984.

For a long period WHO had no technical cooperation with Portugal because of the country’s colonial wars in Africa. Portugal was a European Member State, but only a few research activities could be carried out
jointly, since no budget could be provided at the country level. After the 1975 “Carnation Revolution”, however, the new governments were eager for full cooperation with WHO, asking the Regional Office, for example, to assist in studies to establish a national health service. Primary health care became a controversial question while governments were changing. The National School of Public Health in Lisbon was active in the network of the Association of Schools of Public Health in the European Region. Portugal’s representatives at the Regional Committee became active supporters of health for all.

Spain had been an active Member State during the rule of General Francisco Franco, but the changes in internal politics after his death and the growing pressure for decentralization brought WHO into various new types of cooperation. Both the central level and the newly autonomous regions showed great interest in health for all and primary health care. Spain provided WHO with experts on lifestyle problems and community participation to assist in the preparation of the targets. Spain was eager to participate more fully, hosting the Regional Committee in 1983 and proposing candidates for Regional Director in 1981 and 1984.

Before and after a period of military rule (1967 – 1974), Greece was an active participant in WHO, hosting the Regional Committee in 1976. Greek health and medical leaders have played important parts in the Regional Committee and World Health Assembly, and supported WHO intercountry activities. In addition, the Government cooperates with its Mediterranean neighbours in, for example, environmental and zoonoses control programmes.

Further south, Algeria started to reconsider its membership in the European Region of WHO. Its political interests were increasingly linked with its leading role as a nonaligned country, and it was an active member of the Organization of African Unity. In 1984, despite some opposition from its medical profession, Algeria asked to be transferred to the African Region, and the World Health Assembly accepted this move. Algeria sent an observer to the thirty-fourth session of the Regional Committee for Europe, however, to ease the transfer of programmes.

Israel had always felt that it should belong to the Eastern Mediterranean Region of WHO. The deteriorating political situation, however, isolated Israel from participation in regional intercountry programmes if not from some programmes coordinated by WHO headquarters. Staff of the Regional Office for Europe discussed with the Director-General the possibility of offering Israel full technical cooperation in the European Region. Several Israeli experts had served as staff or consultants at the
Regional Office. Israel was an industrialized country, with a very strong research community and health problems and services similar to those of the European Region. An observer from Israel attended the Regional Committee in 1984, and the World Health Assembly approved its transfer to the European Region in 1985.

In 1984, Morocco was still an active European Member State. After hosting the thirtieth session of the Regional Committee in 1980, it participated in the development of the policy for health for all in Europe, stressing its willingness to act as a bridge between Europe and Africa through joint projects. Unfortunately, Israel's arrival in the Region complicated Morocco's position — despite its policies of international tolerance — and it opted to join the Eastern Mediterranean Region in 1986.

Algeria, Morocco and Tunisia had very similar health problems and close medical, scientific and cultural links with European countries such as France, Italy and Spain. For political reasons, however, each belonged to a different WHO region in 1985.

Three important meetings
As earlier chapters of this book show, meetings are an important tool in the work of WHO, and have various purposes. In the European Region, conferences, for example, are usually held to summarize the results of completed programmes or activities, or to take stock of progress at the midpoint. Three of the numerous meetings held in 1983 and 1984 not only accomplished their particular purposes but, as planned, helped in the preparation of the targets and of their acceptance by the countries of the Region.

The meetings — two conferences and a working group — were all related to new regional medium-term programmes. Each meeting produced a situation or trend report, a summary of related approaches in Europe, and led to further progress in its subject area. In addition the topics of the three — primary health care, planning and management, and the environment and health — were key areas for the development of health targets at the national level.

The Conference on Primary Health Care in Industrialized Countries was held in 1983 in Bordeaux, France, marking the fifth anniversary of the 1978 Declaration of Alma-Ata. The participants came from industrialized countries in the European and other WHO regions (such as Australia, Canada, Israel and the United States), and from a large number of nongovernmental organizations.
Little had changed since 1978. The Conference emphasized the future, and there were good analyses of proposed or experimental ways to expand primary medical care into community-oriented primary health care. The participants also discussed the constraints on this development in the hospital-dominated care of the industrialized world, health promotion initiatives with community participation and other important topics (15).

The Working Group on Health and the Environment met in Vienna in 1983 (see Chapter 3). The Group comprised participants from the various ministries or agencies responsible for the control of environmental health hazards. It focused on risk assessment and the multisectoral management of environmental health. The Regional Office wished to demonstrate its readiness to expand intersectoral cooperation on the international level and to support national activities in environmental health, irrespective of which ministry or agency was responsible.

The conclusions and recommendations of the Working Group (16) helped to set priorities for the work of the Regional Office in environmental health, but they were also remarkably far-seeing, foreshadowing the breakthroughs of the late 1980s and the present (see Chapter 5).

The European Conference on Planning and Management for Health took place in The Hague, Netherlands, just before the thirty-fourth session of the Regional Committee in 1984, with 100 participants from 29 countries. After the Conference, some participants went straight on to Copenhagen for the Regional Committee session. Most of the participants were professional health planners and managers, or teachers and researchers in this field. The more senior experts had been in cooperation with WHO since the 1974 Conference on National Health Planning (see Chapter 3). The participants were an eager, active group, conscious of the task ahead — implementing the new regional strategy — and particularly the national activities that would be involved.

The Conference report (17) was a good starting point for people who had to develop an overall planning framework for target-oriented projects. It defined health planning and management as comprising: “all purposeful approaches to promoting health and improving the equity, effectiveness, efficiency and quality of health systems”. The participants compared various alternative planning methods and supported the new, target-oriented thinking.

This was a watershed in the development of health planning philosophy in Europe. Thus, planning moved beyond its traditional meaning of the all-encompassing, systematic efforts characterizing communist and,
to a lesser degree, socialist countries. The meaning of the term was expanded to include any economic or other measure taken to influence development in a desired direction. This agreement signalled the breaking of a decades-old ideological deadlock and allowed countries with a market economy to plan for health for all development.

The point of departure for planning was no longer to be resources or problems, but desired outcomes: improvements in health and the reduction of health hazards. The participants acknowledged that health planning:

- had to be multisectoral
- was not bound to any specific ideology
- could be centred on the national or the local level
- should include both the public and private sectors.

This led to the start of long-term cooperation between the pluralist countries and the Regional Office.

**A Common Health Policy**

A number of factors created a willingness in the 1984 Regional Committee to reach consensus. One was the consultation of Member States in the writing and rewriting of the target document. Another was the three meetings just described, along with the other meetings of the period (including conferences on such topics as women, health and development, the prevention of cardiovascular diseases and immunization policies). All contributed to the understanding of the health needs of the European population. Third, recent political changes in countries directly influenced their willingness to cooperate with WHO. Fourth, a series of special seminars on health for all was organized for the directors-general of or the secretaries of state for health in the Member States. All these factors created a positive atmosphere for the thirty-fourth session of the Regional Committee.

The Regional Committee had to deal with several important items. From the point of view of this account, the most important was the regional targets in support of the regional strategy for health for all. This was the second and final reading of the target document in what is often called the health parliament of Europe.

The Regional Committee also had to select a new Regional Director. I had served for 17 years, “outliving” in office an average of two
generations of national directors-general and hundreds of ministers and vice-ministers of health.

Dr Asvall, Director, Programme Management, was a strong candidate to succeed me, and the Regional Committee nominated him as Regional Director for Europe early in the session. During the previous three years, he had been the driving force behind the completion of the work on the targets. Having a Norwegian to follow a Finn, of course, been noted during the “election campaign”. In principle, the Member States of southern Europe would have preferred one of their own as Regional Director. They easily accepted Dr Asvall, however, who was very well known. His nomination ensured the smooth continuation of the Regional Office’s work.

The Regional Committee had the honour of having Her Majesty Queen Margrethe II of Denmark as its guest. On behalf of the Danish Government, Her Majesty inaugurated a new extension to the Regional Office, built by the host country. She was not only present on such formal occasions at the Regional Office but also ready to sponsor some technical meetings related to women’s health.

The officers of this milestone session deserve mention. The Chairman was Professor Jakovljevic of Yugoslavia. He had great experience in WHO and, as mentioned, had taken part in the preparatory work on the target document. He was ably supported by Dr Joop van Londen of the Netherlands (Dr van Londen later chaired the World Health Assembly, thus following the other European chairmen, such as Dr Andrija Stampar, Dr Karl Evang of Norway, Sir John Charles of the United Kingdom, Professor Eugene Aujaleu, Professor Samuel Halter, and Dr Meropi Violaki-Paraskeva). The second Vice-chairman, Professor Emil Schultheisz of Hungary, was one of the “more medical than political” ministers of health found in the socialist countries, and was deeply interested in the history of medicine.

As Chairman of the RHDAC, Professor Abel-Smith introduced the targets. Dr Asvall opened the discussion by describing what the Regional Office had done to meet the requests of the previous session of the Regional Committee. He stressed that the regional nature of the targets was now clear; national targets would be the responsibility of each Member State, although they should support the regional targets.

Dr Asvall explained that the final version of the target document had the same basic ideology as that presented earlier, but with an even stronger emphasis on equity. He described the structural changes that had been made and concluded by pointing out the most fundamental question:
whether political will existed to make the change. The challenge was to make today's dreams tomorrow's realities.

In the discussion that followed, the representatives of the Member States expressed overall satisfaction with the document, particularly welcoming the reduction of the number of targets. In addition, some representatives described the work they had already done to apply the regional strategy in their countries.

One of the problems with the proposals that had caused hesitation among some of the representatives of federated countries (often called pluralist countries) was settled after lively discussion. These countries could not commit themselves to making a national plan but would apply the target-oriented strategy inside "the particular structure of their health system".

The Regional Committee unanimously approved resolution EUR/RC34/R5 on the regional strategy for attaining health for all by the year 2000 (Annex 4). The Member States thus made a common health policy for the Region. This was a new and unique achievement.

**Targets for Health for All**

The text approved by the Regional Committee and later published (18) deserves a brief description here. It starts with a policy summary describing the purposes of the text. The first is to propose improvements in health to achieve health for all by the year 2000. The text also indicates where action is called for, the extent of the collective effort required and the lines along which it should be directed. Finally, it is a tool that countries and the Region can use to monitor progress towards the goal and revise their course of action if necessary.

In addition, the policy summary lists six major themes underpinning the targets:

- equity;
- an emphasis on health promotion and the prevention of disease to give people a positive sense of health that enables them to make full use of their physical, mental and emotional capacities;
- the necessity for a well informed, well motivated and actively participating community;
- the need for multisectoral cooperation on coordinated action by all the sectors concerned;
— primary health care — meeting the basic health needs of each community through services provided as close as possible to where people live and work — as the focus of the health care system; and

— international cooperation on health problems that transcend national frontiers.

The policy summary concludes with a description of the value of health for all in the Region (18):

Success of the health for all movement will mean that all children of the Region will have a much better chance of:

— being born healthy to parents who want them and who have the time, the means and the skills needed to bring them up and care for them properly;

— being educated in societies that endorse the basic values of healthy living, encourage individual choice and allow it to be exercised freely;

— being provided with the basic requirements for health and being effectively protected against disease and accidents.

It also means that all people would have an equal opportunity of:

— living in a stimulating environment of social interaction, free from the risk of war, with full opportunities for playing satisfying economic and social roles;

— growing old in a society that supports the maintenance of their capacities, provides for a secure, purposeful retirement, offers care when care is needed and, finally, allows them to die with dignity.

... A joint endeavour of this kind by the ... Member States will not only ensure better health and a better life for people in the Region, but can also help to reduce international tension by creating solidarity and mutual support in health that will cut across political, cultural and ethnic barriers. In this way, it can be a major force in fostering greater understanding and trust among people of the Region and thus contributing to the satisfaction of the most basic need of all — peace.

The vision of the health leaders endorsing this statement can only now be fully appreciated.

Although the targets on the intersectoral prerequisites for health were removed, the text spells out the relationship to health of these
prerequisites — freedom from the fear of war, equal opportunity for all, the satisfaction of basic needs, political will and public support. This view recognizes that work to improve health cannot take place in a vacuum, because health is inextricably linked with other parts of political, social and cultural life. In addition, this limitation of the original approach had the practical advantage of easing the tasks of health ministries in monitoring progress towards health for all — they did not need to ask for information about disarmament!

The targets show the improvements that could be expected if all the will, knowledge, resources and technology already available were pooled in the pursuit of a common goal. The goals set are based on historical trends, their expected evolution and available knowledge on the probable effects of intervention. The targets are not legally binding on any Member State; they are intended to stimulate the public authorities, professional groups and the general public in every country to develop policies and programmes for health for all that are suited to their circumstances and needs.

In the second version, the targets number 38 and fall into three related groups, according to their subjects and their dates for completion. The last seven targets are to be achieved first, since they will supply the various kinds of preparatory action needed to make possible the changes specified in the second group. This group spells out the changes needed to create lifestyles (five targets) and environments (eight targets) conducive to health, and appropriate health care (six targets). The successful achievement of these 19 targets enables the achievement of targets 1–12, which describe the changes in health required to achieve health for all.

The first 12 targets call for two kinds of improvement: ensuring equity in health and strengthening health in three ways. These goals (18) are often quoted and their relative priority is under debate; nevertheless, the first group of targets is intended to:

— *ensure equity in health*, by reducing the present gap in health status between countries and groups within countries;

— *add life to years*, by ensuring the full development and use of people's integral or residual physical and mental capacity to derive full benefit from and to cope with life in a healthy way;

— *add health to life*, by reducing disease and disability;

— *add years to life*, by reducing premature deaths, and thereby increasing life expectancy.
THE 38 REGIONAL TARGETS FOR HEALTH FOR ALL

Health for All in Europe by the Year 2000

1. Equity in health
2. Adding life to years
3. Better opportunities for the disabled
4. Reducing disease and disability
5. Eliminating seven specific diseases
6. Life expectancy at birth
7. Reducing infant mortality rates
8. Reducing rates of maternal mortality
9. Combating diseases of the circulatory system
10. Combating cancer
11. Reducing accidents
12. Stopping the increase in suicides

Necessary Changes for Health for All

Lifestyles conducive to health
13. Healthy public policy
14. Social support systems
15. Knowledge and motivation for healthy behaviour
16. Promoting positive health behaviour
17. Decreasing health-damaging behaviour

Healthy environment
18. Policies for a healthy environment
19. Monitoring, assessment and control of risks in the environment
20. Water pollution
21. Protection against air pollution
22. Food safety
23. Protection from hazardous wastes
24. Healthy homes
25. Healthy working conditions

Appropriate care
26. A health care system based on primary health care
27. Rational and preferential distribution of resources according to need
28. Content of primary health care
29. Providers of primary health care
30. Coordination of community resources for primary health care
31. Ensuring the quality of services
Each target describes the improvement needed and suggests ways to achieve it. Both the problem statement and the suggested solutions are given in the most specific and concrete terms possible.

Regional indicators for all targets are listed in an annex. These allow countries to measure and compare their progress towards health for all. This list was based on many studies and publications and a series of consultations intended to discover whether each indicator was immediately usable or national authorities could find ways to obtain the necessary information to make it so in the near future. The text concludes with a plan of action for the Regional Office and Member States; this includes regular Region-wide evaluations of and reports on progress.

**TARGET 16 PROMOTING POSITIVE HEALTH BEHAVIOUR**

By 1995, in all Member States, there should be significant increases in positive health behaviour, such as balanced nutrition, nonsmoking, appropriate physical activity and good stress management.

This could be achieved if clear targets in these areas were set in each Member State, e.g. a minimum of 80% of the population as nonsmokers and a 50% reduction in national tobacco consumption, and if steps were taken by WHO and other international organizations to promote cooperation in health promotion activities throughout the Region in order to make a wider impact on basic health values.

**Conclusion**

Adopting the European policy for health for all and its 38 targets was a fifth milestone in European cooperation for health. With the adoption of a common health policy, targets for its achievement and plans for its implementation and evaluation, the Member States and the Regional Office were beginning a new era of public health in the European Region.
References


Implementing the common health policy
(1985–1990)

The adoption of a common health policy was a bold step. It was soundly based on the WHO vision of health and on the means and methods employed in more than three decades of European cooperation for health. Nevertheless, in 1985 the Member States and the Regional Office for Europe were entering uncharted territory and taking up an even more demanding task: implementation.

This chapter covers only the beginnings of this work and gives an overview of some of the types of activity that the Regional Office advocated, initiated or carried out. Although both brief and general, this overview shows that the implementation of health for all is not only a dynamic but, more importantly, a continuously accelerating process. The Regional Office coordinates and stimulates this process under the leadership of the present Regional Director, Dr Asvall, who took up his duties in 1985.

The Regional Committee continued its supervision of the work of the Regional Office and its monitoring and evaluation of the achievements of the Member States. As requested by the 1984 session, the Regional Director and the Regional Office concentrated primarily on supporting country health authorities wishing to make and act on policies for health for all. This facilitation of the establishment of strategies and then action programmes based on the health for all approach has taken many forms.

The fundamental changes required to apply the new public health in countries cannot be made quickly, but many promising initiatives were soon under way. Initially, more action and movement were seen in the fields of health promotion and health protection (including environmental health) than, for example, in appropriate care. It was easier to introduce
new and exciting projects for health promotion than to reverse long-
standing trends, even with the laudable intentions of humanizing care,
improving its quality and strengthening primary health care. Progress is
gradually being made, however, in the areas of quality of care and primary
health care and health promotion initiatives often contribute to it.

Health for all is proving to be both a flexible and a very useful tool for
the Member States of the Region, whose health problems and approaches
continuously change in the face of new political developments. One of
the most remarkable of these was the tremendous change, a real revolu-
tion, that took place, as the 1980s ended and the 1990s began, in the
countries located in the central and eastern part of the Region. The start
of democratization was greeted with joy throughout the Region, but the
process has revealed enormous problems in the countries involved,
problems of which health is only a part.

DR JO E. ASVALL

Jo Eirik Asvall was born in Norway in 1931. He obtained his medical
degree in 1956 and the degree of Master of Public Health in 1969. From
the start of his career, Dr Asvall alternated work in Norway with work
for WHO. After work in a research institute, a hospital and public health
in Norway, he trained as a WHO malariologist in Ecuador, Jamaica and
Mexico and became the leader of the WHO malaria team in Togo and
Dahomey (Benin) in West Africa in 1959. Returning to Norway in 1963,
Dr Asvall took up clinical work at the Norwegian Radium Hospital and
became increasingly involved in clinical management and hospital
administration. In 1971, he joined the Hospital Department of the
Ministry of Social Affairs, serving as its director from 1973 to 1976,
where he had a leading role in formulating a new national policy for the
Norwegian health services that was adopted in 1975. During this
period, Dr Asvall also served on several national committees con-
cerned with such issues as cancer, hospitals, research and information
systems development, and re-established contact with WHO through
the WHO Regional Office for Europe. In addition to taking several short
assignments on cancer control and health programme evaluation, he
was a delegate to the World Health Assembly and studied health
planning on a WHO fellowship. He joined the Regional Office in 1976,
serving as Regional Officer for Country Health Programming until his
appointment as Director, Programme Management in 1979. Dr Asvall
became Regional Director for Europe in 1985 and is now serving his
second five-year term of office.
Again, the regional policy for health for all has proved an excellent framework for country development. In 1990, the Regional Office took the initiative to create a new programme — EUROHEALTH — to support the development of health for all in the countries of central and eastern Europe. Helping these countries to close the health gap that lies between them and the other Member States of Europe, and to plan for a healthy future are some of the most important of the challenges involved in carrying work for health for all into the twenty-first century.

The Regional Committee for Europe: Main Concerns 1985-1990

The Regional Committee sessions of the early 1980s were occupied with the formulation and approval of the European strategy and targets for health for all, and the study of related matters such as indicators and monitoring processes. Many of the national representatives assisted the Regional Office by serving on the CGPD, the RHDAC and the EACMR. Others helped to prepare the common health policy as individuals. By 1985 this work was finished. The next task was implementation; the responsibility for this lay with the Member States and the Regional Office.

In the period 1985-1990, the Regional Committee worked in the midst of sometimes startling change, with the Region moving into a political future whose structure is not yet known. The changes that began in the USSR in the middle 1980s started a development that suddenly broke the long-standing political and military stalemate of east against west in Europe. The turn of the decade saw important changes in the political systems of central and eastern European countries and the introduction of multiparty democratic regimes. One important event — the reunification of Germany on 3 October 1990 — reduced the number of WHO’s European Member States to the present total of 31.

Conditions for the Regional Committee and the Regional Office, however, did not change until the 1990 session. The health problems of the central and eastern European Member States — which contain about half the population of the Region — only gradually became public knowledge, in the course of the monitoring of the regional strategy. These problems are quite serious; there are important differences in health between east and west, such as a gap of 5-6 years in average life expectancy. Some gaps are growing wider.
In 1990, the representatives of central and eastern European countries at the Regional Committee were people with a new type of political and health policy background. Nevertheless, they fully endorsed the ideas of health for all as a basis for health development in the new democratic conditions in their countries.

The 1990 session also resolved substantially to increase cooperation with the countries of central and eastern Europe, based on an analysis of the health and health risk factors in these countries. The seriousness of the problem stimulated quick action by the Regional Office, which reallocated funds to help meet the countries’ most urgent needs for new orientations, and worked out with the Regional Committee a longer-term plan for cooperation. In addition, it was decided that work to assist these countries would be a part of all regional programmes. The Regional Office also acted to meet emergencies, such as the tragic HIV epidemic in institutionalized Romanian children and the high maternal mortality in that country. Nevertheless, its main focus is on helping the countries devise policies and programmes that will promote health, protect the environment and ensure health systems that provide high-quality, cost-effective care.

There is also new cooperation in the west. The integration process of the European Community (EC), the new political role of the Council of Europe, the discussion of a European economic space (comprising EC and the European Free Trade Association (EFTA)) creates new scenarios and new opportunities for work in health, as well as in politics and economics. These are concerns for the future.

From 1985 to 1990, the Regional Committee’s major concerns can be said to have fallen into four categories: regional health policy matters, new or increasing health risks, regional contributions to global health programmes, and WHO administrative matters.

Regional health policy matters
Five matters of health policy are mentioned here and more fully discussed later in this chapter. Important in themselves, they show the range of the Regional Committee’s interests in health policy for the Region.

First, the Regional Committee supported the Regional Director in encouraging the Member States to apply their own policies for health for all and the regional strategy and targets. The second concern was to advise on and control the monitoring and evaluation of progress towards health for all in the European Region, and to support work to improve the regional information system.
Third, the Regional Committee turned its attention to research, management and human resource development. New approaches to all three were acutely necessary if Member States seriously wished to apply the health policies they had collectively adopted. Fourth, a topic for concerted action was selected, to provide a rallying point for action to achieve some of the targets.

Fifth, the Regional Committee approved a new format for the programme budget of the Regional Office, to align it with the regional strategy. This eased the role of the Regional Office in the implementation of health for all, made its work more transparent and goal-oriented, and, finally, increased its accountability to Member States.

**New or increasing health risks**

In addition to its traditional interests, the Regional Committee responded to new or increasing health risks, most notably those connected with AIDS and the nuclear accident at Chernobyl. The Regional Committee laid down policies for reducing the transmission of HIV in Europe. In two resolutions, adopted in 1986 and 1987, the Regional Committee first called for greater attention to the problem and then endorsed the proposed regional response. In addition, it commended the immediate and extensive response of the Regional Office to the emergency at Chernobyl, and suggested further work.

**Regional work on global programmes**

In 1985, the Regional Committee studied the analysis of immunization policies in the Region that was made at a conference held in 1984. This was the first joint analysis of such policies since 1959. The Conference analysed the Region’s achievements in the global Expanded Programme on Immunization and recommended that target 5 of the regional strategy be used to ascertain what action should be taken to correct shortcomings. (Target 5 calls for the eradication of indigenous cases of measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis and indigenous malaria in the Region.) The 1985 Regional Committee supported this approach and urged Member States to be more active.

As the 1988 World Health Assembly committed the Member States to the global eradication of poliomyelitis by the year 2000, the Regional Director presented a detailed analysis of the European situation to the 1989 session of the Regional Committee, along with a regional plan of action for the eradication of the disease. The Regional Committee
approved the plan and urged Member States to make concurrent efforts to strengthen their immunization programmes to eliminate the other diseases mentioned in target 5. The programme is now under way.

**WHO administrative matters**

In 1988, the Regional Committee approved, on an experimental basis, a new procedure for the selection of the Regional Director that had been approved by the Executive Board. The procedure used the services of an ad hoc Regional Search Group comprising eight members of the Regional Committee. Having followed the procedure, the Regional Committee nominated Dr Asvall for a second term as Regional Director in 1989. The selection procedure was evaluated and then formally accepted as a permanent mechanism at the 1990 session. This made the WHO European Region the first part of the United Nations system to set clear criteria for the selection of its top leaders.

During Dr Asvall's service as Regional Director, three men have held the post of Director, Programme Management. Dr Jean-Paul Jardel of France was Dr Asvall's immediate successor, having previously been Regional Officer for Epidemiology and Information Support. Dr Jardel was reassigned to WHO headquarters in 1987 as an Assistant Director-General. His successor was Dr Jean Rochon of Canada, who was reassigned to WHO headquarters in 1990 as Director of the Division of Health Protection and Promotion. The present incumbent is Dr I. Sergiu Luculescu of Romania, who returned to the Regional Office from the World Bank, having been Director, Health Policies and Systems from 1987 to 1988, and Regional Officer for Health Policies and Planning from 1980 to 1986.

In addition, the Regional Committee approved current administrative improvements in Regional Office documentation, such as a new format for the programme budget. Biennial budgeting had already been introduced, and the Regional Committee approves each budget two years before the start of the biennium it covers. For example, the regional programme budget for 1986-1987 was approved in 1984, at the same session that endorsed the common health policy. This budget had already been somewhat modified to serve the new approach.

These changes were completed in the budget for 1988-1989, approved in 1986. This change allowed the Regional Director to present a programme budget proposal directly linked to the regional strategy and targets.
Acting on the Common Health Policy

The historic 1984 Regional Committee resolution EUR/RC34/R5 (see Annex 4) gives the terms of reference and a plan of action for the implementation of the Region’s common health policy. The resolution requests the Regional Director to give priority:

- to activities designed to provide Member States with adequate support in working out national strategies for health for all, as well as to those developments in the Region as a whole which may facilitate attainment of the regional targets.

Support for national strategies and facilitating the attainment of the regional targets were the two key tasks. The third task, a joint responsibility of national authorities and the Regional Office, was securing all the information necessary to evaluate the implementation of strategies for health for all. Data related to the global and the essential regional indicators were particularly important.

In 1985, these three tasks formed the immediate challenge facing the new Regional Director. Dr Asvall pinpointed three ways for the Regional Office to promote health for all in Europe:

- promoting the reformulation of health policies and programmes in each Member State to orient them towards health for all;
- through research and development, finding better methods and approaches for countries to apply in order to promote healthier lifestyles, a healthier environment and a better functioning health care system; and
- expanding and working with networks of key partners.

The Member States were receptive. The first evaluation of work for health for all in the Region, completed early in 1985 (1), showed that countries were willing to support and begin to apply the regional strategy. Accordingly, the Regional Office took action in four areas, briefly sketched here:

- leadership through advocacy;
- supporting the development of strategies and action programmes in countries;
- facilitating the attainment of the regional targets; and
- adjusting the regional programme within the framework of the targets.
Leadership through Advocacy

As mentioned in Chapter 4, some Member States had started to prepare national strategies for health for all before the approval of the regional targets in 1984. Influenced by WHO, most such countries started to adapt existing national long-term plans (covering 5–10 years) to take account of the key principles of the regional strategy and the 1983 draft targets. This influence, of course, worked both ways. The experience of these Member States was one of the influences — along with the goals set in such countries as Canada and the United States — on the regional targets on disease prevention and health promotion.

The Regional Director maintains regular contact with health decision-makers by inviting them to the Regional Office, through visits to countries and through meetings of the Regional Committee, the Executive Board and the World Health Assembly. This allows him to explain and promote the regional programme. As Director, Programme Management and Secretary of the RHDAC, Dr Asvall had realized the value of a multidisciplinary approach, with the involvement of political and economic experts, in health for all. As Director, Programme Management and later as Regional Director, he therefore initiated a series of meetings to advocate and explain how to implement strategies for health for all in Europe.

Four meetings were held during the period 1982–1986; they were called European seminars for leading public health administrators on health for all. The idea was for the top health leaders from countries in one part of the Region to meet together in another part. They would discuss their own, rather similar problems in a Member State with somewhat different health problems or another socioeconomic approach to the organization of health services. In addition, speakers at the meetings would include experts from sectors outside health, such as political scientists and experts in management. These seminars were a useful adaptation of the early travelling seminars (see Chapter 2).

The first seminar was held in Antalya, Turkey in 1982, for health leaders from northern and western European countries. The topics discussed included health scenarios, appropriate health technology, health policies and research, intersectoral collaboration, lay care and a case study on the development of national health policy in Turkey.

The second seminar was held in Oslo in 1983, and the first draft of the regional targets was available to the participants. The issues therefore were the regional strategy and targets, the future development of
biomedical research, and four issues particularly relevant to countries in the southern part of the Region: primary health care, drinking-water and sanitation, essential drugs and quality control, and the functions and organization of ministries of health. A case study on Norwegian health development was presented.

The participants at the third seminar, which was held in Corfu in 1985, came mainly from eastern European countries. They discussed issues introduced by the regional strategy and targets, including: alternative scenarios for lifestyles and health, health promotion, quality assurance for care, and the use of health economics in formulating and evaluating health strategies. In addition, the role of research, health personnel and health ministries in policies for health for all was analysed, and a case study on Greece was presented.

The last of this series of seminars was held in Shannon, Ireland in 1986. Participants from Canada and the United States joined those from countries in northern and western Europe. The issues again included health research and the appropriate use of technology. The seminar examined experience with health promotion from the western shores of the Atlantic, as well as European experience with the prevention of noncommunicable diseases. A discussion of national policy-making for health for all was held, based on a case study on a draft national health for all policy for Ireland.

The Member States highly appreciated these seminars, which linked national health administrators, international experts and Regional Office staff in teamwork to implement the regional strategy. This was one of the many implementation activities intended to have the additional benefit of creating or enlarging a network of WHO partners. The seminars enlarged the network of leading public health administrators with personal knowledge of and commitment to health for all. These people were now ready to cooperate with the Regional Office and many took decisive national initiatives in support of health for all. Other networks were built and old ones, particularly those built through the long-term programmes, were reactivated.

Supporting Strategies and Action Programmes in Countries

The Regional Office gave priority to encouraging and supporting the formulation of policies for health for all in countries, and to observing and
learning from countries that had already begun to apply such policies. This task involved not only Regional Office staff — who were very limited in number — but also many experts and administrators from the countries taking the lead in this process. A planning conference held in the Netherlands mobilized many such experts, as did the advocacy activities just mentioned. The Regional Office and a majority of Member States then began intensive consultation and negotiations.

By the end of 1987, 10 countries had a health policy document related to health for all: Bulgaria, Finland, the German Democratic Republic, Hungary, Iceland, Ireland, the Netherlands, Poland, Sweden and Yugoslavia. Some of these, such as Iceland, took further time to finalize their documents. In addition, support was given to the policy for health for all by the Government and the Federal Health Council of the Federal Republic of Germany. By 1989, seven other countries had joined the movement. Norway published its policy, proposals were submitted to the Parliament of Spain, Turkey finalized the first draft of its policy document, Albania incorporated the principles of health for all into its new five-year development plan, Malta decided to push on the development of a national policy, Israel was working on the formulation of a national plan for health for all, and the Parliament of Denmark approved a policy document called “Roads to health for all”. By the end of 1990, England was developing a target document, while five Swiss cantons, one German Land and several Spanish provinces were working along similar lines, and Andorra and one Belgian community were contemplating doing so. Also in 1990, the central and eastern European countries with new democratic governments renewed their commitment to health for all by agreeing to cooperate with the Regional Office in reformulating their national policies.

During the 1989 session of the Regional Committee, which was held in Paris, the French Government issued an extensive analysis of the health situation in France and linked it to the 38 regional targets.

The initial hesitation of the “pluralist countries” to adopt health for all was mentioned in Chapter 4. They were concerned about how they could apply a national target system. Between 1985 and 1987, the Regional Office established contact with these countries through a series of meetings. In September 1988, people from eight pluralist countries, including ministers of health, senior public health managers, presidents of medical associations, trade union leaders and representatives of health insurance organizations, met to discuss future health policy. They fully agreed that health for all was the best basis for their countries’ health policies. This opened the door for requests from the Federal Republic of
Germany and Switzerland for cooperation with the Regional Office in developing health for all policies at the subnational level.

In addition, provinces or counties in a number of countries have shown particularly strong interest in health for all policy-making. It is worth mentioning, as a curiosity, that Andorra, which is not a WHO Member State, produced the first draft of a health for all policy after consulting the Regional Office. This was the first health policy ever developed for its population.

Finally, many organizations of public health professionals, such as the Faculty of Public Health Medicine in the United Kingdom, have embraced the regional policy for health for all and some have sponsored target-oriented activities.

FINLAND: A PIONEER IN POLICY FOR HEALTH FOR ALL

A review of events in one Member State may serve as an example of the process in others. As mentioned in Chapter 4, Finland was one of the first Member States formally to adopt the regional strategy for health for all and to use the target approach in its national health planning. The Ministry of Social Affairs and Health used the 1983 draft of the targets as background for the formulation of a Finnish plan for health for all. The Finnish Parliament approved the plan, in the form of a health policy report by the Government, in 1985. In 1988, Finland hosted a Meeting on National Health for All Policy Formulation and Implementation. The participants took stock of experiences in the development of policies for health for all in various countries, and critically assessed the making and implementing of such a policy in Finland.

WHO and the Government agreed in 1989 to an evaluative independent review of Finnish health development and the extent to which it has truly followed the philosophy of health for all. Accordingly, WHO set up a group of leading European health experts that took up this task in 1990. Of course, the review is expected to benefit Finland by evaluating the progress made. In addition, it is hoped that other countries will learn from Finland's experience about the issues and problems of making and carrying out policies for health for all. The report on the review, which is expected late in 1991, can be the focus for in-depth policy discussions between Member States. Further, the review offers the Regional Office the chance to learn more about the process of health policy development in countries and how to conduct high-quality, in-depth policy studies for Member States. This type of analysis could also give the Regional Office a better understanding of the needs of Member States and thus assist in the tailoring of regional programmes to their needs.
Flexibility is one of the strengths of the regional strategy for health for all. It was designed to furnish a framework for health development that Member States could adapt to their particular characteristics and circumstances. Given the diversity of the countries of the Region, the speed and breadth of the development of policies for health for all are a remarkable proof of their flexibility and usefulness. As this sketch of events from 1985 to 1990 shows, many people have contributed to such policymaking in a variety of ways and at a variety of levels. This progress is continuing.

Monitoring and Evaluation of Progress towards Health for All

Indicators to monitor progress towards achieving health for all were developed in parallel with the regional targets. Preparations began with the drafting of the proposed European strategy in 1980. Throughout the formulation and adoption of the common health policy, regional indicators remained a constant concern of not only the health leaders representing their countries on the Regional Committee, but also their advisers, the people who had to do the work of collecting the information needed. Because monitoring was an important part of both the global and regional strategies, information had to be sent to the Regional Office and to WHO headquarters for use in a uniform evaluation process that would result in a new type of report on the world health situation. A regional evaluation would be prepared as a summary of the national reports.

This part of the common health policy was prepared as carefully as the others. The indicators and monitoring process were discussed in briefing sessions during or in connection with the Regional Committee sessions of 1980-1984 to prepare Member States to use them. The epidemiological information collected for the formulation of the targets was also the baseline material for indicators. An expert group met to finalize proposals for the 1984 Regional Committee. The nature of the indicators was made clear; they were trend indicators for use in monitoring progress towards the achievement of the regional strategy.

Like the targets, the indicators first proposed had been too numerous. In 1984, the RHDAC advised that the number of indicators per target be decreased. This was done; the 150 essential indicators of 1983 were reduced to 65. Several criteria were used in selection, including: the relevance of the indicator to the target, the availability of data in most countries, and problems that might arise in data collection if special
surveys were necessary. The World Health Assembly had already accepted the need to monitor progress on 12 basic global indicators; to ensure consistency with the global instrument for data collection, the global indicators were included in the regional set.

The Regional Committee approved the list of proposed indicators and urged the Member States "to give special emphasis... to information systems in order to ensure coverage of the lists of global and essential regional indicators" (see Annex 4). This decision established the principle of full transparency among the Member States. This meant that the results of countries' work to improve health would be clearly visible to them and others, and that they would be obliged to evaluate their national policies. The evaluations in central and eastern European countries were particularly revealing.

Monitoring and evaluation are part of the continuing and dynamic process of implementing health for all. They require data on a very broad range of health-related activities in society, changes in the behaviour of individuals and communities. Data collection had to be reorganized to meet this need, and the regional monitoring reports have demonstrated that this is a great challenge for national statistical systems.

Most countries had started or completed the collection of information for the first global evaluation during the period in which the regional targets and indicators were approved and published (2). The 1985 Regional Committee discussed and endorsed a draft report of the results. Unfortunately, not all countries had replied within the time limit, and the Regional Committee noted the difficulties in obtaining information in countries and urged the Member States to promote research to improve information systems, to permit the collection of relevant data. The final version of the report was published in 1986 (1).

The monitoring and evaluation challenge showed many health authorities how little they still knew about health, despite complete information on mortality and hospital morbidity. It also demonstrated to the experts how much research was needed to elucidate the relationships between human behaviour and health.

The first regional monitoring report was released in 1989. The information was incomplete for several indicators as it was unavailable at the national or local level in some countries. Nevertheless, the report (3), released in 1989, gave a clearer picture of both health trends (compared with a historical year such as 1980) and the constraints in data collection on the national level. Some targets, especially those to be achieved throughout the Region by 1990, would not be reached. Still, several
Member States were obtaining promising results. It was too early to know how much was due to continuously favourable conditions in the countries and how much to intensified activity based on the regional strategy.

A new monitoring report will be presented to the 1991 Regional Committee, based on indicators that have been continually refined since 1984. In a similar way, the experience gained and the results of regional evaluations have led the Regional Office to update the targets, to improve their usefulness to Member States. Revised targets for health for all will be submitted to the 1991 Regional Committee.

Facilitating the Attainment of the Regional Targets

Events have also moved quickly, and in a number of ways and sectors, in work to facilitate the attainment of the regional targets. The first step was to change the format of the programme budget, to show how every activity contributed to the goal. In addition, many activities were developed to widen the understanding and acceptance of the philosophy of disease prevention and health promotion that was necessary to the implementation of health for all. Here, too, advocacy has been a vital tool in a number of areas, such as health promotion, healthy public policy, a healthy environment and people’s participation in their own care.

Advocacy has been equally important in the mobilization of networks of professionals in health, the mass media and politics at the international level. Creating a public opinion favourable to health for all has meant not only building such networks but also linking them at the national and other levels through various activities. The 1984 Regional Committee may not have fully realized the forces in industrialized society that its decision would involve in health!

Health promotion

As discussed in Chapter 3, health promotion gradually became important in the work of WHO in Europe. Three factors made it even more popular as an interdisciplinary movement in the late 1970s and early 1980s. First, epidemiological studies — including those made in 1982-1983 by the Regional Office on health development in various Member States of the Region — gradually convinced health authorities that the social and economic behaviour of individuals and communities could either damage or improve health. Second, the cost of medical care, especially hospital-dominated, high-technology care, started to reach levels that worried
economists and politicians alike. The oil crisis in the middle 1970s had led to policies of austerity and the wish to decrease public spending. Third, people were dissatisfied with the care available. The huge investment gave back only marginal improvements in health. Hospitals were like factories and treated patients as products, rejected if dying and considered unimportant if old. The needs of women were often neglected, and medical care offered little to people with alcohol or drug problems. These factors, of course, also provided the rationale for the adoption of the regional strategy and targets.

After the recognition of health promotion as a theme of health for all, the next step was to define this tool and its usefulness in the implementation of health for all. The WHO Director-General and the Regional Director supported the idea of an international conference to supply these definitions. Accordingly, the Director-General asked the Regional Office to organize on his behalf the International Conference on Health Promotion — the Move towards a New Public Health, which was held in 1986 in Ottawa, Canada.

The Conference spread the news of the usefulness of health for all to the needs of industrialized countries and defined health promotion, in the well known Ottawa Charter for Health Promotion (4), as the process of enabling people to increase their control over and thereby improve their health. The Charter called for action in five areas:

- building health public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.

The Ottawa Charter extended partnership for health promotion and health for all to the rest of the industrialized world. New links were made, through the participants and their networks, with, for example, universities, public health associations, women’s associations, health research units and local health authorities. In addition, the Charter was followed by similar charters and declarations on a number of other topics. The signatories of these documents, like those of the Ottawa Charter, endorsed health for all and chose principles and priorities for action in the areas concerned.

The success of the Ottawa Conference inspired a follow-up meeting on healthy public policy, which was also organized by the Regional Office on behalf of the Director-General. People from 42 countries attended the
Second International Conference on Health Promotion — Healthy Public Policy, held in April 1988 in Adelaide, South Australia.

Both conferences were strongly supported by the top health leaders of the host countries and the Director-General, in addition to the Regional Director. Dr Mahler was active at both, and Dr Hiroshi Nakajima of Japan attended the Adelaide Conference as WHO Regional Director for the Western Pacific before taking up his duties as Director-General later that year.

I, too, attended the two conferences, and felt that it saw the emergence of well educated, independent-minded women into the health policy arena. Such people are relatively free to act in the so-called western countries. More time may still be needed before the women of developing countries can form similarly independent, active groups. Will a future WHO director-general or regional director be a woman? I think that could speed up change in global attitudes.

Before 1989, socialist countries were hesitant about decentralized approaches. People from these countries were not really active in regional work on health promotion or at the conferences. The exception was Hungary, which had already taken steps to integrate the regional health promotion project into its health services.

Although most of the participants at the Adelaide Conference came from industrialized countries, some were from developing countries. Case studies on health promotion were presented and covered both types. Despite the emphasis on developed countries, the regional health promotion programme moved on to the world stage at Adelaide. The Conference defined healthy public policy as policy (in any sector) that includes an explicit concern for health and equity, and acknowledges accountability for its effects on health. The participants also recommended areas for action (5).

The two conferences started to build consensus on concepts in health promotion and offered a forum for the presentation and discussion of health promotion initiatives. A third conference in this series, on environments supportive of health, will be held in June 1991 in Sundsvall, Sweden.

Health promotion is the subject of one Regional Office programme (6) and central to many others, such as the two programmes discussed in the following sections. These two also share another important characteristic; they were designed as “vehicles”, to carry the message of health for all to defined user groups. Experience has shown that this characteristic has appeared in numerous other programmes, as well.
Healthy Cities project

Evaluation (1) and the experience of the Regional Office staff in health policy and health promotion showed that work at the local level, the level at which the people of the community could participate, could be particularly effective in promoting health and acting on the principles of health for all. In addition, concentrating on a setting for action rather than a particular problem would avoid the risk of fragmentation and allow intersectoral action to tackle all important local health problems on the spot. This was the thinking behind the Healthy Cities project.

The Regional Office launched the project in 1986 to strengthen the implementation of the regional strategy for health for all at the municipal level. It is intended to strike a balance between a political goal — putting health high on the social and political agendas of cities — and a technical goal of promoting action and changes in structures, organization and budgetary processes that will improve health in cities.

The project has proved politically relevant and widely acceptable to local governments. Thirty cities in nineteen countries deal directly with the Healthy Cities project office in the Regional Office. The project has also attracted over 300 cities in the European and other regions. They are organized in national Healthy Cities networks that are linked to WHO and the project cities through national networks. In short, the project comprises a rapidly growing movement, and more project cities are expected to be designated in 1991.

The main purpose is to create a pattern of healthy public policy at the local level. Such policies enable cities to experiment with ways to promote health by improving the urban environment. They also open entry points for a number of other Regional Office programmes. The multi-city action plan, in which groups of cities combine to address topics of common concern, is already involving the regional programmes on such topics as aging, tobacco, accidents, AIDS, housing, nutrition, mental health and hospitals.

The most recent demonstration of the commitment of local political leaders to the project is the Milan Declaration on Healthy Cities (7), made in April 1990. In the Declaration, the mayors and senior political representatives of the WHO project cities pledged their active support for the principles of the Healthy Cities project: the regional policy and targets for health for all, healthy public policy, sustainable development, equity, intersectoral action and accountability. The signatories also pledged to take action to ensure the effectiveness of the project in their cities. They concluded by recognizing “health and its maintenance as a major social
investment”, and the importance of the Healthy Cities project in solving ecological issues of people’s way of living, and urging other cities, throughout Europe and beyond, to participate.

Statements such as the Milan Declaration, of course, are the most easily visible part of the project. Behind them lie numerous initiatives made by municipal administrators and the activities of many voluntary citizens’ groups.

Of the countries in central and eastern Europe, Hungary has led the way in accepting Healthy Cities activities. These could become a means to improve health in the other countries, whose new political cultures allow more independence and initiative at the local level. The project’s intersectoral approach could also benefit the developing countries in which structurally advanced district systems of health care are emerging.

A recent review of progress (7) shows that the Healthy Cities movement has rapidly gathered new forces and resources to promote health. The project is one of the most promising applications and of the principles of health for all at the grassroots level of society and of the healthy public policies advocated by the Ottawa Charter.

Countrywide integrated noncommunicable disease intervention (CINDI) programme

The CINDI programme takes an integrated, comprehensive approach to the prevention and control of noncommunicable diseases, specifically cardiovascular diseases, cancer, diabetes, mental ill health, chronic respiratory diseases and accidents. Besides being the most important causes of morbidity and premature mortality in the Region, these health problems are closely linked to lifestyle and the environment, and they share a number of risk factors: smoking, unhealthy nutrition, alcohol abuse, physical inactivity and psychosocial stress. The main objectives of the CINDI programme (8) are to establish effective collaborative mechanisms and methods to reduce the common risk factors.

The programme is concerned with applying existing knowledge and developing and testing new approaches to control risk factors or prevent their development. This requires:

— work with clinical health services on primary and secondary prevention;
— health promotion and health education to help people adopt new behaviour patterns; and
— mobilizing the community and sectors other than health to act to support healthy behaviour.
In collaboration with the Division of Noncommunicable Diseases at WHO headquarters, the Regional Office for Europe sponsors the programme, provides some equipment and supplies, and organizes international coordination meetings.

The CINDI programme is the heir of the regional long-term programme on cardiovascular diseases, the North Karelia project and their successors (see Chapter 3). Thus its constituency has tended to be somewhat more medical than those of the other programmes discussed here. Physicians have given the programme invaluable assistance and the programme won immediate support in central and eastern Europe, where health promotion was slow to win acceptance.

Nevertheless, CINDI represents the resolution of an earlier, rather sharp difference of opinion. On the one hand, health promotion experts demanded changes in communities' lifestyles and rejected the idea of blaming individuals for health problems influenced by social factors. On the other hand, the initiators of CINDI focused on the individual and the disease. Today, the programme combines these approaches. It is accepted as an effective tool in work towards achieving the targets on improvements in health. In 1990, 15 countries had CINDI programmes, involving numerous centres in a wide range of activities and collaborating with the Regional Office and each other.

The Regional Programme within the Framework of the Targets

This section discusses work that is outstanding in many ways. Although the programmes address different topics and targets, they share some important characteristics. For example, the success of each shows its usefulness to Member States, and, while each grew from earlier work by the Regional Office, all make important contributions to achieving health for all. More, each delivers the message of health for all particularly clearly by demonstrating some of its most important themes, such as health promotion, a comprehensive approach, intersectoral action and international cooperation.

These programmes also hint at the remarkable diversity of regional programmes, which are too numerous to discuss in detail here. Naturally, some regional activities are developing further and others are losing importance as needs change.

Some of the regional activities related to the targets deserve special mention. They show some of the variety of the work of the Regional
Office and, in most cases, contribute to the achievement of targets in different groups: health for all, healthy lifestyles, healthy environment, appropriate care, and research and health development support. Funds are allocated to each target area. While a reduction in deaths from cancer, for example, is specified in the first group of targets, work to achieve this involves improvements in lifestyles, the environment and health care. The following are some examples of how programmes are adjusted to work within the framework of the target structure. They act on the principles of health for all and employ methods ranging from advocacy to direct technical involvement. They are an important part of the implementation of the regional strategy.

**Health for all in Europe**

**Equity**

The large differences in health between and within Member States show the need for greater emphasis on equity in health. It has a long history in public health movements and tremendous importance for global development. The adoption in 1984 of equity by the Regional Committee as the focus for the first of the 38 targets signified a turning point in political will.

In the European Region, the differences in health between social classes and the effects of factors such as unemployment on health led to regional projects for equity in the late 1970s. These have continued, and the concept of equity has been more precisely defined in an excellent discussion document (9). Intended to spark wide debate and thus action on the issue, the document explains that inequity in health refers to differences in health status that are unnecessary and avoidable, gives working definitions of inequity in health and health care, and includes clear principles for action. The document stresses the importance of action at all levels and by all sectors in solving problems of inequity.

**Healthy aging**

As mentioned, health care of the elderly was the subject of a regional and then a well established global programme even before the approval of the targets. After 1984, however, the programme seemed to fall between several targets, and the regional indicators did not pay special attention to the health of people over 65 years old. The targets intended to add life to years and years to life and those on appropriate care were all applicable to the elderly. (These problems will be solved if the forty-first session of the Regional Committee adopts the new, updated version of the regional
targets (10), which includes a special target for the elderly.) Despite these
difficulties and the return of the global elements of the programme to
WHO headquarters in 1989, the programme remained very active (11) in
its new guise of elderly, disability and rehabilitation. Between 1984 and
1988, the programme concentrated on collecting demographic and epidemi-
ological data and evaluating and using them to support policies for the
elderly in the health and social sectors, and giving guidance on the
implementation of health policies for the elderly on such topics as
personnel development, health facilities, patterns of care delivery and the
regulation of health care (12).

Interest in the topic has grown as the elderly increase in numbers and
longevity. Both the Regional Committee and the Regional Office have
responded to this concern. Healthy aging was the topic of the tech-
nical discussions at the 1990 session of the Regional Committee (13) and
will be the focus of the programme until 1995. A variety of activi-
ties will be aimed at reducing the functional dependency of the elderly
due to the deterioration of their health and their social and economic
status (14).

Lifestyles conducive to health

Tobacco or health

A Regional Committee resolution (EUR/RC35/R7) of 1985 endorsed the
proposal of a campaign to increase the awareness of the regional health for
all policy by taking concerted intersectoral action throughout the
European Region on one important health problem. The next step was to
choose the problem. Three were proposed: the eradication of measles, the
control of cardiovascular diseases and action against tobacco. Measles
was considered too limited and too “easy” a target; it would be eliminated
in any case. The control of cardiovascular diseases, on the other hand, was
too complex a task to show quick results. Smoking, however, was a
lifestyle issue of growing concern in the Region and known to make a
significant contribution to premature mortality. For example, 100 million
of the 850 million people in the European Region are expected to die from
diseases caused by their smoking habits.

For these reasons, the 1986 Regional Committee chose tobacco or
health as the theme for the campaign to promote the health for all policy.
In 1987, the Regional Committee adopted a five-year Action Plan on
Tobacco. With strong backing from the Regional Office, the tobacco
or health programme attracted growing support from partners that in-
cluded health authorities, intergovernmental and nongovernmental
organizations, and organizations of health professionals. In November 1988, representatives of all the Region’s Member States met in Madrid at the first European Conference on Tobacco Policy. The Conference became a “summit meeting” that provided a unique blend of scientific fact, lively debate, stimulating panel discussion and finally a clear blueprint for action (15).

This blueprint was based on a Charter against Tobacco, outlining six fundamental “rights”.

- Fresh air free from tobacco smoke is an essential component of the right to a healthy and unpolluted environment.
- Every child and adolescent has the right to be protected from all tobacco promotion and to receive all necessary educational and other help to resist the temptation to start using tobacco in any form.
- All citizens have the right to smoke-free air in enclosed public places and transport.
- Every worker has the right to breathe air in the workplace that is unpolluted by tobacco smoke.
- Every smoker has the right to receive encouragement and help to overcome the habit.
- Each citizen has the right to be informed of the unparalleled health risks of tobacco use.

On this basis, the Conference drew up 10 strategies for a smoke-free Europe.

1. Recognize and maintain people’s right to choose a smoke-free life.
2. Establish in law the right to smoke-free common environments.
3. Outlaw the advertising and promotion of tobacco products and sponsorship by the tobacco industry.
4. Inform every member of the community of the danger of tobacco use and the magnitude of the pandemic.
5. Assure the wide availability of help for tobacco users who want to stop.
6. Impose a levy of at least one per cent of tobacco tax revenue to fund specific tobacco control and health promotion activities.
7. Institute progressive financial disincentives.

9. Monitor the effects of the pandemic and assess the effectiveness of countermeasures.

10. Build alliances between all sections of the community that want to promote good health.

Thus, the Conference gave to the European Member States, WHO and other intergovernmental organizations, and nongovernmental organizations a comprehensive and up-to-date strategy to reduce tobacco use. Such reductions would help to achieve regional target 16 (see Chapter 4).

Mobilizing countries and institutions to implement national programmes accordingly is the current challenge. The Action Plan is intended to help countries create comprehensive tobacco control policies and programmes that use a wide range of health promotion measures to promote nonsmoking and smoke-free environments, and to help people stop smoking. The programme offers ideas for intersectoral action in all these areas (16).

Part of this work is to keep the issue of tobacco or health in the public eye. The Regional Director was a party, along with Olympic officials and government officials at the local, regional and national levels in Spain, to an agreement that the 1992 Olympic Games in Barcelona will be smoke-free.

**Nutrition**
While better nutrition has an environmental aspect — food safety — the regional programme on nutrition concentrates on health promotion and lifestyle measures. It publicized the link between diet and health and countries’ efforts to improve nutrition (17), and evaluated methods of assessing people’s diets (18). This work was an important part of the programme’s advocacy of comprehensive, intersectoral nutrition policies, in addition to the existing policies on food.

With FAO, the Regional Office organized the First European Conference on Food and Nutrition Policy. Held in Budapest from 1 to 5 October 1990, the Conference was the scene of many interesting events. One of these was the merger of two national delegations in the middle of the week, owing to the reunification of Germany. The main business of the Conference, however, was the discussion of the current status and future development of food and nutrition policy, and a framework and options for action (19).
AIDS
Regional work to combat AIDS provides an excellent example of cooperative action against a serious health problem. The Regional Office alerted the Member States to the threat of the disease in 1983, and moved quickly in 1984 to establish common surveillance mechanisms and a WHO collaborating centre in Paris to report on its spread. The Regional Office also prepared the first WHO guidelines on AIDS in 1985 (20). The regional work began within the programme on communicable diseases, but became a branch of the Global Programme on AIDS when this was later set up by WHO headquarters. In the absence of a vaccine, health promotion is the most effective way to combat the disease, so AIDS is now considered primarily a lifestyles issue and the programme therefore became a part of the Lifestyles and Health Department of the Regional Office.

The programme works in many areas and with an astonishing range of partners. It offers individual countries assistance — ranging from expertise and equipment to some funds — with their programmes on AIDS. Its research and development activities focus on:

- health promotion measures (including the annual World AIDS Day on 1 December) to help people protect themselves against the disease (21);
- social and behavioural issues, concentrating on a group at special risk (injecting drug abusers) and on combating discrimination; and
- care management issues, promoting the establishment of networks of comprehensive care and support services.

In addition to cooperation with WHO headquarters and hundreds of organizations of all kinds concerned with AIDS, the programme is a particularly good example of cooperation within the Regional Office. Its staff work particularly closely with those of the programmes on sexuality and family planning, mental health, the abuse of psychoactive drugs (22) and nursing, midwifery and social work. The programme is also active in the multi-city action plan of the Healthy Cities project.

A healthy environment
As a global organization, WHO has always worked to eliminate health hazards from the environment, whatever their nature or location. On the global level, a safe water supply, the treatment of sewage and disposal of waste are as important to public health as immunization programmes. In
Europe, the environmental health problems created by industrialized society have been as high a priority in regional programmes as more medical or sociomedical problems.

The experience gained from earlier environmental programmes was used in the formulation of the common health policy and the regional targets, eight of which describe the changes necessary to create environments conducive to health. During the period 1985–1990, the Regional Office built a growing understanding of the link between human health and the environment and a broader basis for intersectoral action.

Although environmental issues receive much attention from politicians, the mass media and the public, it remains difficult to ensure that the effects of the environment on health secure sufficiently high priority. The problem is a familiar one to WHO. In most countries, the power to act on the environment lies outside the health sector, with new ministries for the environment or groups of ministries or agencies.

Solid intersectoral cooperation at the international, national and local levels is as necessary to systems to protect human health as it has been difficult to achieve. The Regional Office helped lay the foundation for such cooperation by organizing a meeting of ministers and other senior representatives of environment and health administrations, as well as a member of CEC. This was a momentous event: the First European Conference on Environment and Health. The Conference was held in Frankfurt-am-Main in December 1989, and the ministers adopted the European Charter on Environment and Health. In addition, as a formal participant at the Conference, CEC adopted the Charter to guide future action by the European Community on the many environmental questions for which it is responsible. This was an important step towards achieving regional target 18, which urges Member States to make multisectoral policies (2):

that effectively protect the environment from health hazards, ensure community awareness and involvement and support international efforts to curb such hazards affecting more than one country.

What does the Charter (23) cover and what is its main message? Having been approved by ministers of environment and of health, it is a powerful instrument for change. Some of its clauses go surprisingly far in the direction of more comprehensive management of environment and health. Its principal achievement, however, is perhaps the marshalling of all the various policy and strategic elements involved in such management to form a package that encompasses all sectors of society and many disparate fields of endeavour.
The Charter spells out both the entitlements and responsibilities of many groups: individuals, all sectors of society, government and public authorities, public and private bodies, the mass media and nongovernmental organizations. It also gives 14 principles for public policy. One of these has already provoked considerable discussion (23): "the health of individuals and communities should take clear precedence over considerations of economy and trade". Six strategic elements are discussed and the point is made that "the environment should be managed as a positive resource for health and well-being". The Charter concludes by pointing the way forward, listing priorities for action. These priorities include issues of both global and local significance, such as safe water supplies, air quality and the disposal of hazardous waste.

The Charter has been widely disseminated and taken up by both governments at all levels and a range of nongovernmental groups. Action has already begun. By adopting the Charter, the Member States of the Region pledged to take all steps necessary to reverse negative environmental trends, and they now face the challenge of reporting on their success to a second ministerial conference, which will be held in Finland in 1994. In addition, countries and WHO have acted on an idea promoted by the Charter by developing a WHO European Centre for Environment and Health as a fully integrated part of WHO's work in the Region. With funds provided by Italy and the Netherlands, units are being set up in Rome, Bilthoven and Copenhagen. As a first priority in its work, the Centre will emphasize mapping and monitoring the environmental health situation throughout the Region, in addition to helping to solve the many health problems resulting from environmental degradation in countries, not least those of central and eastern Europe.

In addition to building international and intersectoral cooperation on environment and health through the European Charter, a number of programmes are making important contributions towards environments conducive to health. Among other activities, they have given useful guidance to countries on such issues as air quality (24), food safety (25), nonionizing radiation (26) and occupational health (27).

Such work results from careful planning and effort over a long period. The Regional Office has also worked to handle the problems arising in the wake of unexpected events, natural and technological disasters. As mentioned earlier, the Regional Committee praised the quick and effective response to one such disaster, the nuclear reactor accident at Chernobyl, USSR.
Immediately after receiving news of the accident, the Regional Office organized a special team of staff and other experts to respond to the emergency. The team quickly prepared guidelines, answered queries and collected, analysed and disseminated data to keep Member States informed, to guide their responses and to inform the public. The Regional Office was in a strong position to act, on the basis of its long-term programme on environmental health, which included work on the effects of ionizing radiation.

On 6 May (10 days after the accident), 10 experts attended an emergency meeting at the Regional Office to advise on appropriate countermeasures. Their findings were announced at a press conference held on the evening of the same day, and the Regional Office issued their report four days later to both the Member States and the delegates at the World Health Assembly. The report supplied facts on which discussion could be based, and allayed panic.

Later, when the Regional Committee met and discussed the accident, it commended the work of the Regional Office and requested that a special project on the public health response to nuclear accidents be established. The project reviewed the experience gained from Chernobyl, stimulated long-term studies and provided guidance on a harmonized public health response system in the event of another accident with transfrontier consequences (28). Work continues in scientific meetings on the psychosocial effects of the Chernobyl accident, and the effects on the thyroid, particularly in children.

Appropriate care
WHO advocates reasonable general approaches in the vast field of health care and the work of the Regional Office in this field covers a wide range of issues.

Maternal and child health
Many Member States have already reached the regional targets on the reduction of maternal and infant mortality. In addition to work to help other countries match this achievement, the regional programme on maternal and child health focuses on appropriate care for the natural phenomenon of childbirth.

Based on the results of a study of perinatal care in the Region (29), the programme supports national meetings to build consensus on this hotly debated topic; so far, 40 have been held in 20 countries in the European and other regions. On the one hand, physicians are accused of relying too heavily on technology, and medicalizing pregnancy and birth. On the
other hand, advocates of “normal childbirth” are accused of taking chances with the health and safety of women and babies. The purpose of consensus meetings is to build workable compromises between these antagonists, which ironically are both dedicated to the goal of better and safer perinatal care.

The programme also stresses the appropriate use of technology in services for families, advocating that new equipment, drugs or procedures be used equitably and only in the cases for which thorough evaluation has shown them to be useful. Present topics of interest include in vitro fertilization and genetics services (30, 31).

Sexuality and family planning
Family planning programmes are strong and successful in most countries of the Region, and the health of the people is generally good and the position of women relatively strong. The Regional Office programme on sexuality and family planning focuses on countries and groups that need special assistance to rise to the level of reproductive and sexual health prevailing in the Region. The programme works towards this goal in two ways.

The first relates to the fact that WHO is the executing agency for UNFPA in Europe. Although the programme gives technical assistance to all countries in the Regions, it focuses on the 10 Member States entitled to UNFPA assistance, according to the indicative planning figures (IPF). The IPF countries are: Albania, Bulgaria, Czechoslovakia, Hungary, Malta, Poland, Portugal, Romania, Turkey and Yugoslavia. The programme advises the countries on their requests and carries out the projects agreed to be within the UNFPA mandate. Country projects include, for example, work to fight infertility and improve sex education in Bulgaria and to improve family planning services in Portugal, particularly those for teenagers.

Second, the programme works to create a shared vision and a sounder view of sexuality, health and family planning. An important step in this process was a conference co-sponsored by UNFPA, WHO, the International Planned Parenthood Federation (IPPF)/Europe and the Zhordanian Institute of Human Reproduction. Held in Tbilisi, USSR in October 1990, the conference was called From Abortion to Contraception and is expected to have major effects. The programme also pursues activities in a number of other areas, such as demographic change and the reproductive health of adolescents and women.
Quality of care and technologies

The activities of the regional programme on the quality of care and technologies included studies in the field of diabetes to evaluate and perhaps generalize the use of insulin pumps. Although this work demonstrated the limitations of the innovation, the contact with experts in diabetes treatment and the encouragement of the active participation of patients in their own care have led to close cooperation with the International Diabetes Federation (IDF), which comprises national associations of both physicians and patients. A joint WHO/IDF Secretariat is located in the Regional Office to administer a collaborative strategy for the improved management of diabetes mellitus in Europe, an attempt through a five-year plan to prevent some of the serious complications.

Further, the programme has a project that offers a way to improve diagnostic radiology at the periphery of the health care system: an imaging technology first called the basic radiologic system (BRS) and now named the WHO radiologic system (WHO/RS). The diffusion of the WHO/RS is intended to result in greater access to and more rational use of radiologic services.

The WHO/RS project is a service and training activity that includes hardware, software and training manuals. The hardware was designed to be inexpensive, accessible to providers and societies with limited resources, simple to operate, dependable in field conditions and easy to install, maintain and repair.

Designed for use in small hospital primary care centres, the WHO/RS can perform all the basic radiologic examinations required for general practitioners to help ensure correct diagnosis and follow-up of patients’ most common complaints, and handle 80–85% of the radiologic procedures requested in a large hospital. The evaluation data gathered so far show that the WHO/RS is used in more than 50 developed and developing countries in all WHO regions, and that it is dependable and easy to install and use.

In addition, the regional programme has developed a package called WHOCARE, containing a manual, software and textbook. It will enable its users to monitor surgical wound infections (manually or on computer) and to use the results to evaluate and improve their performance. Surgical wound infections account for about 60% of all extended hospitalization and 40% of the additional costs incurred. The package was developed from an earlier monitoring system tested in 22 hospitals in 11 European countries; the preliminary results showed a decrease of 30–50% in
surgical wound infections in the participating hospitals. Thus, the WHO CARE package tackles an important problem in hospital care, but can be used not only to improve the quality of surgical care but also in other quality assurance projects.

Finally, the programme on the quality of care and technologies is starting work in important new areas. This includes developing indicators of the outcome of care, which are essential to judging its quality. In addition, the programme is expanding its focus to cover various aspects of primary care — in addition to hospital care — as an area for quality assurance.

Important work is being done in other areas related to care, such as the use of pharmaceuticals (32,33) and care for people dying of cancer (34).

**Research and health development support**

*Research*

As mentioned in Chapter 4, the Regional Office maintained contact with the research community in the Region through the EACMR. Europe had many research coordination agencies, both general (such as the European Medical Research Councils) and specific (such as the European Molecular Biology Organization). The role of the EACMR was to keep itself informed of research activities in general and encourage studies related to prevention, promotion, health services and operational research. In its early years, the EACMR focused on advocating health services research. Gradually, however, this focus shifted to the task of ensuring that existing research resources were used more effectively in all major areas of the regional programme. The Regional Office had relatively little money to spend on research.

In the early 1980s, the EACMR members worried that regional targets would be “speculative”. They thought it unscientific to create targets on topics about which there was insufficient knowledge. They recognized, however, that the role of research was to fill the gaps between what was socially desirable and what science actually knew. Chapter 4 told the story of the writing of target 32. In composing it, the EACMR listed six broad areas of study that would help to provide knowledge to facilitate the implementation of health for all strategies (2):

- a description of the health of the population in all its facets;
- ascertainment of the biological factors that determine health;
- determination of the role of lifestyles in maintaining health;
— determination of the ways in which the physical, psychological and social environment, including the prerequisites for health, influence the health of individuals and of populations;
— the devising of effective and efficient ways of providing people with appropriate care;
— improvement in policy-making procedures, planning and management in regard to health for all.

The Advisory Committee also suggested that a specific programme of research related to the regional targets be prepared. After approving the targets, the Regional Committee asked the EACMR to help the Regional Office to prepare proposals. After almost two years of intensive work, the proposals were presented to the 1986 Regional Committee in two documents on the implications of health for all for research policy and priorities.

The Regional Committee requested the Regional Office to consult the Member States and the European research community, with the objectives of improving the documents and giving advance notice of their arrival to the research community. After this consultation, the proposals for research policy and action were modified. In addition, the EACMR reflected the new focus in the regional programme by changing its name to the European Advisory Committee on Health Research (EACHR). The Regional Committee approved the modified proposals in 1987 and they were published in the following year. The first book advocates the making of policies on research for health for all in countries, and sets out a regional research strategy, a model for countries to adapt to their own use (35). The second book discusses the major themes of the common health policy and points out the areas in which research is most needed to achieve the targets (36). Both have been useful in winning the cooperation and support of national and international research organizations for using existing resources more effectively in target-oriented research.

Management
During the second half of the 1980s, questions about the organization, management and financing of health services took on a new urgency. This urgency arose from the rising costs of health care and as a reflection both of general political views on private versus public ownership of health institutions and services and of increasing concern with the quality of care. The issue was further dramatized by the rapid changes in the countries of central and eastern Europe, which brought about a desire for a fresh look at health service management, organization and financing.
In response, the Regional Office reoriented its programmes and strengthened its capacity to deal with these issues, including the question of information support for health care, and a number of new activities took place.

Medical education

WHO has always had great interest in influencing both the quality and priorities of medical education. European medical faculties cooperated with WHO on experiments and reforms. In addition, WHO encouraged medical faculties to establish education in geriatrics, genetics and other topics as part of the teaching of public health, epidemiology, statistics and behavioural sciences.

Unfortunately, work to influence medical education encountered the same problems of divided authority that hindered progress in work to improve the environment. In western Europe, health ministries did not supervise university medical faculties. Health decision-makers and universities often had virtually no direct contact. Further, relatively few universities allowed their medical faculties to cooperate on formal terms with WHO, since they thought that specialist-oriented hospital training was of much higher priority than preparation for general practice or primary health care. The health for all movement, however, opened new options for medical education and universities are gradually beginning to work with WHO. Recent developments may further stimulate this change.

The World Conference on Medical Education was held in Edinburgh in 1988. The World Federation for Medical Education (WFME) organized this important meeting in collaboration with WHO and other organizations. The Association for Medical Education in Europe (AMEE) and the Regional Office had organized a preparatory regional meeting in Dublin in 1987. The goal of the Conference was the adoption of an internationally agreed approach to medical education. The participants approved the Edinburgh Declaration, which stressed the importance of the global health for all movement and offered a new ideological basis for medical education.

To give impetus to the outcome of the Conference, a Ministerial Consultation on Medical Education in Europe was held in Lisbon later in 1988. European ministers of education and of health attended. The Consultation participants adopted the Lisbon Initiative, stating that medical education in Europe should be based on the regional policy and targets for health for all, as well as the Edinburgh Declaration, outlining key issues in that regard. The Consultation was one of many regional activities designed to improve medical education (37,38).
Partnership Networks

Partnership is a fundamental theme of the health for all philosophy. A common health policy cannot be successful without the support of people in all sectors of society. All important statements of health for all principles, no matter their particular topics — from the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion to the European Charter on Environment and Health — stress the necessity of intersectoral cooperation.

Politicians in many countries have considered WHO, in view of its standing in the international health community, as an important factor in lobbying for increased emphasis on health and for larger financial contributions from governments to both national and international health activities. The new healthy public policy advocated at the Adelaide Conference was intended in part to change that narrow view. A broader perspective on the role of health in society was a necessity for other groups, as well. In particular, health professionals of all kinds needed a better understanding of the people's right to health.

In the European Region, with its generally highly educated population and strong professional groups, participation in health matters can be both easy and difficult. The public is more interested in health and favours more humane health services, reacting against the excessively technical, industrial approach of many hospitals. On the other hand, many physicians, nurses, technicians and researchers dislike what they often feel to be outside interference in their work. The value of equity and participation is not always self-evident in these conditions.

Earlier sections of this chapter have mentioned a few of the new partners that have joined the Regional Office in work for health for all, and briefly sketched some of the programmes through which these new links have been forged. Trade unions, for example, have joined in activities to create healthy workplaces. Earlier chapters have described parts of a long and fruitful partnership between WHO and health professionals. The adoption of the targets in 1984, however, changed the scene. The Regional Office was now asked to stimulate motivation towards and action for health for all throughout Europe. This could only be done, it was realized, if the Regional Office actively sought out a wide range of new partners. Long-term cooperation had to be developed with these partners to make them active catalysts for the ideas of health for all in their own spheres of influence.

Since 1985, the Regional Office has won support from growing networks of international and national associations and groups of health
professionals. This is one of the most important achievements of the implementation process. There are two types of network. Both are important in advocating the principles of the common health policy and gathering support in its implementation.

The first comprises networks with which cooperation was established through earlier WHO programmes. One example is the Association of Schools of Public Health in the European Region (ASPHER).

The European common health policy has given ASPHER a new basis for the study of the training of public health experts and the search for educational modules to be applied all over Europe; they can now be applied to the countries of central and eastern Europe, which used to take a different approach to social medicine than the other Member States. In 1989, a joint WHO/ASPHER task force was created to prepare a revised framework for a European degree of Master of Public Health, based on the regional policy for health for all.

Another network with a long history of cooperation with the Regional Office comprises nurse educators and nurse research workers in the Region. WHO has always supported European nursing schools in their struggle to produce nursing leaders with strong academic backgrounds. This was a controversial issue in several European countries and completely out of the question in the USSR, where nurses, or feldshers, were advised to go to medical school if they wanted a career. The Regional Office also recognized the need for research on nursing, organizing, for example, a large collaborative study on people’s needs for nursing care, carried out from 1976 to 1985 by 23 centres in 11 countries (39).

These close contacts with the nursing profession enabled the creation of a real mass movement of nurses interested in improving their profession through the implementation of health for all. In 1987, through the unprecedented cooperation between the nursing programme in the Regional Office, ministers of health and national nursing associations, national seminars were held on nursing and health for all, involving 155 000 nurses and all the Region’s Member States. The debates raised awareness of health for all throughout the Region and highlighted the need for changes in the roles and functions of nurses, to the provision of humane and efficient nursing care and subsequently the training of nurses. This work culminated in the European Conference on Nursing, which was held in Vienna in 1988.

The participants stated their views in the Vienna Declaration on Nursing in Support of the European Targets for Health for All, emphasizing that a new type of all-round, well trained nurse was required, who can
work autonomously in both hospital and community and thereby play a crucial role in the health for all movement (40).

A third network familiar to the Regional Office comprises medical educators in three related groups, WFME, AMEE and the Association of Medical Deans in Europe (AMDE). In addition, the International Federation of Medical Students’ Associations (IFMSA) has returned to closer cooperation with WHO.

People in Europe usually trust the opinions of the medical profession. Physicians’ views on medical and health problems can sway political decision-makers at the national, regional and local levels. Although the medical profession could give vital support to health for all, in 1977 physicians in developed countries thought the idea was utopian for developing countries and irrelevant to their own. The European common health policy changed these attitudes, although not immediately. Late in 1984, medical associations from EC and Nordic countries were ready to listen to Dr Asvall at a Joint Meeting between WHO and National Medical Associations on Health for All in Europe.

They liked what they heard; the meeting was the first of a series of annual meetings that established strong links between WHO and national medical associations. These links certainly make it easier for health authorities to implement the common health policy and to obtain support from the physicians for national or local policies for health for all and specific campaigns such as the Action Plan on Tobacco.

Reflecting the stronger links, a European Forum of National Medical Associations and WHO was established early in 1990 to place cooperation with the Regional Office on a more formal basis. The new, independent medical associations in the countries of central and eastern Europe were keenly interested and began to join later in the year. The Forum is expected to develop cooperation between medical associations and the Regional Office in such areas as the European Action Plan on Tobacco, the quality of care, and continuing education.

Cooperative networks in special target areas are being developed through intensifying cooperation in specific fields, such as cancer and cardiovascular diseases. A good example is the new collaboration with the International Diabetes Federation mentioned earlier in this chapter. Organizations such as the Federation collaborate with the Regional Office through their European-level groups or associations. In addition, their national associations will support efforts to reach national and local goals, for example, through the CINDI programme or the Healthy Cities project.
Conclusion

The forty years of WHO in the European Region have comprised a story of continuous change in the health problems of Europeans, a steady rise in countries’ socioeconomic resources, a move towards shared vision and political will for joint action by the Member States, and change in the scope and strategy of the work of the Regional Office. From the 1950s’ concentration on the destruction left in the wake of the Second World War, attention focused on a broader public health orientation of the 1960s, and the long-range programme development and the pilot efforts at community mobilization of the 1970s. In the 1980s, the movement towards a broad common policy and its implementation brought a completely new dimension to WHO’s work to help the 31 Member States of the European Region create better health for their 850 million citizens.

The health for all movement shows that the Member States and the Regional Office have created an inspirational, practical and flexible tool to improve health for everyone in the Region, a tool that will be especially useful for the half of the Region’s population now experiencing new democratic social development.

Since 1984, the work of WHO in the European Region has awakened decision-makers in all sectors to the realization that health is an important part of a country’s wealth. This work has also deepened and widened European cooperation for health further than ever before. It has resulted in the construction or revitalization of partnership networks that extend throughout the Region, reaching to the city level and mobilizing health professionals and groups in all other sectors to support the achievement of the common goal. This in itself is a remarkable achievement that will strongly encourage the creation of better health conditions and more humane health care. I hope, too, that these achievements can be shared with the developing world, where health hazards threaten survival.

This book has sketched the growth of European cooperation for health from the planting of the seed in a continent devastated by war to its latest flowering in a common health policy. The first six years of the implementation of the regional strategy and targets for health for all have brought substantial achievements, and the momentum of the health for all movement is now strong enough to take Europe on a better road to health in the twenty-first century.
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Annex 1

The Regional Committee for Europe

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<td>Dr A. Engel (Sweden)</td>
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<td>Dr V. Kalajdziev (Bulgaria)</td>
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<td>Dr Z. Szabo (Hungary)</td>
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<td>Dr Esther Ammundsen (Denmark)</td>
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<td>Algiers</td>
<td>Professor O. Boudjellab (Algeria)</td>
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<td>Dr Méropi Violaki-Paraskeva (Greece)</td>
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<td>The role of nursing staff in the health field in the 1980s</td>
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<td>Professor H.-G. Wolters (Federal Republic of Germany)</td>
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<td>Sir Henry Yellowlees (United Kingdom)</td>
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<td>Helsinki</td>
<td>Professor E. Kivalo (Finland)</td>
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<td>The problems of medical technology</td>
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<td>Professor L. Mecklinger (German Democratic Republic)</td>
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<td>Medical and social problems of disabled persons</td>
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<td>Dr U. Frey (Switzerland)</td>
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<td>Dr P. Sabando (Spain)</td>
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<td>Amsterdam</td>
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<td>Dr Judit Cséhák</td>
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<td>Healthy aging</td>
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## Annex 2

### Membership in the European Region

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<td>Norway</td>
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<td>1946</td>
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<td>Yugoslavia</td>
<td>1947</td>
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</table>

* Participated in the European Region from 1949 to 1962 as a part of France.
* Became inactive in 1950
* Since 3 October 1990, participating as part of Germany.
* Participated as an Associate Member until independence, afterwards becoming a full Member State.
Annex 3

European Winners of the Léon Bernard Foundation Medal and Prize

1951  Professor René Sand (Belgium)
1953  Dr Johannes Frandsen (Denmark)
1954  Professor Jacques Parisot (France)
1955  Professor Andrija Štampar (Yugoslavia)
1957  Professor Marcin Kacprzak (Poland)
1962  Sir John Charles (United Kingdom)
1964  Professor Robert Debré (France)
1966  Dr Karl Evang (Norway)
1968  Professor Josef Charvát (Czechoslovakia)
1971  Professor Eugène Aujaleu (France)
1972  Sir George Godber (United Kingdom)
1975  Professor Boris Petrovskij (USSR)
1977  Professor Giovanni Alberto Canaperia (Italy)
1978  Professor Francisco José Carrasqueiro Cambournac (Portugal)
1979  Professor Bror Anders Rexed (Sweden)
1980  Professor Samuel Halter (Belgium)
1981  Professor Ihsan Doğramaci (Turkey)
1982  Professor Ana Aslan (Romania)
1985  Professor Raoul Senault (France)
1987  Sir John Reid (United Kingdom)
1988  Dr Méropi Violaki-Paraskeva (Greece)
1991  Dr Pierre Recht (Belgium)
Annex 4

Resolution
EUR/RC34/R5

adopted by the thirty-fourth session of the
Regional Committee for Europe,
Copenhagen, 24–29 September 1984

The Regional Committee,

Bearing in mind resolution WHA30.43 which calls upon all countries to collaborate in the achievement of the goal of health for all by the year 2000 (HFA2000) through the development of corresponding health policies and programmes at the national, regional and international levels;

Recalling resolution EUR/RC30/R8 which endorses the regional strategy for attaining HFA2000 and acknowledges that it should foster the development and implementation of national health policies, strategies and plans of action;

Further recalling resolution EUR/RC33/R4 which requests the Regional Director to submit a final version of the regional target document to the thirty-fourth session of the Regional Committee, together with a plan of action and a list of indicators for monitoring progress towards achieving the targets in the Region;

Having considered:

(a) the proposed regional targets in support of the regional strategy for health for all (EUR/RC34/7);

(b) the list of proposed indicators for monitoring progress towards health for all in the European Region (EUR/RC34/13);

(c) the proposed plan of action for implementation of the regional strategy for attaining HFA2000 (EUR/RC34/14);
(d) the reports of the Consultative Group on Programme Development (EUR/RC34/8 and EUR/RC34/8 Add.1), the Regional Health Development Advisory Council (EUR/RC34/5), and the European Advisory Committee for Medical Research (EUR/RC34/6);

1. THANKS the Regional Director, the advisory groups and the other experts involved in the preparation of these documents for their valuable contributions;

2. ENDORSES, for application as appropriate, having regard to the particular circumstances of individual Member States;

(a) the regional targets in support of the regional strategy for health for all (EUR/RC34/7);

(b) the list of indicators for monitoring progress towards health for all in the European Region (EUR/RC34/13) as being preliminary only, to be used for the first time in the 1985 evaluation — the results of which will be discussed at the next session of the Regional Committee — and thereafter adjusted as necessary;

(c) similarly, as being preliminary only, the plan of action for implementation of the regional strategy for HFA2000 (EUR/RC34/14);

3. URGES Member States:

(a) to step up their efforts to establish national policies and programmes that are in line with the regional strategy for health for all, and to set national targets in such a way that they also contribute to attainment of the regional targets;

(b) to give special emphasis, when so doing, to the managerial processes and structures required to support national developments towards health for all, and to information systems in order to ensure coverage of the lists of global and essential regional indicators as far as possible;

(c) when reporting to the Regional Director, as far as possible to provide all the necessary information on progress and effectiveness in implementing their strategies for health for all, and in particular data related to the global and essential regional indicators, as reflected in the plan of action and by resolution WHA35.23;

(d) to seek cooperation as and when required for these purposes;
4. REQUESTS the Regional Director:

(a) to transmit these documents, amended where necessary to take account of constitutional matters in particular Member States, together with the minutes of the Regional Committee, to the Director-General as a European regional contribution to attainment of the global target of health for all;

(b) to give priority, in the programme of work and budget allocations of the WHO Regional Office for Europe, to activities designed to provide Member States with adequate support in working out national strategies for health for all, as well as to those developments in the Region as a whole which may facilitate attainment of the regional targets;

(c) to report to the Regional Committee in accordance with the plan of action.
The Europe of 1991, when this story finishes, is vastly different from the continent of 40 years ago when the WHO Regional Office for Europe began its work. Europe not only lay devastated by the Second World War, but was embarking on decades of what came to be known as the "cold war" between east and west.

Yet despite the apparently irreconcilable ideological differences, and their expression in political and military confrontation, the record of the Regional Office and its Member States of all political persuasions is one of unqualified success.

This is a story of growing tolerance and intellectual courage in building international health cooperation.

Much earlier than political leaders, the health authorities of the Region, under the umbrella of WHO and working in the forum of the Regional Committee for Europe, reached both an understanding of the similarity of their problems and a common solution. Accordingly, the Regional Committee agreed on the European strategy for health for all in 1980, and approved a common health policy in 1984: a blueprint to be applied independently in each country, but monitored and reported on jointly.

During the recent rapid political changes in the Region, this joint policy has proved to be an extremely useful framework for further cooperation.

Professor Kaprio's book is intentionally far from exhaustive. It is a subjective account of development in cooperation for health among the European Member States — both with one another and with WHO.

It will delight both those who have shared in the building of that cooperation and those who are coming fresh to this historic episode.

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