

Address by Zsuzsanna Jakab, WHO Regional Director for Europe
Ministerial Conference on “Innovative ways to look at prevention of
chronic diseases: a holistic approach to common risk factors”

Brussels, Belgium

20 October 2010

SLIDE 1

**Innovative ways to look at
prevention of chronic diseases:
a holistic approach to common
risk factors**

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 World Health Organization
Regional Office for Europe

Ministerial Conference, Brussels, Belgium
20 October 2010

Chronic diseases, both communicable and noncommunicable, have emerged as the number one challenge facing human health across the world. In part, this is due to better treatments, which have enabled us to transform mortality rates to prevalence among patients with diseases such as cancer or HIV/AIDS. Demographic and lifestyle changes have done the rest, as the population rapidly ages, and habits that undermine health have extended throughout society.

SLIDE 2


Global Risks 2010
A Global Risk Network Report

WORLD ECONOMIC FORUM
COMMITTED TO IMPROVING THE STATE OF THE WORLD

Noncommunicable diseases

A risk to health and to the economy

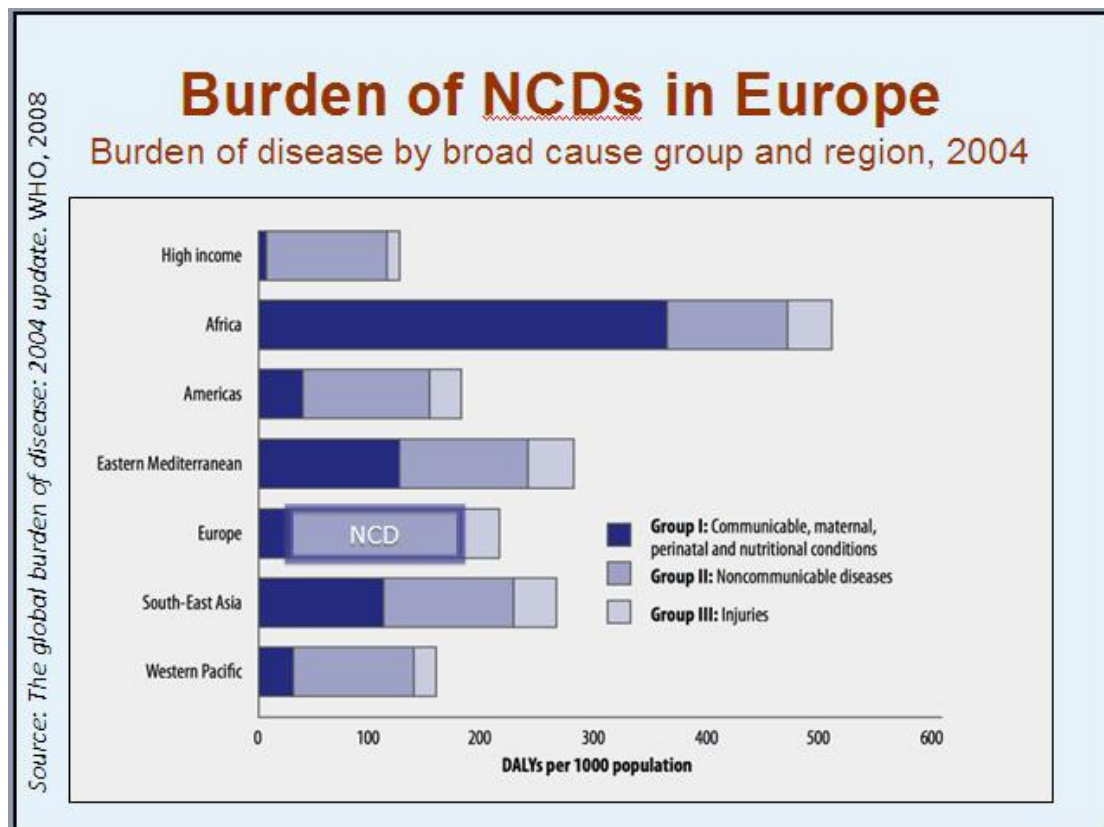
A World Economic Forum Report
in collaboration with:
Citi
Marsh & McLennan Companies (MMC)
Swiss Re
Wharton School Risk Center
Zurich Financial Services

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On a global level, noncommunicable diseases have been shown to be intimately linked to human, social and economic development. In both 2009 and 2010, the World Economic Forum, surveying the global risks landscape, ranked chronic diseases among the most severe risks to the global economy, comparable in their effects to risks as such spikes in the price of oil.

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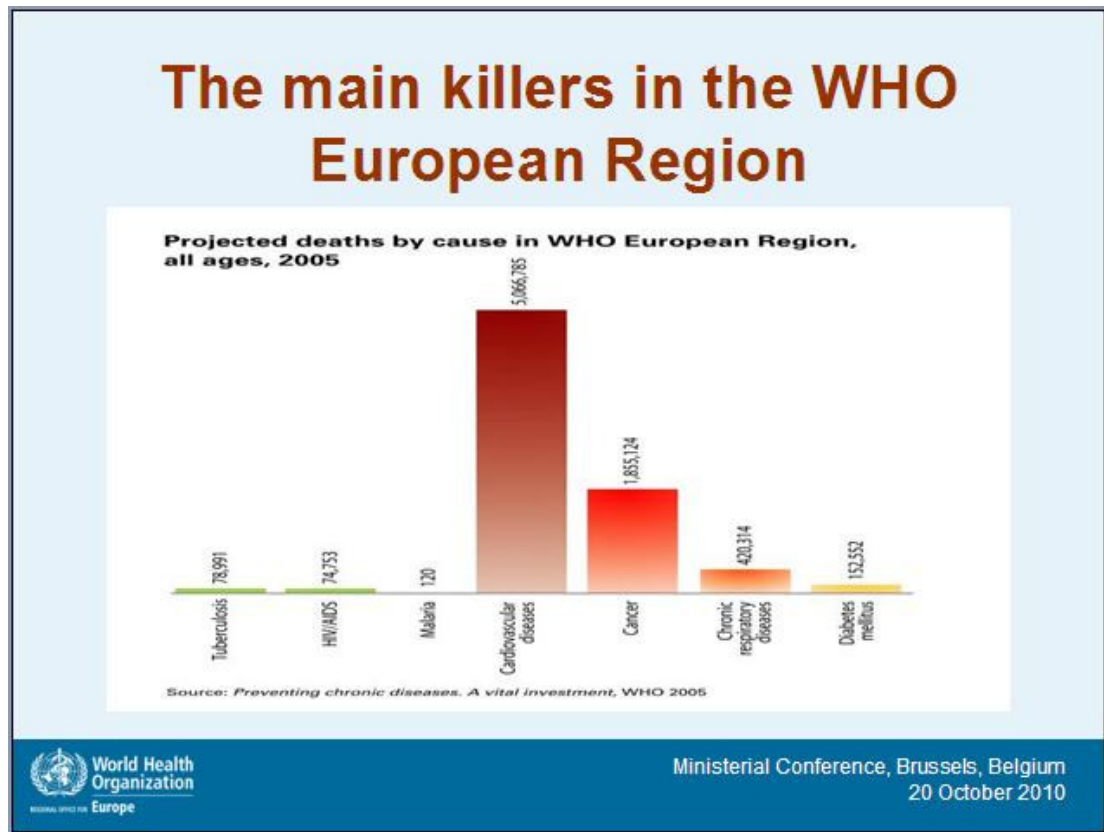


Within this global epidemic, the WHO European Region is the most heavily affected.

Here in Europe, the lion's share of the disease burden comprises just four groups of pathologies: cardiovascular diseases (CVDs), cancer, diabetes and chronic respiratory diseases. Together, these and other noncommunicable diseases, or NCDs, account for 86% of deaths and 77% of the disease burden in the European Region.

The great progress made in past decades by western nations in lowering the mortality rates from CVDs is proof that this challenge is not insurmountable. However, nor is it simple or straightforward. CVD incidence rates are rising quickly in different areas of the Region, such as central Asia.

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Regionwide, CVDs are by far the leading killer.

Cancer is the second most common cause of death after CVDs. In 2005, there were about 1.7 million deaths from cancer in Europe, or 19% of all deaths. In the western part of the Region, cancer stands out as one of the biggest threats both to health and to health systems. Indeed, it has replaced CVDs as the main cause of death in at least 28 of the Region's 53 countries, requiring sharp adjustments to health systems to address the complex needs of cancer patients.

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An important note
"No health without mental health"



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As I talk about the burden caused by these four physical pathologies, let me emphasize that I am far from ignoring the important links they have with mental health.

There are many examples of these links.

First, harmful stress in settings such as the workplace is associated with CVDs.

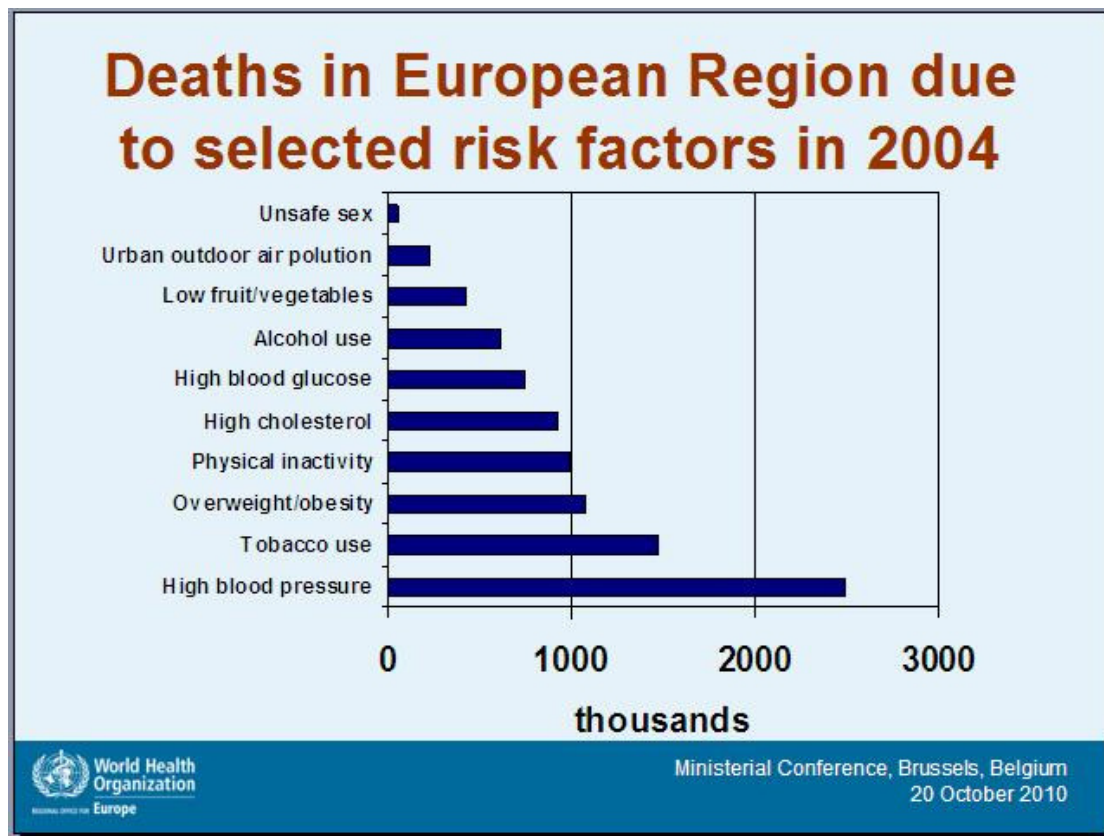
Second, the prevalence of depression is a predictor of poor life expectancy in CVDs and cancers.

Third, unemployment, poverty, debt, inequality and low social status all predispose to both NCDs and a range of mental disorders and, in turn, poor mental health is strongly associated with poverty, a minority background and low status.

Finally, some lifestyles can protect against or are a risk for both NCDs and mental disorders, such as physical activity, poor eating habits and the harmful use of alcohol.

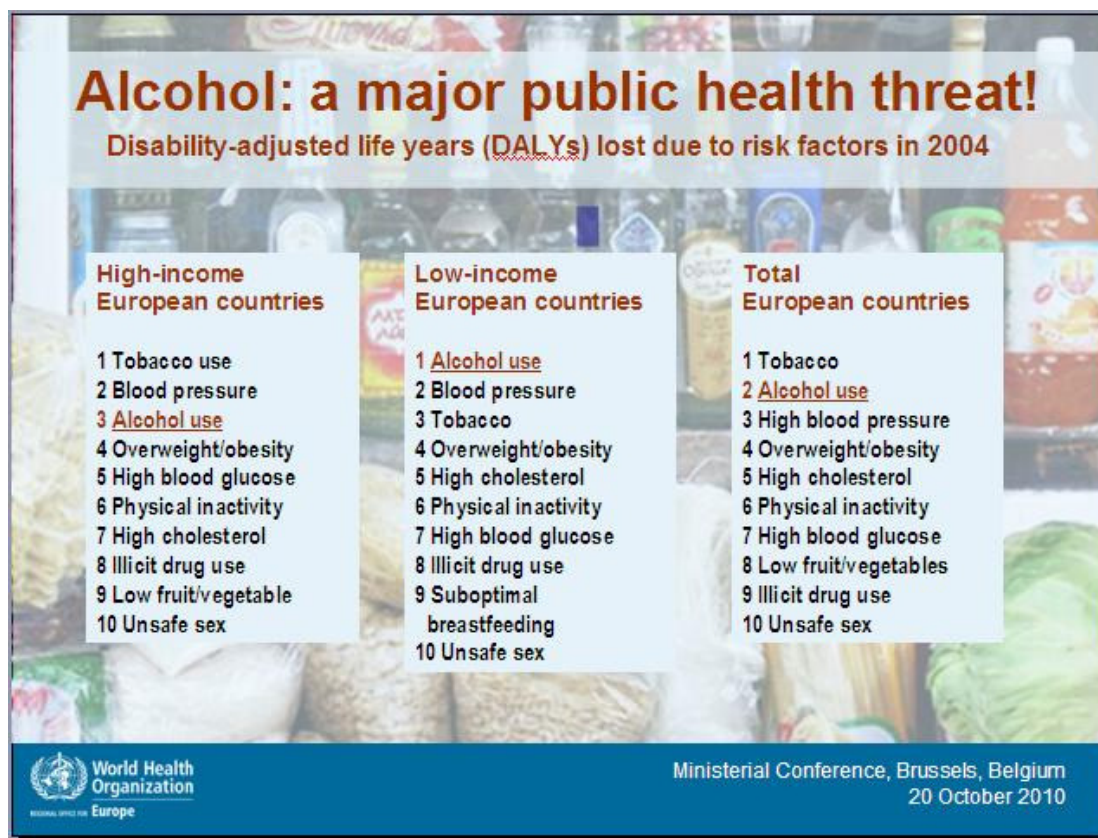
While I continue to talk about the physical NCDs, I again emphasize that mental health deserves attention in its own right, for the burden that it causes and for the links that it has with other NCDs.

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The fight against NCDs in Europe begins by acknowledging that they are linked by common determinants and opportunities for shared policy intervention. Indeed, almost 60% of the disease burden in Europe is attributable to seven leading risk factors: high blood pressure, tobacco use, harmful use of alcohol, high blood cholesterol, overweight, low fruit and vegetable intake and physical inactivity. Tobacco smoking leads the behavioural risk factors as a cause of death and disease in this Region, but it is also the Region with the highest alcohol intake in the world and a per capita consumption twice as high as the world average.

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Alcohol is the second largest risk factor for disability-adjusted life years (DALYs) and, in low-income European countries, it is the main risk factor. For this reason, it is my intention to develop a regional implementation plan that builds on the recent Global Strategy to Reduce Harmful Use of Alcohol and on the Framework for Alcohol Policy in the WHO European Region. In June, the Regional Office organized a national counterparts meeting at the kind invitation of Spain, where all countries agreed to such a plan.

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Regional alcohol policy

- New European framework will be developed, built on Global Strategy to Reduce Harmful Use of Alcohol.
- New evidence has been collected with the support of the European Commission.
- New alcohol information system will be launched in October 2010.



A regional alcohol policy is needed, as the disease burden attributable to the harmful use of alcohol is significant. None of us is proud of this, but the Region is the leader in alcohol consumption.

A new European framework will be developed, built on the Global Strategy to Reduce Harmful Use of Alcohol. New evidence has been collected with the support of the European Commission; and a new alcohol information system will be launched in October 2010.

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A presentation slide titled "Tobacco control" with a background image of a lit cigarette. The slide contains a list of bullet points and a footer with logos and text.

Tobacco control

- It is 5 years since the entry into force of the WHO Framework Convention on Tobacco Control in February 2005.
- 46 countries and the European Community are Parties to the WHO Convention while 7 countries in the Region have not yet ratified it.
- Several countries in the Region have become global leaders in tobacco control: Ireland, United Kingdom and Turkey have adopted 100% smoke-free public places.
- Belgium, Romania, United Kingdom, Latvia, France, Malta, Spain and Turkey have introduced pictorial health warnings.
- The WHO Director-General's special World No Tobacco Day award was given to the Prime Minister of Turkey for his national and international commitment to tobacco control.

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Substantial progress has been achieved in tobacco control throughout the Region. Several countries have adopted or strengthened tobacco legislation and improved its enforcement. Momentum was created by the entry into force of the WHO Framework Convention on Tobacco Control (FCTC), which was reinforced by concrete actions in countries. This year marks the fifth anniversary of the FCTC, and we celebrated it by highlighting its main achievements during the WHO Regional Committee for Europe meeting in Moscow.

One of the highlights of the tobacco control efforts this year was the WHO Director-General's special World No Tobacco Day award, given to the Turkish Prime Minister for his outstanding and continuous leadership nationally and internationally, which I had the honour and privilege to present to him on 19 July this year in Ankara.

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Implementation of the WHO European Action Plan for Food and Nutrition Policy 2007–2012

- Overweight still a big public health challenge, particularly in low socioeconomic groups
- 47 (90%) Member States developed a national policy in the area of food, nutrition, and/or obesity.
- Six action networks established:
 - ✓ Childhood Obesity Surveillance Initiative (COSI)
 - ✓ Salt intake reduction in the population
 - ✓ Marketing of foods and beverages to children
 - ✓ Nutrition-Friendly Schools Initiative (NFSI)
 - ✓ Hospital nutrition
 - ✓ Obesity and inequalities
- Foodborne diseases due to multiple causes also constitute a considerable challenge. Holistic, intersectoral and risk-based food safety systems are being developed to prevent and control food safety hazards.




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Overweight is one of the biggest public health challenges of the 21st century: all countries are affected to a different extent, and this poses serious problems, particularly in the lower socioeconomic strata. The WHO European Action Plan for Food and Nutrition Policy 2007–2012 sets goals and targets related to food safety and nutrition in the Region. More than 90% of European Member States have developed a national policy. The Regional Office worked with Member States to reduce salt intake and provide information to consumers, and facilitated six action networks. In recent weeks, we also had discussions with the food and drink industry to define coordinated efforts to implement WHO policies, guidelines and standards in the production of food and drink. There is great potential in this collaboration and we are therefore willing to explore it further.

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Strategy

A mandate for the WHO European Region

Gaining Health
The European Strategy for the Prevention and Control of Noncommunicable Diseases

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The first reaction of the politician faced with the challenge of investing in the prevention of NCDs would be to shift the responsibility to individuals, claiming, that “people should be responsible for their own health”, implying that they should adopt “healthy lifestyles” as if the behaviours are somehow independent of the policy environments that make healthy choices easier or more difficult.

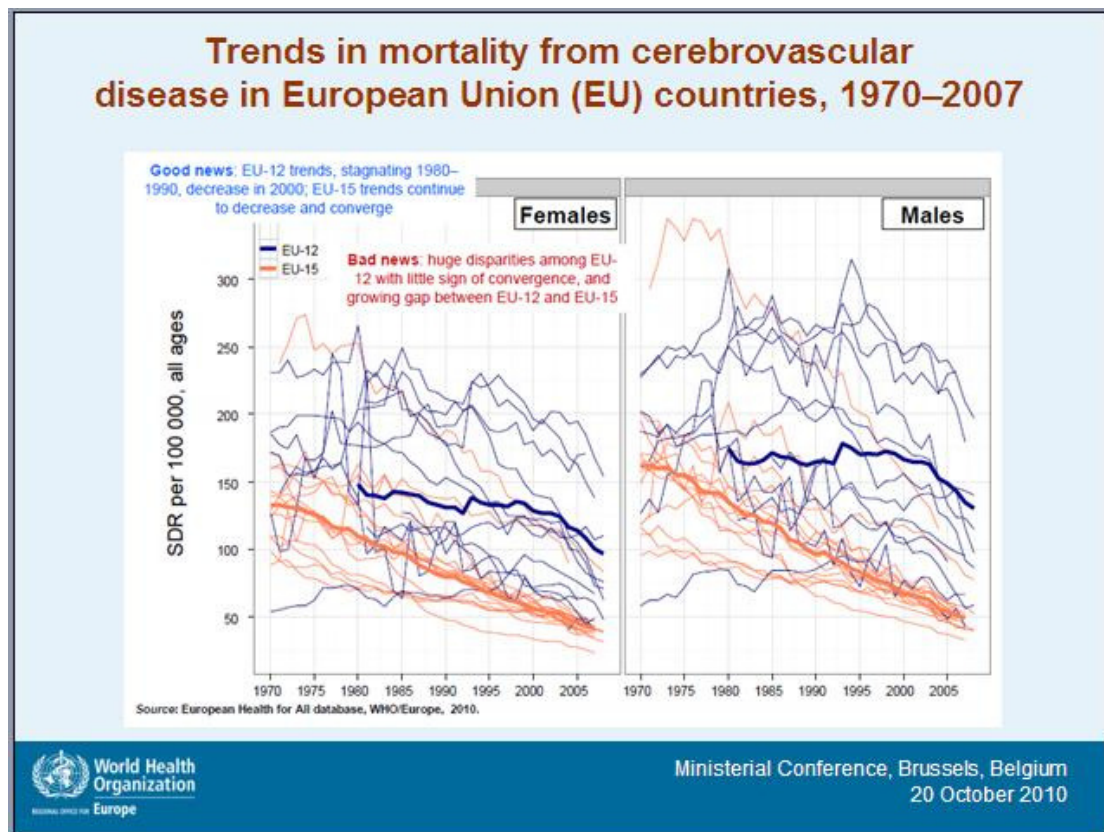
In Europe, these simplistic arguments have long since been discarded by policy-makers. We have strong collective experience on the use of price as an incentive or disincentive for behaviour, on the control of advertising of unhealthy goods, on the reduction of salt through food product reformulation, and on the planning of urban environments to facilitate the use of active transport, among others. Healthy choices are easier when the policy environment nudges us in that direction or when the environment makes them the automatic choices.

This approach was the one taken by the European Strategy for the Prevention and Control of Noncommunicable Diseases that was adopted by the Regional Committee in 2006. It provides us with a strong framework for action based on:

- advocacy
- knowledge generation, exchange and management
- regulation and financing
- capacity building
- community support
- health service delivery.

We at the Regional Office have now started to work on an action plan for its implementation, which will come to the Regional Committee in 2011.

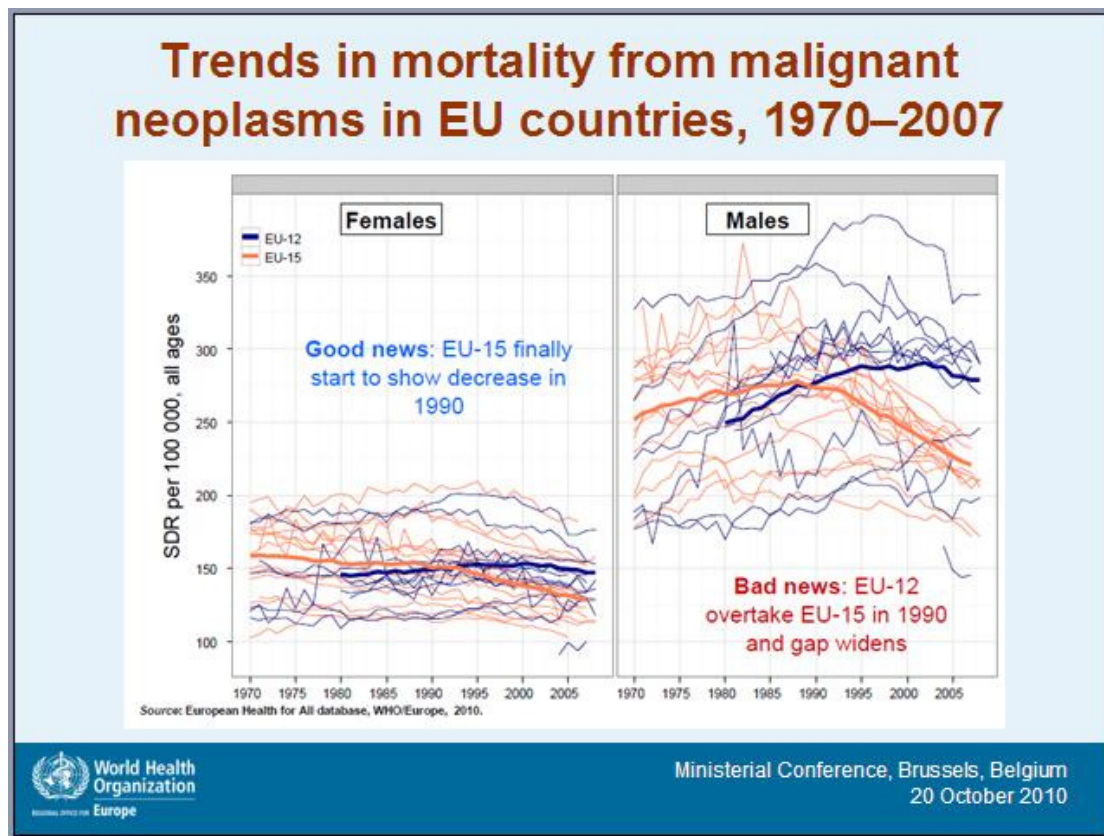
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As we embark on this process, we must examine the reality of the epidemic in Europe, and look at the implications of both the good news and the bad.

For example, as we look at the trends in mortality from cerebrovascular disease in European Union (EU) countries, we see a decreasing tendency in both males and females in both the EU-12 and EU-15 countries, but there are signs of huge disparities among the EU-12, with little sign of convergence between them and a growing gap between the EU-12 and the EU-15 countries.

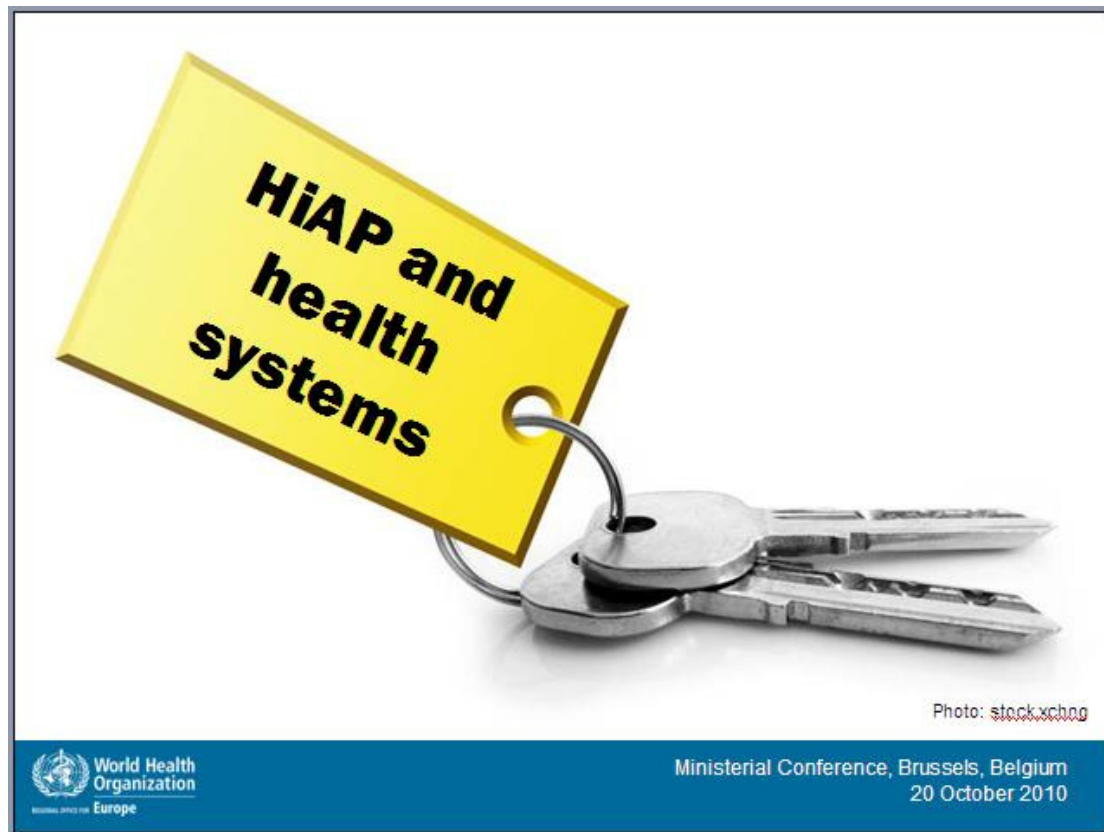
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As another example, I offer the trends in mortality from malignant neoplasms in EU countries over the same period.

The good news is that cancer mortality in the EU-15 started to decline in 1990 for both males and females, a result of improvements in prevention and care. On the other hand, for both sexes, the EU-12 did not show such a reduction and in fact this group of countries overtook the EU-15 in 1990, at the same time as they started to decline.

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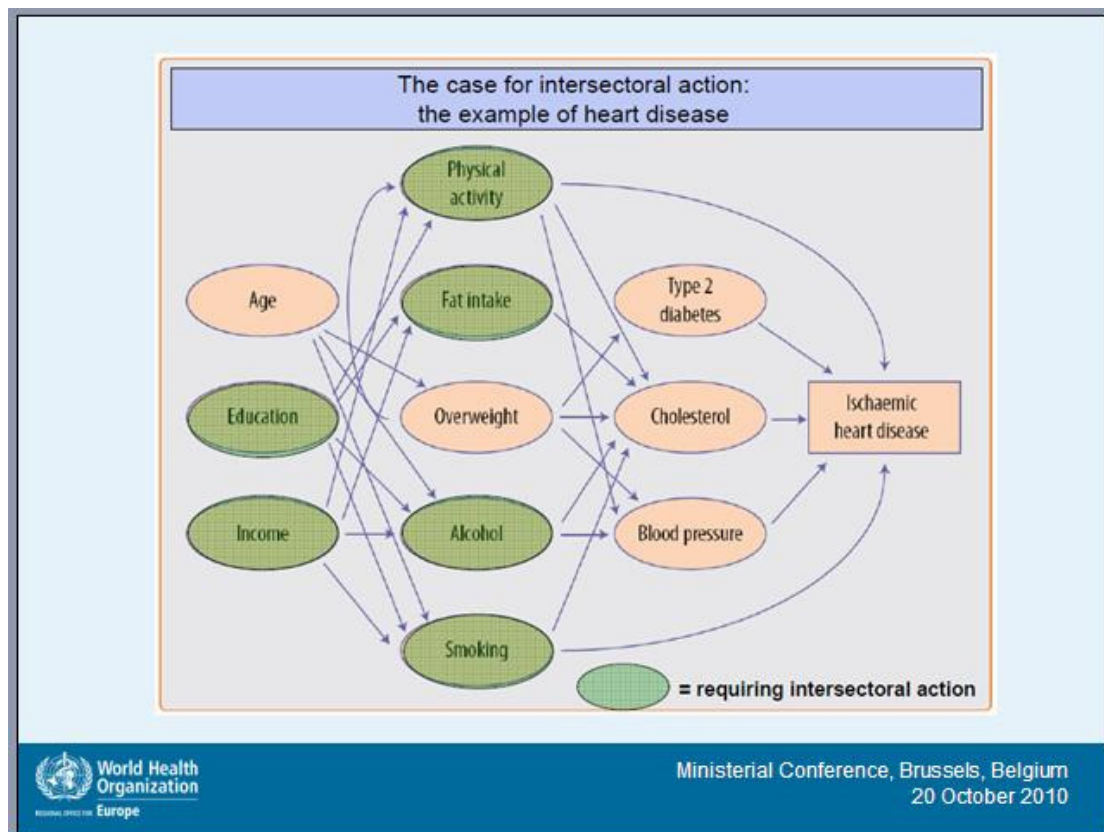
Parts of our Region improve, as others decline. Health gain is possible, but unevenly distributed. Signs are clear that effective prevention and care are possible, but the benefits are not accessible to all. Thus, as we move forward with developing the NCD action plan, I believe we cannot just have business as usual. We need to think outside the box and also have to address the root causes of these problems. I believe there are two keys to our success.

One key is to focus on the fact that the determinants of health in general, and of NCDs in particular, lie outside the health sector, and we will only be able to address the epidemic if we work effectively across sectors, and put in practice the principle of health in all policies (HiAP) with the underlying social determinants.

Another key is to recognize that the existing burden of NCD requires us to concentrate a strong part of our efforts on building health systems capable of integrated control and management of disease with a patient-centred focus.

Let me briefly talk about both of these keys.

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First let me talk briefly about health in all policies.

It is enough to look at a simple diagram of the web of causation of ischaemic heart disease to realize that the factors that are amenable to change lie outside the remit of the health sector.

“Intersectoral action for health” has been a buzzword of public health for decades. The challenge has been to put intersectoral action into practice, successfully and sustainably. It is also a challenge to create replicable mechanisms for intersectoral action.

Europe has coined the phrase “health in all policies” as a key insight into enabling intersectoral action for health. The idea of health in all policies turns the problem on its head and looks at the objectives of the other sectors and examines the ways in which health can facilitate the attainment of those objectives. Instead of asking the other sector what it can do for the health agenda, we look instead at the ways in which healthy public policy can benefit other sectors’ self-interest. Transport policies, for example, can increase mobility and quality of life in cities, while also increasing physical activity, reducing injury, and reducing pollution. Health in all policies aims to engage other sectors in broad coalitions that enable benefits across different areas. As this conference considers innovative actions for the prevention of chronic NCDs, we should consider how intersectoral action could be governed, evaluated and sustained.

Key features of the HiAP approach

- It is a coordinated (joined-up) approach to government policies, where health and health equity are considered core values in government vision and strategies.
- HiAP applies to the international level, as well as to all levels of government in countries.
- Health most often is not an (explicit) value or goal in most of other sectors' policies, so aiming for common, consistent (health-enhancing) goals is essential.
- HiAP is increasingly becoming imperative in the light of accumulating knowledge on the determinants of health (and the root causes of ill health) and a number of pressing global challenges: climate change, economic crisis, the ageing of the population, urbanization, chronic diseases, growing inequalities, migration trends.

A successful HiAP approach has certain features.

It requires a coordinated (joined-up) approach to government policies, where health and health equity are considered core values in government vision and strategies.

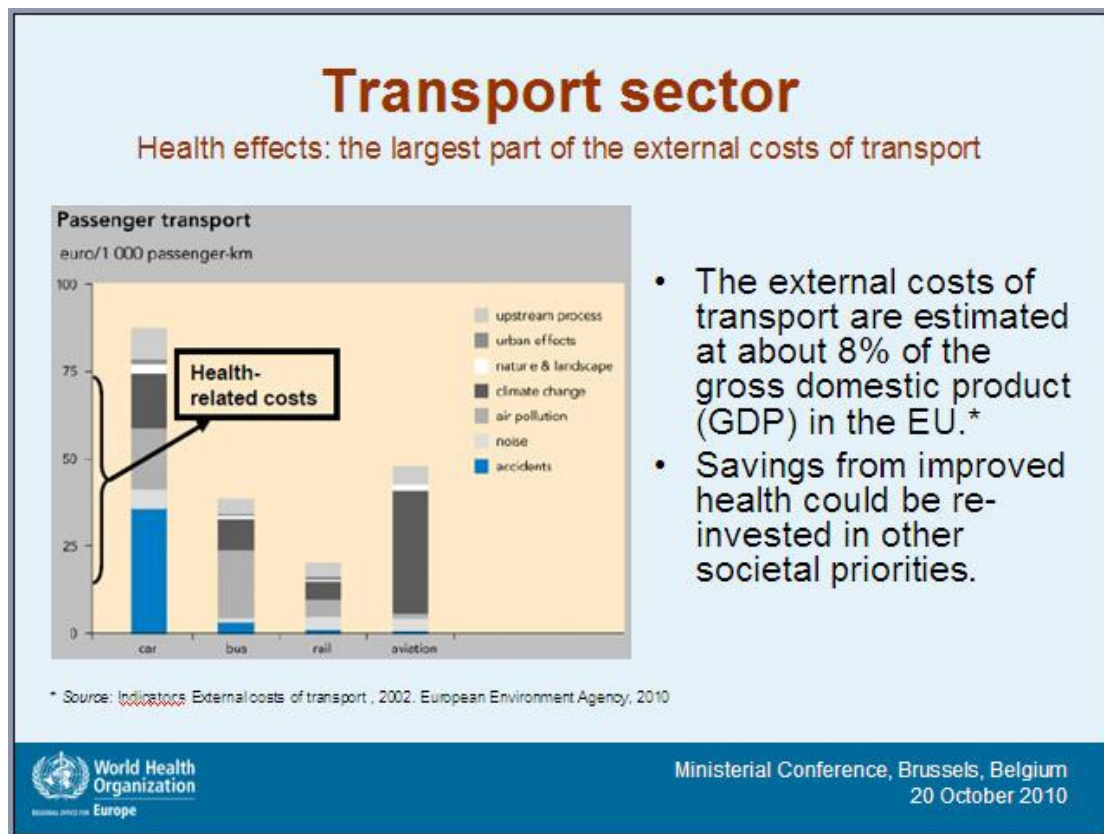
It should be seen to apply to policy-making at the international level, as well as to all levels of government in countries.

We need to recognize that health most often is not an (explicit) value or goal in most of other sectors' policies, so aiming for common, consistent (health-enhancing) goals is essential.

Finally, HiAP is increasingly becoming imperative in the light of accumulating knowledge on the determinants of health (and the root causes of ill health) and a number of pressing global challenges, with the epidemic of NCDs among them.

But, one may ask, how can we put HiAP into practice? I will outline the approach with reference to the transport sector.

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When working with another sector, one may seek to quantify the ways in which health can benefit the other sector, for example by addressing common costs.

In the transport sector, for example, the motorist is only paying a small portion of the costs that society has to pay (in the form of pollution, noise and injury, among others). Most of these effects are health-related. Both the transport and the health sectors have an interest in reducing these costs.

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Helping each sector achieve its own goals



Goals	Interest
Reduce emissions of: - air pollutants - greenhouse gases - noise	Environment Health
Reduce congestion	Transport
Reduce road traffic injuries	Transport Health
Reduce investment in infrastructure to cater for more cars	Transport
Improve accessibility and quality of urban life	Transport Health
Complement technological improvements to vehicles and fuels	Transport
Increase physical activity	Health


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The emphasis on co-benefits is crucial to health in all policies. This slide illustrates how the goals of a healthy transport policy unites the environment, transport and health sectors in a natural alliance.

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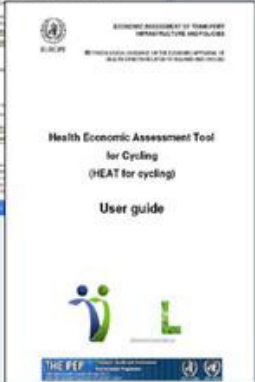
Consider health effects in investment decisions



ECONOMIC ASSESSMENT OF TRANSPORT INFRASTRUCTURE AND POLICIES
Methodological guidance on the economic appraisal of health effects related to walking and cycling




Parameter	Value
Number of people per day	1000
Number of people per year	365000
Number of people per month	30000
Number of people per week	7000
Number of people per day (including weekends)	1000
Number of people per year (including weekends)	365000
Number of people per month (including weekends)	30000
Number of people per week (including weekends)	7000



Health Economic Assessment Tool for Cycling (HEAT for cycling)
User guide

Develop tools that help transport and urban planners to include health in their economic analyses

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It is useful to provide tools for other sectors to examine the health impact in their investment decisions and to include health benefits in their economic analyses. These are some examples of such tools in the transport sector, providing economic assessment tools for walking and cycling, tools that make the health benefits tangible to policy-makers in the other sector and do so in language that is meaningful to them.

SLIDE 20

Strengthening of the health and public health systems

The Tallinn Charter: Health Systems for Health and Wealth

We, the Member States and partners, BELIEVE that investing in health is essential to human development, social well-being and wealth. Investing is an obligation that goes beyond mere care and includes disease prevention, health promotion and efforts to advance other sectors to address health concerns in their own right. Health systems are essential to improving health, strengthening...

Renew commitment to public health and rejuvenate the work of the Regional Office in this important area

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The second key to success is to have health systems that are able to provide integrated prevention, control and management of NCDs. The Tallinn Charter, while recognizing that health systems are much more than health care, lays down the general principles for our work here, and we need to find ways of putting these principles into practice.

The principles include:

- provision of quality services to all, and particularly to vulnerable groups
- the use of evidence-based care and appropriate technology
- a respectful, dignified relationship between patient and health care provider
- integrated health promotion, disease prevention, care and outreach
- integrated services for specific diseases, rather than vertical specialized delivery programmes
- a holistic patient-centred service.

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New European health policy: Health 2020

- Will be developed through a participatory process with Member States, sectors and partners;
- will be informed and underpinned by a European study on social determinants;
- will integrate policy areas and renew the commitment of the Regional Office to public health;
- will renew emphasis on further developing public health systems, capacities and functions and promoting public health as a key function in society;
- will clarify the linkages between public health, the health care system, and in particular primary health care (Tallinn Charter 2008);
- will position health as a critical development sector, and make linkages with other sectors to promote health as a governmental responsibility under the ministry of health;
- will be an inspiration to Member States to develop, renew and update their national health policy and strategies;
- will be led by the global policy council.



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In conclusion, I would like to talk about how we can bring it all together.

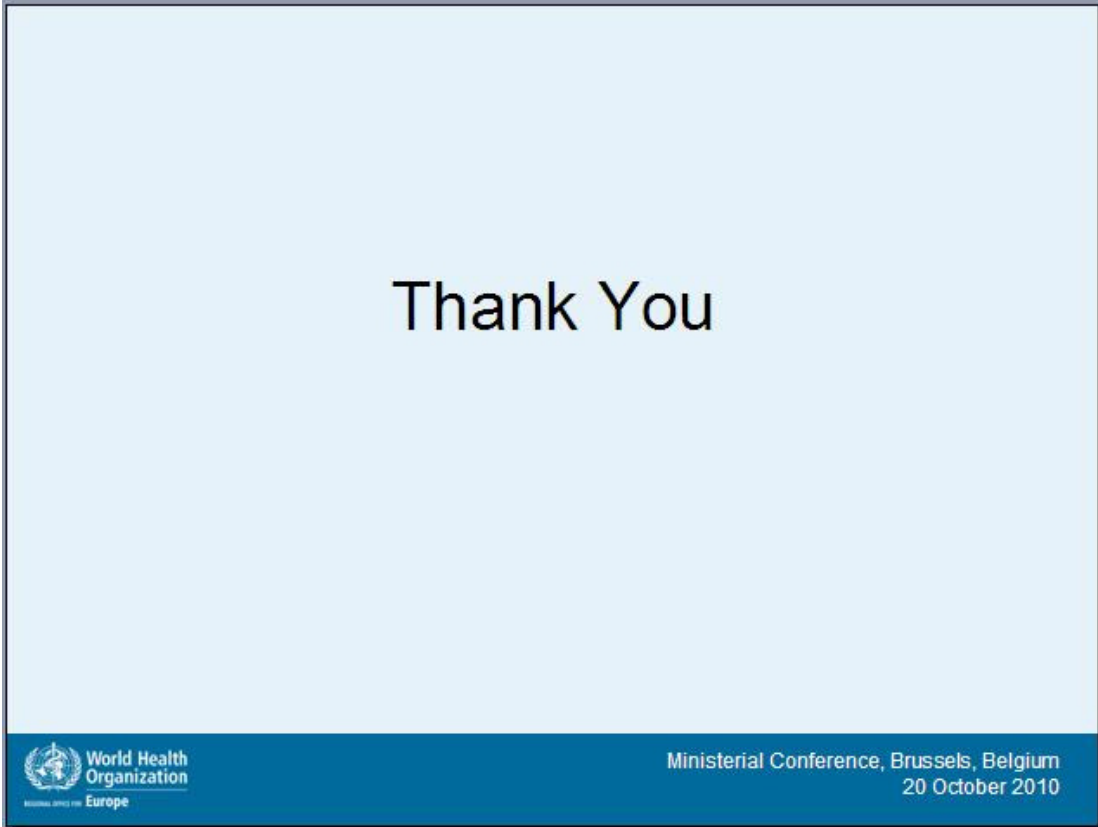
If we are to address the epidemic of NCDs, if we are to find ways of addressing the social determinants, if we are to strengthen our public health capacity, and if we are to strengthen prevention and to reach out from our comfort zone and engage in meaningful policy discourse with other sectors, we need a driver, the force of a united vision, a unifying message.

We are developing such a grand vision of health, to drive the work of WHO, of Member States, and of collaboration with our partners. We believe that a strong European health policy, a coherent policy framework, mandated by the Member States, can be a strong catalyst for success in the fight against the NCD epidemic.


This policy will be developed through a participatory process with Member States, sectors and partners.

It will be informed and underpinned by a European study on social determinants. It will integrate policy areas and renew the commitment of the Regional Office to public health and prevention. It will renew emphasis on further developing public health systems, capacities and functions and promoting public health as a key function in society. It will clarify the linkages between public health, the health care system, and in particular primary health care (Tallinn Charter 2008). It will position health as a critical development sector, and make linkages with other sectors to promote health as a governmental responsibility under the ministry of health. It will be an inspiration to Member States to develop, renew and update their national health policy and strategies.

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Thank You

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It will be a policy that reflects all our aspirations and an instrument of unity in the joint actions for public health in Europe. I thank you for your attention and I look forward to the outcomes of your discussions.