Regional Committee for Europe
Fifty-fourth session

Copenhagen, 6–9 September 2004

Provisional agenda item 8(a)

EUR/RC54/8
15 June 2004
40209
ORIGINAL: ENGLISH

Towards a European strategy on noncommunicable diseases

Noncommunicable diseases comprise the main burden of disease worldwide and more so in Europe than in any other WHO region. These diseases make a huge contribution to inequalities in health in the Region. Their causes are known and effective interventions exist and are being applied in many countries in Europe. The potential for health gain is enormous, but so far the benefits within and between countries have been uneven. A number of important initiatives have been taken in recent years, both in Europe and globally, to raise awareness, inform policy-makers and commit Member States to action. While the task of tackling the risk factors for noncommunicable diseases has moved higher up the political agenda in recent years, a more comprehensive approach to the prevention and control of these diseases is still lacking.

This report reviews the situation, pointing out achievements but underlining an important need for action. It describes the challenges being faced and increasingly the problems being recognized and it sets out the case for a specific European strategy on noncommunicable diseases, to be submitted to the Regional Committee in 2006.

A draft resolution is attached for consideration by the Regional Committee.

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Introduction

Importance of the problem

1. Noncommunicable diseases (NCD) present a considerable challenge to health globally, both now and for the foreseeable future. In 2002, they accounted for an estimated 59% of deaths and 47% of the global burden of disease.[1] *(1)* These diseases place an increasingly heavy burden on people's health, on health systems and they threaten economic and social development. Of all the WHO regions, the European Region is the most afflicted.

2. Although much is known about the causes of NCD and the interventions that are effective against them, much still needs to done to ensure that this knowledge is put into practice, that all sections of society benefit and that these benefits are spread across the entire Region. This is not just a matter of healthy lifestyles and personal responsibility. This problem requires political commitment and clear policies at all levels of government to create supportive environments.

Purpose of this paper

3. Following a WHO expert consultation in May 2002, the Regional Director proposed to the WHO Regional Committee for Europe at its subsequent session that the Regional Office for Europe (EURO) programme on noncommunicable diseases should be strengthened to match the burden imposed by these diseases and that a European strategy should be drawn up in consultation with Member States. This would be within the framework of the global strategy for the prevention and control of noncommunicable diseases and the reporting deadline proposed was 2004. The timetable agreed with the Standing Committee of the Regional Committee (SCRC) in November 2003 was that a concept paper would be discussed by the Regional Committee in 2004, followed by a proposal for a European strategy in 2006. This would allow for extensive consultations with Member States during the period 2004–2006, in the interests of ensuring the transparency and sustainability of the strategy. It would also allow due account to be taken of the outcomes of the relevant European ministerial conferences and action plans during the intervening period.

4. This paper sets out to review the situation, highlighting the remaining challenges and putting forward the case and concept for a European NCD strategy. It aims to stimulate debate on the main issues and seek direction from Member States on the way forward for the European Region. The paper was prepared as the outcome of a process comprising three meetings of staff throughout EURO, interviews with managers of 15 relevant WHO programmes, an external expert meeting involving members of the SCRC and staff from the European Commission and WHO headquarters. In order to go beyond the findings of scientific research alone, the process deliberately sought to involve experts, academics, policy advisors and policy-makers. The group of collaborators with the EURO Countrywide Integrated Noncommunicable Disease Intervention (CINDI) programme had prepared a proposal for the Regional Director in November 2003, which served as a background paper for the process and other sources of published material were reviewed as necessary.

5. It should be noted at the outset that, although they are frequently used interchangeably, there is a difference in the definition, scope and implications of the two terms "noncommunicable diseases" and "chronic diseases". Chronic diseases are health problems that require ongoing management over a period of years or decades; besides noncommunicable diseases, they can also include diseases of an infective aetiology but persistent, chronic nature. Some noncommunicable diseases may take a chronic course and become chronic conditions, but not all do so. While recognizing the differences, this paper primarily focuses on noncommunicable diseases, as the Secretariat was originally charged to do. Decisions on terminology and the scope of the strategy depend on discussions at sessions of the Regional Committee

[1] As measured in disability-adjusted life years (DALYs)

and the direction set by it. However, WHO headquarters has itself now chosen to use the term "chronic diseases" rather than "noncommunicable diseases".

Recent trends in the European Region of WHO

The current problem

6. In 2002, an estimated 86% of all deaths and 77% of the burden of disease in the European Region of WHO were due to NCD and these figures are rising. In terms of mortality, the leading NCD[2] for Europe in 2002 were cardiovascular disease (CVD), cancers, respiratory disorders, digestive disorders and neuropsychiatric disorders. In terms of burden of disease, the chief contributions were estimated to come from CVD at 23% and neuropsychiatric disorders at 20%, with cancers contributing 11%.

7. Cardiovascular disease (heart disease and stroke) caused more than half of all deaths in Europe in 2002. Over the past 30 years, mortality from CVD (all ages) has been declining steadily in the developed economies of western Europe and some new European Union (EU) countries. In contrast, there has been a general increase in mortality in the newly independent states (NIS), reaching a maximum around 1994. In 2000, the average figures for CVD mortality (all ages) for NIS were three times higher than those for the then EU. Cancers were responsible for around 20% of all deaths in Europe in 2002, with cancer of the trachea/bronchus/lung being the leading cause.

8. Most resources of health systems go on chronic conditions. In health care practice outside the hospital, about 80% of the diseases treated are chronic. In the Netherlands, 23.2% of all health service costs were estimated to be devoted to mental disorders in one year. In Sweden, 6% of total health care expenditure for 1998 was due to type 2 diabetes and predictions for Tajikistan are that 10.7 to 19.3% of total national health expenditure will be spent on diabetes by 2025. In the early 1990s, the Federal Ministry of Health estimated the total costs of diet-related diseases to the health service in Germany at about DM 83.5 billion, equivalent to 30% of the total cost of health care, with the highest costs resulting from CVD (12% of total national health care costs).

9. The economic impact of NCD goes beyond the costs to health services. A significant proportion of the total cost of care falls on patients and their families. Indirect costs in terms of lost productivity can nearly match or in some cases exceed the direct costs. In Sweden, the cost distribution for diabetes mellitus has been estimated at 28% for health care, 31% for the municipality and relatives and 41% in terms of lost productivity. In the United Kingdom, the total annual cost of coronary heart disease in 1999 was estimated at £7.06 billion, of which only 25% was costs to the health care system, with the rest coming from informal care costs and lost productivity; about three quarters of lost productivity was due to morbidity rather than mortality.

10. Noncommunicable diseases are frequently under-diagnosed and under-treated. In Scotland and elsewhere, it has been found that half of hypertensives were undetected; of those detected, half went untreated; and only half of those treated were controlled. While this "rule of halves" may be improving in recent years for hypertension in some industrialized countries, it has been found to apply to other chronic diseases and suggests that the true economic burden could even be higher than the figures mentioned above. For the United Kingdom, it is estimated that delivering best practice in the four disease areas of coronary heart disease, renal disease, mental health and diabetes would be likely to add between 5% and 9% a year in real terms to the costs of treating these diseases.

Predictions for the future

11. Based on current trends, the global toll of NCD is estimated to increase to 73% of all deaths and 60% of disease burden by 2020. Risk factors can act as indicators of future health status and whereas data

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[2] Ranked in order of proportion of all deaths caused by disease

on disease and its outcomes tend to focus on the need for curative and palliative services, assessments of burden resulting from risk factors estimate the potential of prevention. Risk factors accumulate throughout the life course, from foetal life to adulthood and the future burden of chronic diseases reflects a lifetime's accumulation.

12. A few common risk factors are responsible for the bulk of the burden of disease from NCD. In developed countries (including all of Europe), just seven risk factors are the main contributors to the burden from noncommunicable diseases. These are: tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, being overweight, low fruit and vegetable intake and physical inactivity. In developed countries, more than half the disease burden for each of five major conditions (ischaemic heart disease, cerebrovascular heart disease, alcohol use disorders, chronic obstructive pulmonary disease and trachea/bronchus/lung cancers) is attributable to just four risk factors: tobacco use, alcohol abuse, raised blood pressure and raised cholesterol. The major CVD risk factors of tobacco use, inappropriate diet and physical inactivity (expressed through unfavourable lipid concentrations, high body mass index and raised blood pressure) explain at least 75–85% of new cases of coronary heart disease.

13. Tobacco consumption is estimated to be responsible for 12.2% of the total disease burden in developed countries. Around 30% of the adult population smoke in Europe, but prevalence varies according to country, gender and socioeconomic group. The smoking epidemic is increasing among women in high-income countries and slightly among men in low-income countries; overall, poor men are more likely to smoke than rich ones. Smoking rates of school-aged children are increasing in some European countries and decreasing in others and a broad geographical pattern for gender differences is emerging.*(2)* In the Baltic states and the Czech Republic, for example, daily smoking rates for 15 year-old boys and/or girls have increased by up to 12% in the past four years, whereas daily smoking among 15 year-olds has stabilized or fallen by less than 5% in most western European countries. The proportion of girls who smoke is rising and among 15 year-olds smoking rates are now higher among girls than boys in many northern and western European countries.

14. The predominant concern for alcohol consumption relates to its harmful effects, although there is some evidence that low volume of consumption combined with non-binge drinking patterns is associated with some reduction in risk of coronary heart disease in middle-aged and older people. Alcohol products are estimated to be responsible for 9.2% of the total disease burden in developed countries. High alcohol use also has a social burden. In central Europe, alcohol is estimated to be a factor in 50%–75% of drownings, unintentional injuries, homicide and motor vehicle crashes. Overall, the European Region has the highest alcohol consumption in the world and the proportion of countries with high levels (above 10 litres per person per year) is increasing. Considerable increases in alcohol consumption were recorded between 1988 and 1998 for the Russian Federation, Belarus, Ireland, Latvia and the Czech Republic, although in some countries, such as France, consumption per capita has been decreasing. Figures for morbidity and mortality due to alcohol are higher in men than in women for all European countries and even among school-aged children, boys are more likely than girls to drink alcohol regularly and have higher rates of drunkenness.

15. Physical inactivity is responsible for an estimated 3.3% of the total disease burden in developed countries. Among school-aged children, patterns of physical activity vary widely according to geography, gender and age group. In all countries, boys are more active than girls but the frequency of physical activity declines with age, this being more apparent among girls than boys in most countries. Rates of physical activity are higher in Austria, England, Ireland and Lithuania and lower in Belgium (the Flemish community), France, Italy and Portugal, and a similar picture exists for adults. More than 30% of adults in Europe are not sufficiently active in their daily life and levels of physical activity are continuing to decline.

16. Diet contributes to NCD in a number of ways: through high salt, high sugar and high fat consumption, as well as low fruit and vegetable intake. The latter is estimated to be responsible for 3.9% of the total disease burden in developed countries. A consequence of economic growth, with shifts in income, prices and food availability, has been the nutrition transition towards diets with a high proportion

of saturated fat, sugar and salt. No Member State in the Region has fully achieved WHO's recommended dietary goals, but Greece, Portugal and Spain come close to the goals for fat intake. High consumption of sweets and soft drinks is common among adolescents with about one third of boys and one quarter of girls drinking sugared soft drinks daily. Only 30% of boys and 37% of girls report eating fruit daily, with consumption highest in Israel and lowest in Estonia, and less than 50% eat vegetables daily. In almost all countries, the proportion of young people eating fruit and vegetables every day decreases with age, with the decrease greater in boys.

17. Obesity is increasing in Europe and is becoming a significant problem in children. In most European countries, more than half the population are overweight, with 20–30% of adults categorized as clinically obese. In Finland, Germany and the United Kingdom, one in five adults is obese, while in the countries of central and eastern Europe (CCEE) and the NIS even higher levels are found. The prevalence of childhood obesity in Europe has increased rapidly, with up to 27% affected in some regions. Eighty percent of the prevalence of diabetes can be attributed to obesity.

18. These common risk factors have economic, social, gender, political, behavioural and environmental determinants. There is a complex interplay between risk factors and other determinants of health in attribution of disease.*(3)* Hazardous and harmful use of alcohol and tobacco use are closely associated with markers of social and economic disadvantage. People on low incomes are least able to eat well and access fresh food. Social and psychological circumstances can cause long-term stress, with people becoming more vulnerable to depression and cardiovascular disease. Social isolation and exclusion are associated with increased rates of premature death and poorer chances of survival after a heart attack. Having little control over one's work is strongly related to an increased risk of low back pain, sickness absence and cardiovascular disease. People in low socioeconomic groups have at least twice the risk of serious illness and premature death as those in high socioeconomic groups. Differences between socioeconomic groups in mortality from and risk factors for, cardiovascular diseases have been reported in many countries. Within western Europe, a north-south gradient is apparent with relative and absolute inequalities being larger in the north than in the south.*(4)* Closing the gap between low and high socioeconomic groups offers great potential for reducing mortality from cardiovascular and other noncommunicable diseases.

Main strategies and focuses of action

Interventions

19. Effective interventions already exist for preventing and treating NCD and reducing the impact of disease and the disability that results. Putting current knowledge into practice would see people being offered – across their lifespan – prevention, treatment and long-term management.

20. Much is already known about how to reduce risks effectively and there is substantial agreement between the public health and international scientific communities. It is clear, for example, that the single most effective means of tobacco control is to increase taxes on all tobacco products. A price increase of 10% on a packet of cigarettes would be expected to reduce consumption by about 4% in high-income countries and by about 8% in low- and middle- income countries. Europe is already rich in experience in NCD interventions, with some countries leading the way. In Finland, the North Karelia project reduced mortality from coronary heart disease by 73% over 25 years through community-based activity encouraging a healthier diet, supported by national policies on risk factors. In Poland, a change in dietary fats resulted in a 20% decline in mortality from heart disease.

21. Prevention is a long-term undertaking, but the real short-term gains are to be made in treating people at high risk, such as those with established coronary heart disease or asymptomatic individuals at high risk of developing disease. Drugs such as beta blockers, aspirin and lipid-lowering agents can be highly effective in reducing risks of cardiovascular morbidity and mortality.*(5)* In terms of prevention, the

more immediate gains can be achieved by identifying and targeting individuals at high risk of new or subsequent events.

22. Effective approaches to chronic disease management have been identified.*(6)* Introducing evidence-based tools can provide a means for improve the quality of management of a range of chronic health problems. Disease management programmes can improve the quality of care of people with chronic diseases, as measured by performance indicators. Effective strategies also exist to decrease the amount of disability associated with an existing disorder or illness. For patients with cancer, for example, simple measures including pain relief, sensitive communication and well coordinated care are effective in relieving symptoms and suffering.*(7)*

23. Intervention is worthwhile throughout the life course. The foundations of adult health are laid in early childhood and before birth. Poor circumstances during pregnancy can lead to poor foetal development which is a risk for health in later life (low birth weight is associated with increased risk of diabetes, for example). Good health-related habits start in childhood. Adoption of healthy lifestyles in older age can prevent disease and functional decline, extend longevity and enhance the quality of life. Studies in the Netherlands have shown that the greater the physical activity of older men, the lower the subsequent mortality rate, with the rate halving among the most active third of older people.

24. Interventions can be more effective in combination, both for individual and for common risk factors. Implementing multiple policies on individual risk factors in a systematic way has been shown to have the greatest potential in both tobacco control and alcohol control. Recognizing that a few risk factors are common to the major NCD leads to an integrated approach to prevention. Combining population-based cholesterol reduction strategies with interventions to reduce salt intake at the population level is very cost-effective in reducing hypertension and high cholesterol levels. A combination of measures aimed simultaneously at the entire population as well as at those individuals who are at high risk of developing disease is also cost-effective. There are positive evaluations, for example, of population interventions aimed at reducing salt intake, lowering cholesterol and reducing body mass index, alongside the implementation of an absolute risk approach to managing cardiovascular disease risks. There are already many examples of successful implementation of an integrated approach in countries throughout Europe.

Principles for action

25. In order to protect and improve health, more emphasis needs to be placed on preventing the actual causes of important diseases, as well as treating the diseases themselves. The aim is to develop a high-quality health service in combination with successful public health measures. Greater government investment in risk prevention is needed, in order to contribute substantially to avoiding future mortality. Priority should be given to the control of risks that are well known, common, substantial and widespread, and for which effective and acceptable risk reduction strategies are available.

26. Policy makers should consider those evidence-based interventions that are likely to yield the greatest health gain for the available resources, judging which are feasible within their own particular context. Substantial health gains can be made for relatively modest expenditures on interventions – and some interventions (increased taxes on tobacco and measures to reduce the proportion of salt and other unhealthy components in food, for example) should be within the reach of even the poorer countries. Sustained and determined action starting today against only a relatively few major risks to health is likely to lead to large health gains within ten years, with potential benefits applying to poor and rich countries alike.

27. Across all interventions to prevent and control NCD, certain principles underlie the framework for action: a focus on reducing inequalities in health; attention to the most vulnerable people in society; taking a life course perspective; involvement of the citizen in decision-making; putting the patient at the centre of care; making best use of primary and community health services; mobilizing all relevant sectors

of society; engaging all levels of government; using the potential of settings where people learn, live, work and play; and integrating policy within broader, comprehensive public health efforts.

Challenges

Systems of care

28. Many NCD take a lifelong, chronic course and patients (and their families) need help in managing complex, multiple conditions over sustained periods. This can place demands on health care delivery systems that have been designed with a focus on episodic, acute care. Serious shortfalls can exist. Many chronic diseases are under-diagnosed and under-treated and patients who would benefit from secondary prevention or drug treatment frequently do not receive the support they need. Adherence to long-term therapies and medication among patients with chronic conditions averages only 50% in developed countries.*(8)* In some countries, less than 25% of patients treated for hypertension achieve optimal blood pressure and only 28% of patients treated for diabetes achieve good glycaemic control.

29. Common strategies are needed across the different chronic conditions. Patients with chronic conditions do better if they receive effective treatment within an integrated system, with multidisciplinary teams, support for self-management and regular follow-up. Enabling this requires a paradigm shift from a medical, curative model of health care towards a coordinated, comprehensive system of care. The patient should be the primary manager of the chronic disease, guided by the health professional. Health care teams need to be organized so that care is coordinated across providers and settings. Physicians, nurses and other health professionals need to be equipped with the necessary training and skills, which has implications for undergraduate curricula, specialist training and continuing education.

Poverty and inequity

30. The burden from NCD is unevenly distributed throughout society. The poor are disproportionately affected: they are more vulnerable to NCD, which trap them further into poverty. They may also have greater difficulty accessing health care services.*(9)* Furthermore, the NCD burden is unevenly distributed throughout Europe. In the central and eastern European countries, for example, the age profile of all chronic disease mortality is dramatically younger than in the 15 countries of the EU before 1 May 2004. Premature death of main wage earners and skilled, trained workers can have an impact not just on household income but also on countries' economies.

31. The level of spending on health in low-income countries is insufficient to address the health challenges they are facing. In the European Region of WHO, eight countries have a per capita gross national product (GNP) of less than US$ 750. For these countries, total health expenditure per person is in the region of US$ 11 to US$ 54 and a substantial, and most likely growing, share of this is made up of is out-of-pocket payments. The systems in these countries have insufficient capacity to deal with NCD. Furthermore, there is a "double burden" of disease in some parts of Europe, with an increasing burden from NCD coming on top of the persistent threat of communicable diseases. Health systems are required to deal comprehensively with all common diseases, irrespective of their origin. Investment needs to be scaled up to enable the systems to cope.

Gaps in knowledge

32. There are a number of common myths prevailing about NCD: that they are "diseases of affluence"; that they are hard to treat; that they are a natural consequence of ageing and degenerative processes; that prevention takes a long time to have impact; that it is impossible to change lifestyles and behaviours. Misconceptions such as these not only abound among citizens but can also occur in the minds of policy-makers. Clear communication, accessible information, health education and transparency are needed, so that people are well informed.

33. While much is known about the causes of disease and effective interventions, there are still gaps in our knowledge in applying that knowledge. Advice to policy-makers needs to take account not only of the best available evidence but also of the “generalizability” and transferability of that evidence to other settings factors that in some cases are not known. It is important to identify the gaps, focus the research and seek to ensure that policies have a solid evidence base. Effective Europe-wide surveillance systems need to be put in place, particularly in relation to risk factors, to allow assessment of the full extent of the problem for the Region as a whole, comparative analysis within and between countries, monitoring of trends, evaluation of interventions and modelling of future scenarios.

Policy agenda

34. In 2001, a WHO survey found that while many ministries of health recognized NCD prevention as a significant health priority, fewer had translated this into comprehensive policy development.*(10)* Policies on NCD existed in 59% of the 41 countries in Europe that responded, with specific cardiovascular, diabetes and cancer plans existing in 50%, 54% and 62% of Member States, respectively. Less than 46% reported having a budget line specifically allocated to NCDs. The approach to policy development and management of NCD seemed fragmented and uncoordinated in many cases and health system infrastructure appeared to be inadequate to deal with NCD. A priority need emerged for expertise and assistance in national policy development, better quality surveillance systems and capacity-building of health professionals and administrators.

35. NCD need to be high on the agenda of other sectors at national level, however, beyond just the health sector. Issues like diet and physical activity require multisectoral responses. To make a real impact and create a favourable policy environment for change, NCD need to be considered a governmental concern as well as a health concern.

Market forces

36. Many societies and health systems are not prepared to counter the threats that come from opening borders, market forces and globalization. As transnational corporations search for new markets for their goods, their marketing campaigns reach a global audience. Images, products and, in turn, risk factors such as tobacco and alcohol, flow in the global economy. While the flow of tobacco is always negative, the flow of food products can have both positive and negative consequences.

37. Rational prescribing strategies can be undermined by commercial interests. Drug companies can use promotional techniques to influence prescribing. Drug treatment is favoured over non-drug treatment options. In the media, excessive emphasis can be placed on medical “solutions”; for example, statins for controlling cholesterol are promoted over lifestyle modifications. Public money may be invested in expensive new drugs when equally effective and cheaper alternatives already exist.

Achieving a balance

38. Tackling NCD requires a balance to be struck in a number of areas that make up a complex field. First, there is the balance between personal and governmental responsibility. Many risk reduction strategies involve a component of health behaviour change but, to be successful, some types of behaviour change require active government intervention.

39. Second, there is a balance to be achieved across the continuum of health promotion-disease prevention-health care. Combinations of approaches are needed: population-wide and individual-based; prevention and treatment. Some areas are relatively neglected and the resources already available within the health system are not utilized to their full potential. Opportunities for secondary prevention may be being missed. The place of disease prevention needs to be reviewed, as does the role of health personnel in disease prevention and health promotion.

40. Third, a balance needs to be struck between the role of health systems and that of other sectors and settings. Non-health sectors have greater control over the determinants of health than the health sector and are more able to facilitate supportive environments. For example, promotion of physical activity as a part of everyday life benefits from the involvement of urban and transport planners.

Foundations for action

41. Some foundations for action already exist. At global and European levels, Member States have made commitments to preventing and controlling NCD, although in recent years emphasis has been placed on primary prevention of the main risk factors.

42. A global strategy for the prevention and control of noncommunicable diseases was adopted by the World Health Assembly in 2000. It focuses in an integrated way on the risk factors common to the most prominent NCD and has three components: surveillance, prevention and health sector management. Member States were urged to develop national policies and programmes for the prevention and control of the major NCD.

43. Within this same framework, a global strategy on diet, physical activity and health was adopted in May 2004. It urges Member States to promote healthy diets and physical activity as part of their overall policies and programmes, mobilizing all concerned social and economic groups, engaging the relevant sectors and fostering a supportive environment for behaviour change.

44. Preceding these but still supporting the overall theme of healthy diet are the global strategy for infant and young child feeding (2002), which includes specific action to reduce the risks associated with obesity and the First European Action Plan for Food and Nutrition Policy (2000–2005). A new regional food and nutrition action plan (2006–2010) is expected to be launched at a ministerial food and nutrition conference planned for 2006.

45. Within Europe, physical activity and the impact of the physical environment on human health have been highlighted in the Regional Office's Environment and Health process, with conferences most recently in London (1999) and Budapest (2004), as well as in the Transport, Health and Environment Pan-European Programme (THE PEP), which specifically promotes cycling and walking.

46. Strategies on diet and physical activity build on the substantial work already done on tobacco and alcohol. At global level, the Framework Convention on Tobacco Control is the first international legal instrument designed to limit the harm to health caused by tobacco products. The European Strategy for Tobacco Control (2002) provides an evidence-based strategic framework and guidance for effective national action and international cooperation. The Stockholm Declaration on Young People and Alcohol, endorsed by the Regional Committee in 2001 and the second phase of the European Alcohol Action Plan (2000–2005) provide a basis for the development and implementation of alcohol policies and programmes in Member States.

47. Mental illness is both a disease and a contributor to other noncommunicable conditions. *The world health report 2001*, affirmed at the Fifty-fifth World Health Assembly, raised awareness of the real burden of mental disorders and provided Member States with useful guidance on evidence-based actions to take in response. Action on mental health policy in Europe is supported by the Athens Declaration on Mental Health and Man-made Disasters, Stigma and Community Care and the preparations for the ministerial conference to be held in 2005 with the slogan "Facing the challenges – building solutions". Otherwise, in recent years the main focus in chronic disease management has been more on systems of care rather than on individual diseases. Diabetes mellitus last received individual attention globally in 1989 with the Saint Vincent Declaration, for example.

48. Still relevant today, the Ottawa Charter for Health Promotion of 1986 called for the health sector to move increasingly in a health promotion direction and beyond its responsibility for providing clinical and curative services. Ten years later, in Europe, the Ljubljana Charter articulated a set of principles to

improve health care, including that health systems should be centred on people and reoriented towards primary care. It called for the basic training, specialization and continuing education of health care personnel to go beyond the traditional, curative approach and for quality of care, disease prevention and health promotion to be an integral part of training. The Global Meeting on Primary Health Care (Madrid, 2003) and a number of World Health Assembly resolutions have maintained a focus on primary health care when strengthening health systems and on enabling coordinated, patient-centred care across the continuum of prevention and care. The WHO medicines strategy of 2000 has guided work to secure and expand access to essential drugs and promote rational drug use.

49. There are also strategies for specific age and population groups that take a life course approach to NCD prevention and control. The global strategy on reproductive health, adopted by all Member States in May 2004, highlights cancer prevention as well as the importance of good antenatal, maternal and neonatal care, The global strategy for improving the health and development of children and adolescents (2003) provides the framework for a European strategy planned for 2006. Among other things, it promotes good nutrition and health-promoting behaviours and emphasizes that support during the early years has a significant impact on later life. Furthermore, the World Health Assembly lent its support to active and healthy ageing in 1999, echoed later at the Second World Assembly on Ageing in 2002 through the adoption of the International Plan of Action on Ageing.

A European strategy for noncommunicable disease

50. In summary, NCD place a considerable burden on Europe; if they are unchecked, the picture is set to worsen, particularly in the eastern part of the Region; common risk factors have been identified; effective interventions exist and are working; some countries are leading the way and benefits can be shared between all countries; clear principles provide a basis for action; closing the gap between low and high socioeconomic groups offers great potential for gain; countries are facing particular challenges, for which support and international action is needed; substantial foundations already exist on which to build; Europe is diverse and “one size does not fit all”.

51. Certain matters are clear. The field of NCD is complex, in political and public health terms. Comprehensive intersectoral approaches are needed, but countries should not feel so overwhelmed that they take either no action or only the easiest options. When deciding on the measures to take, policy-makers need to carefully consider a range of factors, including which key risks to tackle, the balance between primary, secondary and tertiary prevention and the management of uncertain risks and feasibility within their own contexts.

52. A European strategy on NCD should inspire and support but not confuse. Member States do not need additional burdens placed upon them. Instead, the strategy should help them put into place and implement approaches that are already known and to which they have already made commitments. It should identify what is unknown and where further work is needed; it should strengthen those areas where little action has been taken; and it should seek to bring all Member States up to at least a minimal level of functioning in key areas, with the potential for further action where and when their circumstances allow.

53. There is a strong case to be made for a European NCD strategy. It would make explicit the importance of this problem for the European Region and the political commitment to taking priority action. It would take account of the diversity of the Region and assist countries at different stages of knowledge and experience. It would put in place supportive infrastructures from which Member States could benefit. It would support countries in tackling this problem in the face of challenges. It would add value to what already exists, helping countries to meet their existing commitments. It would enable the Region as a whole to benefit, an important consideration in a Europe increasingly without borders. It would provide a means to link existing foundations together into a coherent, synergistic approach. It would provide an instrument for building further relations with the European Commission, WHO

headquarters and other international bodies on common goals, dovetailing with global and other regional strategies.

54. The central concept would be one strategic framework that takes account of the diversity of the European Region. It therefore, seeks to identify cost-effective measures that all countries (even those with a low resource base) can take now and then to build up in complexity in a step-wise fashion, so that countries can add further measures when timing and resources allow. The emphasis will be on putting together an integrated, cost-effective "basket" of policies and helping Member States to find the right policy mix for their circumstances. While intensified action on primary prevention is essential, there also needs to be better implementation across the Region of what is known, as well as an emphasis on those aspects not adequately covered in recent years: secondary and tertiary prevention and disease management and management of health system resources. The strategy should be action-oriented with a focus on implementation, balancing the respective roles of the countries and WHO.

55. The process of developing a strategy is important. The pathway taken can be as important as the paper that results. A participatory, consultative process is envisaged, with the engagement of Member States (representing the diversity of the European Region) as well as partners who are crucial for implementation: nongovernmental organizations, patients' associations, professional associations, other relevant sectors and international bodies important to the Region such as the European Commission. To support the process of developing the strategy and its later implementation, certain tools and systems may need to be established (in particular, surveillance may need to be strengthened for example).

56. In conclusion, the time is right for development of a European strategy on noncommunicable diseases and the case for doing so is a strong one. The proposed timetable is for a strategy to be developed for the Regional Committee session in 2006, thereby allowing sufficient time for extensive consultation and debate with Member States, collection of experiences, raising of awareness and increased collaboration with partners. Member States are asked to consider the draft resolution contained in document EUR/RC54/Conf.Doc./3, to agree on the timetable prepared and to outline their preferred course of action, messages and emphases for the European Region.

References

1. *The world health report 2002* – Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002 (table, page 162 and Annex Table 16, page 232).
2. Currie, C. et al (eds.) *Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen, WHO Regional Office for Europe, 2004 (Health Policy for Children and Adolescents series, no.4).
3. Wilkinson, R. Marmot, M eds. *Social determinants of health – the solid facts*. Copenhagen, WHO Regional Office for Europe, 2003.
4. Mackenbach, JP. et al, Socioeconomic inequalities in cardiovascular disease mortality: an international study. *European Heart Journal, 21*(14): 1141–51, (2000).
5. European guidelines on CVD prevention. *European Journal of Cardiovascular Prevention and Rehabilitation*. (10), Supplement 1 (2003).
6. *Innovative care for chronic conditions. Building blocks for action*. Geneva, World Health Organization, 2002.
7. Davies, E. Higginson, IJ. eds. *Palliative care – the solid facts*. Copenhagen, WHO Regional Office for Europe, 2004.
8. *Adherence to long-term therapies. Evidence for action*. Geneva, World Health Organization, 2003.
9. *Health systems confront poverty*. Copenhagen, WHO Regional Office for Europe, 2003.

10. *Assessment of national capacity for noncommunicable disease prevention and control. The report of a global survey*. Geneva, World Health Organization, 2001 (document WHO/MNC/01.2).