European Strategy for the Prevention and Control of Noncommunicable Diseases

Meeting of the National Counterparts
London, United Kingdom, 2-3 May 2007

Report
Abstract

The meeting of the National Counterparts for the European Strategy for the Prevention and Control of Noncommunicable Diseases, which took place in London, United Kingdom, on 2–3 May 2007, was the first since the adoption of the Strategy. The key items for discussion included the proposed action plan for the implementation of the European Strategy, the forthcoming WHO European report on NCD, and recent developments in countries in the prevention and control of NCD. The progress and challenges in this area faced by different countries were also presented.

Keywords

CHRONIC DISEASE - prevention and control
STRATEGIC PLANNING
DELIVERY OF HEALTH CARE - organization and administration
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Executive summary

No less than 86% of all deaths and 77% of the disease burden in the WHO European Region are caused by noncommunicable diseases (NCD). The quality of life and the well-being of both the individual and the society as a whole could be improved by investing in the prevention and control of this broad group of disorders, which are linked by common risk factors, underlying determinants and opportunities for intervention. Effective interventions would bring significant health and economic gain to all Member States but the greatest impact would be felt if the benefits derived were equitably shared.

At the fifty-sixth session of the WHO Regional Committee for Europe in September 2006, Member States endorsed Gaining health. The European Strategy for the Prevention and Control of Noncommunicable Diseases (European NCD Strategy) (1). It promotes a comprehensive and integrated approach to NCD prevention and control, taking the commitments and experience of the Member States in this area into account. By preventing premature death and significantly reducing the burden of disease caused by NCD, it aims to improve quality of life and make healthy life expectancy more equitable within and between the Member States in the European Region. It also seeks to combine the integrated action being taken by the different sectors to combat NCD risk factors and their underlying determinants with efforts to strengthen health systems towards improved NCD prevention and control.

Resolution EUR/RC56/R2 (2), adopted by the Member States at the fifty-sixth session of the WHO Regional Committee for Europe, requested the Regional Director to establish a network of national NCD counterparts as an international advisory mechanism on the implementation of the European NCD Strategy (1), and to find ways of strengthening bilateral and multilateral cooperation to this end. The Regional Director was also requested to report on progress made to this end at the fifty-eighth session of the Regional Committee for Europe in 2008.

This meeting of the NCD counterparts was the first since the adoption of the Strategy (1). Key items for discussion included the proposed action plan for its implementation, the forthcoming WHO European report on NCD, and recent developments in countries in the prevention and control of NCD (Annexes 1 and 2).

Seventy-four delegates from 36 countries, representatives of the European Commission, the World Bank and non-governmental organizations (NGOs), WHO temporary advisors and WHO staff participated in the meeting (Annex 3).

Opening of the meeting

Dr Haik Nikogosian, Deputy Director, Division of Technical Support, WHO Regional Office for Europe, welcomed the participants to the meeting. He thanked the Government of the United Kingdom for hosting the meeting and providing an opportunity for countries to share their experiences and thus strengthen the collective knowledge base.

In welcoming the participants on behalf of the Government of the United Kingdom, Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, said that the United Kingdom is
keen to support the Regional Office in implementing the European NCD Strategy (1) and she applauded the integrated approach, which is essential if health systems are to be strengthened and health inequalities tackled. The meeting was a great opportunity for the participants to learn from each other about how to translate the Strategy (1) into action.

Several parallel WHO events and action had been important in developing the Strategy (1): the elaboration of the WHO European Action Plan for Food and Nutrition Action Policy (4); the WHO Ministerial Conference on Counteracting Obesity, Istanbul, Turkey, November 2006 (5); the Second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Bangkok, Thailand, 30 June–6 July 2007; and work on the social determinants of health and on a forthcoming WHA resolution on alcohol control2.

There has been a shift in WHO from biannual planning to medium-term strategic planning over a six-year period. The priorities for the period 2008–2013 include the area of NCD, which will receive a substantial increase in budget.

**Appointment of Officers and adoption of agenda**

Dr Fiona Adshead, United Kingdom, was elected as Chairperson of the meeting and Dr Else Smith, Denmark, as Rapporteur.

The programme was adopted (Annex 1).

**Report on developments since the endorsement of the European NCD Strategy**

**WHO European Region**

The European NCD Strategy (1) was endorsed by 53 Member States of WHO European Region at the Fifty-sixth Session of the Regional Committee in September 2006. The following key messages encapsulate its direction and thrust:

1. Prevention throughout life is effective and must be regarded as an investment.
2. All settings should be health-supporting and enable healthy choices to be easy choices.
3. People should be empowered to promote their own health, actively manage disease and interact effectively with the health services.
4. Health and medical services should be fit for purpose, respond to the current disease burden and increase opportunities for health promotion.
5. Universal access to health promotion, disease prevention and health services is central to achieving equity in health.
6. Governments at all levels are responsible for building healthy public policies and ensuring action by all sectors concerned.

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The objective of the European NCD Strategy (1) is to improve NCD prevention and control by combating NCD risk factors and their determinants through multisectoral integrated action, and by strengthening health systems.

The WHO action plan for the implementation of the Strategy (1) needs to address: governance (strategic planning, NCD Counterparts); alliance (at both national and international levels); communication (translation, publication, dissemination); priority areas; monitoring and evaluation; research and development; training and capacity-building, and resource mobilization.

The following parallel initiatives were important to the development of Strategy (1):

- Ministerial Conference on Counteracting Obesity, Istanbul, Turkey, November 2006 (4) (which resulted in the European Charter on Counteracting Obesity);
- Elaboration of the WHO European Action Plan for Food and Nutrition Policy 2007–2012 (5);
- Move for Health Day, 10 May 2007;
- Intersectoral workshop on capacity building in tobacco control for the south-eastern European countries, Bled, Slovenia, 11–13 October 2006;
- WHO European workshop on standardized tobacco control surveys, Athens, Greece, 22–23 February 2007 (in collaboration with the Centers for Disease Control, Atlanta, United States);
- World No-Tobacco Day, 31 May 2007;
- Development of the Heart Health Charter for Europe3.

**Global level**

The global NCD strategy was reviewed by Member States to ensure that all strategies were in line with each other. The Executive Board requested an outline for presentation at the next session of the World Health Assembly (May 2007).

**Challenges and priorities I: A comprehensive and integrated approach to NCD prevention and control**

A study carried out by the Organisation for Economic Cooperation and Development (OECD) (6) shows that although CVD causes 46 times as many deaths as HIV/AIDS, the funding allocated to population-wide prevention and relevant public health programmes is very limited.

The aim of this session was to gather information on ongoing country activities in this field and on what kind of WHO assistance the countries would find useful.

**The experience of England, United Kingdom: addressing the challenge of NCD**

The approach of England to addressing NCD is characterized by a devolved health care system with universal access to services. There are concerns about the sustainability of the system’s

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funding. Among the OECD countries, England is that which spends the least on prevention (6). Increasing emphasis is being placed on providing preventive services locally, as well as on greater patient involvement and choice. In the United Kingdom, public health services are delivered through a range of national and local bodies and other delivery agents. Particular emphasis is placed on intersectoral collaboration (involving various ministries, civil society organizations and the business sector).

Work at the national level is based on several decades of experience in the integrated approach to NCD prevention and control and is carried out across government to change the environment for health. There is strong focus on inequalities and monitoring and evaluation, as well as on learning from the different approaches that exist within the United Kingdom. At the local level, there is an annual planning framework for the health services that outlines the priorities for the coming year. Activities are carried out through local delivery plans in partnership with local government and in accordance with local agreements. Public health targets include tackling inequalities in health, sexual health, obesity, alcohol, drugs and smoking.

Smoking was presented as a case study. Although smoking has declined in England, it remains a problem among lower socioeconomic groups, with a geographically variable prevalence. The objectives of the tobacco control programme in England are: to help smokers quit; to reduce second-hand smoke; to promote health through education and the media; to reduce the promotion of tobacco; to address labelling and regulation; and to tackle taxation and smuggling. Interventions include smoking cessation services for which national standards of practice have been drawn up, and there has been focus on determining the effectiveness of interventions, regulations, evaluation and inspection, as well as on regional variability.

How to maximize the impact at the population and individual levels remains a challenge. Thus, in order to improve access to smoking cessation services, several steps have been taken, such as setting national targets, increasing the demand for services at individual level (through, for example, social marketing), providing more accessibility, developing new delivery models to improve access, and evaluating the impact of the services. Evaluation will help find ways to improve health and health care on commissioning, clarify reasons for variation in delivery, and provide a better understanding of the public. For example, the impact of smoke-free legislation has raised the profile of the dangers of smoking and created an impetus for change. Currently, the four countries of the United Kingdom have different approaches to smoking, including national cessation targets, smoking cessation clinics at local level, and support for clinicians in targeting their efforts on intervention.

People must come first and, as the inequity gap is increasing for the poorest in society, so is the emphasis on health inequalities. Furthermore, although the health system is managed at national level, decision-making and commissioning are increasingly being devolved to local level. There are many challenges yet to be overcome and it is important not to become complacent. Integrating and repositioning the NCD strategies within an approach that draws on local partnership, education and business will be a step in the right direction.
The experience of Canada: towards a comprehensive and integrated approach to NCD prevention and control

The Canadian publicly-funded health care system is an interlocking set of ten provincial and three territorial health insurance plans. This national programme adheres to the Canada Health Act (7) in providing access to universal, comprehensive coverage for medically necessary hospital and physician services.

Since the Ottawa Charter for Health Promotion (8), a fair amount of effort has been made to move toward population-based programmes in Canada. The public health service is multi-level, with public health units at local and municipal levels, and there is a move towards a more dedicated focus on public health at the provincial/territorial level.

The burden of NCD in Canada is increasing. Though smoking control is one of the biggest success stories, the results do not show the existing disparities. Although there has been a decline in CVD, there is an obesity crisis: three out of five Canadians are overweight and the rates of physical activity and fruit and vegetable consumption are low. Furthermore, the health status of certain population groups, such as First Nations, is poor (9).

The longest-standing integrated NCD programme in Canada is that on tobacco control, a multisectoral, multi-pronged programme. For the last 15 years, there has been focus on access, advertising and promotion, packaging and labelling, product regulations, taxes, smuggling, enforcement and education and the many lessons learnt can be applied to the obesity epidemic. Disease-specific strategies are shown in Table 1.

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<td></td>
<td>• Demonstration programmes in 10 provinces</td>
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<td></td>
<td>• Partnership and linkage model:</td>
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<td></td>
<td>o international, national, provincial, and community</td>
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<td></td>
<td>o public, private and voluntary sectors</td>
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<td></td>
<td>o knowledge transfer between researchers and decision-makers</td>
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<td>Building the capacity of the public health infrastructure to address chronic disease prevention:</td>
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<td></td>
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<td>• development of tools and methodologies:</td>
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<td>• process evaluation, dissemination, research</td>
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<td>Canadian Diabetes Strategy, 1999</td>
<td>A partnership model: Diabetes Council of Canada</td>
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<td></td>
<td>A comprehensive approach: social marketing; knowledge development and exchange; community-based programming;</td>
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<td></td>
<td>national diabetes surveillance system; addressing needs of vulnerable populations (Aboriginal Diabetes Initiative); moving towards increased focus on populations at risk.</td>
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<tr>
<td>Canadian Cancer Control Strategy, 2006</td>
<td>Governance, a thorough and inclusive process: Canadian Partnership against Cancer Corporation (2006)</td>
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<td></td>
<td>• Priorities for action: clinical practice guidelines; primary prevention; screening/early detection; rebalancing focus; health human resources; research; surveillance.</td>
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What is the impetus of the integrated approach in Canada? At the national and provincial levels there are alliances, such as the Chronic Disease Prevention Alliance of Canada and the Coalition on Enhancing Preventive Practices of Health Professionals. Moreover, civil society plays an important role: NGOs at the national and provincial levels have advocated together for integrated chronic disease systems.

At the national level, the Integrated Strategy on Healthy Living and Chronic Disease combines intersectoral action in the areas of diet and physical activity and disease-specific action related to cancer, diabetes and CVD. This involves a three-pronged approach to: (1) promote health through intersectoral action; (2) minimize the risk of chronic disease and injury; and (3) detect chronic health problems and injuries early and manage them effectively. Implementation is carried out by combining public health and primary health care action in multiple settings with the involvement of various sectors. At the provincial level, there is a move towards chronic care models with greater emphasis on preventive care through preventive care guidelines, preventive care service incentives and collaborative models of primary care service delivery (such as the Health Care Transition Fund).

Integrated action calls for the collaboration of all sectors and levels of government, and of civil society, health professionals, the media, employers and the corporate sector. It also requires supportive mechanisms, most notably the following:

- **Knowledge synthesis and development** including: (a) comprehensive learning systems, such as the Canadian Best Practices Portal for Health Promotion and Chronic Disease Prevention\(^4\) and the WHO–Public Health Agency of Canada (PHAC) Observatory of Chronic Disease Policy\(^5\); (b) a supportive infrastructure for research on NCD prevention (e.g. Canadian institutes for health research; the Health Promotion Research Consortium; knowledge networks); and (c) a new demonstration area for the monitoring and evaluation of integrated NCD prevention approaches (e.g. the WHO Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme demonstration area in Alberta);

- **Surveillance**, such as the development of a pan-Canadian strategy for a chronic diseases integrated surveillance system that has expanded existing chronic disease surveillance systems to include information on determinants, risk factors and interventions, with a stronger emphasis on data analysis, interpretation and dissemination.

- **Policy levers**, such as food labelling, fitness tax credits\(^6\), advertising control.

- **New national governance mechanisms**: the Public Health Network (cross jurisdictional); expert groups on chronic diseases, such as the Intersectoral Healthy Living Network (moving towards “whole of government approaches” at the national level) and national collaborating centres.

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\(^6\) Issued to families that send children under 16 years of age to recreation facilities so that they can claim tax reductions.
Facilitated discussion

The discussion was started by a question to the speakers about what factors they would consider important to achieving a successful integrated approach to NCD prevention and control. These were: looking at ways of collaborating with industry, particularly the food industry; engaging the health professionals; and investing in the health system.

Questions and comments

• Though Albania is not at the same level as Canada and the United Kingdom in addressing NCD, there has been progress. The focus has been on women and children but it is now recognized that the big issue is CVD. There has been some success, such as the introduction of the law on tobacco control in 2006 and the development of a cancer prevention strategy.

• The question was raised as to whether the use of CINDI demonstration areas was still valid for countries that are starting to develop national NCD prevention strategies. It was considered worth remembering the context within which the CINDI demonstration areas were developed, which was at a time when the Ottawa Charter on Health Promotion (8) was advocating multilevel strategies, a good concept but difficult to apply in practice. CINDI was a first approach to bringing an important science foundation to the community level and to responding to the question of who would take the lead in bringing forth an integrated approach. Demonstration areas are still valid as natural experiments of the integrated approach and they provide a powerful means of sharing experiences across countries.

• A question was raised on how intersectoral action was sustained and how the priorities for an all-government approach were determined. In Canada, a number of the vertical programmes were actually intersectoral but did not have a systematic approach – it was a question of the health sector engaging other sectors. There were no legislative mechanisms for intersectoral action, which was carried out on an ad hoc basis with very little evaluation. Now, with obesity as a leading health issue in Canada, there is leadership from central government, with incentives to take action on and be accountable for certain targets. It is very important that the public health infrastructure be supported by technical backup, such as health impact assessments, documented monitoring and evaluation.

• In the United Kingdom, the Ministry of Finance has looked at how they can motivate individual ministries by giving them shared targets. For example, three ministries are responsible for obesity. They are jointly accountable and report to Parliament as a united front. In arguing the case for an integrated approach, it is important to do so not only from a health perspective but also from an economic and social policy perspective, keeping the health benefits as a clear objective and working towards them. In terms of setting priorities, the United Kingdom tends to do so across government, committing to those that cross different government departments. This is very challenging because traditionally the machinery of government has not been set up to work in this way. The trick is to gather evidence and show impact. Accountability is critical.

• A participant asked whether the prevention and control of injuries was part of the comprehensive strategy. In England in the early 1990s, much emphasis was placed on injuries, particularly in children. Road traffic accidents represent one of biggest causes of
disability and reduced life expectancy. There has been less emphasis on this area in recent years because priorities shifted to other areas but the Government was continuing to work with national charities. The difficulty was deciding what to focus on at any one time. Thus, the key was to join up with local authorities as injury prevention was often on the agenda at the local level.

**Key points raised**

- Finding the right balance between legislation and self-regulation.
- Giving people autonomy to make their own decisions.
- Involving opinion-formers and the public.
- Making services accessible.
- Providing financial incentives for organizations and individuals to do the right thing.
- Involving industry and economic stakeholders.
- Focusing on promoting health and achieving culture change.

**Challenges and priorities II: Progress and challenges faced by countries**

**The experience of Ireland**

Ireland has a young population, which will have an impact on the future modelling of chronic diseases. The country is making good progress in terms of population lifestyle, for example in the area of smoking. Three years ago, Ireland became the first country in the world to introduce a ban on smoking in the workplace. There is no national integrated chronic diseases policy but they are working towards it. They have a series of national health strategies, national risk factor strategies (smoking, alcohol, nutrition, etc.) and various diseases strategies.

In Ireland, there are two initiatives relating to economic and social development:

1. a national partnership process to develop the economic and social agenda, including health issues; and
2. a national poverty and social inclusion strategy.

The latter-mentioned moves a lot of the intersectoral work forward.

Within the context of the *Ottawa Charter on Health Promotion (8)*, Ireland has had various experiences in health promotion. Cabinet subcommittees on health have been established but there have been difficulties in maintaining them. There are many risk factor strategies, each with an intersectoral component, but they tend to operate independently. Ireland has been doing disease modelling and there is concern about lifestyle and demographic changes and their impact on the capacity of the hospital system to deal with chronic diseases.

In terms of intersectoral action, the challenge of sustaining and maintaining it has been an issue. Work is ongoing at various government levels to put chronic diseases high on the political agenda. The social inclusion and poverty group is being joined with a health intersectoral group
because inequalities and health determinants are so closely linked. Work on social inclusion and poverty has been successful in driving policy initiatives and the health sector associates itself increasingly with this group, with government backing.

The challenge remains of reorienting the system towards primary care and integrating it with the acute hospital services. The implementation of chronic disease policy will require additional resources. The development of disease registers and systems to monitor progress is a further challenge and there is a need for benchmarking experiences that work.

**The experience of Georgia**

Georgia has changed a lot over the last decade. The first challenge in addressing NCD is the transition from tertiary care to primary health care. There has been some capacity-building in terms of addressing the NCD risk factors, such as food intake and dietary cultures that may not always be conducive to health. Physical activity is improving. There are several state programmes, for example, a cancer registry, a programme on early detection and epidemiological studies on CVD. As the main causes of death in Georgia are now clearly NCD (infectious diseases no longer taking precedence), efforts are being made to introduce NCD as a government priority. It is hoped that NCD will be placed high on the political agenda in the near future. It is essential to be able to convince decision-makers of the cost-effectiveness of investing in this area, bearing in mind the fact that it takes time before an impact on the health status can be seen.

Tobacco is a major problem in Georgia, especially in young people. However, although the Government is in agreement that there is a need to reduce tobacco consumption and there are many smoking programmes, this will take time to achieve. There is a conflict of interest: even though there is no tobacco industry in the country, the taxes on imported tobacco are quite high and profit the budget. Therefore, a ban on tobacco would mean loss of income.

Georgia’s main direction is connected with developing the primary health care sector, which includes retraining all health professionals, including non-medical health professionals. There is also an urban/rural divide and efforts are being made to build primary health care centres in rural areas.

The economy of Georgia is greatly improving and this will hopefully help to bring about some of these changes. There is a national NCD strategy that includes small programmes but it is just a guideline. Hopefully it will become the main policy and the Public Health Department of the Ministry of Health will be the main driver of intersectoral work in this area.

**Facilitated discussion**

The floor was opened for questions and comments.

**Inequalities**

- With respect to social inequalities in rich countries, where the unhealthy part of the population tends to be found among the uneducated groups, in Denmark the challenge is how to identify the best approach with respect to interventions. The variation in perception of health also plays a role. For example, in young, uneducated Danish men, this perception is
different to that of an educated person earning a high income. It is important to know how to approach such issues. Perhaps there are lessons to be learned from Canada regarding the connection between public health managers and researchers in relation to knowledge application. The media has a role to play in addressing such issues, but the aim of the population does not always match the aim of government as regards health.

- In Armenia, there is a lack of information and awareness about disease burden at both the political and population levels. There is a need to draw upon scientific evidence on prevention in order not to reinvent the wheel and repeat the mistakes made by other countries having undergone similar processes. In small countries with poor resources, the challenge is how to focus effort on NCD and use the guidelines in practice.

- In rich countries, the problem of poverty and inequalities applies only to a small portion of the population, which makes it easier to address. They also have the necessary resources to develop a strategy to combat it. In developing countries, however, the problem is much greater owing to lack of resources. It is difficult to implement strategies.

- There is a distance between priorities at political level and priorities at the level of public opinion. The concept of the European NCD Strategy (1) is that health is a value, which is not always the case for other policies. In general, politicians do not consider it to be concrete and this is perhaps the first challenge to address.

**Availability of research**

- There is a lot of research and information available on chronic diseases though sometimes it is inconsistent. WHO could consider using this information to produce guidelines on best practices. Countries would be able to learn from these and adapt them to their own infrastructures. The economic aspects should also be considered and arguments put forward to ministries of finance. The cost and effect of NCD on health have to be expressed in clear and practical terms.

- The challenge is to package and streamline the existing information in terms of the different principles emanating from the diverse experience available. The experience of Canada, for example, points to the importance of bringing together the research community and the programme community. The evidence is two-fold: (1) evidence-based policy practice: Canada has created knowledge networks to bring programme people, policymakers and researchers together, which helps makes sense of the evidence; the knowledge networks have been critical in terms of synthesizing it and finding common principles; (2) practice-based evidence, which can give an indication of how to capitalize on the rich experience existing everywhere. Canada is bringing all of the federally-funded initiatives together to maximize know-how and create frameworks with common indicators. From the point of view of politicians, it is not only a question of bringing forward the economic argument but also of showing where has there been success so that politicians can act in those areas.

**Narrowing the health equity gap**

- Long-term action is essential. For example, action to improve health under the Irish health strategy was joined with initiatives relating to poverty and social inclusion as these issues are considered to be intrinsically linked. Progress made on general inequalities will also have an impact on the health status of the population. Another challenge is to narrow down the priorities for improvement in health to 10–20 key areas. For example, the tobacco control
initiative was clear and focused involving an alliance between policymakers, NGOs and other groups.

- There are inequalities in Georgia between the urban and rural settings. The infrastructure at the local level is key in terms of tackling NCD. The European NCD Strategy (1) clearly shows that all Member States of the European Region are grappling with this issue. In Georgia and other former Soviet Union countries, the Strategy (1) is important for government as it is a document upon which they can base a national strategy. Doing so will be very much connected with the economic status of the country.

**Priorities and challenges**

- In Slovenia there has been successful intersectoral collaboration on health and other policies and there are good examples of intersectoral policies that influence risk factors and health determinants. In addition, there is a new approach to dealing with health inequalities. This is being done through pilot programmes to strengthen primary health care and tackle all risk factors. In order to successfully implement a NCD strategy in Slovenia, it will be important: (1) to place NCD very high on the political agenda; (2) to focus on changing policies with a negative health impact, such as the Common Agricultural Policy7, by empowering international and national policy-makers; (3) to develop a common tool, such as a binding health impact assessment tool, for use in every step of policy development; and (4) to strengthen health systems.

- Even good practices can produce bad results if politicians are not equipped with the knowledge and skills necessary to deal with health policies.

- In the Russian Federation, the problem of NCD is urgent and its repercussions are broadly felt. Health professionals are working hard to put the issue on the political agenda and are satisfied with cooperation with the WHO Regional Office to this end. The challenge is to improve the management of prevention and control measures in order to attain intersectoral interventions and prevention. The World Bank has also been instrumental in working on NCD prevention in the Russian Federation. WHO could consider targeting conferences of prime ministers and bring up issues of intersectoral action, inequalities, etc. These are areas which lie within the competencies of high-ranking officials.

- On the one hand, it is important that there is a dialogue between stakeholders but, on the other, trustworthy baseline information, which can be shared by all parties, is also crucial, as well as the establishment of a critical mass of people who understand these concepts. For example, in Lithuania, the National Board of Health is different to many other models in Europe. It is a small body that represents an intersectoral group and reports to Parliament on an annual basis. This is based on the surveillance system that exists in the country and the solutions proposed are based on public health concepts. Currently, at high political level, public health issues are accepted although the distribution of resources does not necessarily reflect this. However, the process is ongoing and it is very clear that, without changing the social environment, it is difficult to change the goals. For example, smoking among men has decreased but it is still increasing among young women. The work that WHO carries out together with Member States is very important; Lithuania is happy that NCD is finally on the

agenda. The National Board of Health has created a national task force to develop NCD policy for Lithuania, making it clear that public health approaches and capacity-building are key components in every stage of this development.

- In Kyrgyzstan, there are various national problems that need to be taken into consideration, such as the fact that the country is not very rich and depends on donors to fund much of the work carried out by the Ministry of Health. Another challenge is the high turnover at government level.

- Putting public health on the development agenda is important. It has proved to be a successful way of engaging other sectors, such as those for education and transport, and of augmenting their understanding of health in relation to their own sectors. Intersectoral work can be partly through health policies and partly through other policies. An example of this is the work carried out on economics and health under the United Kingdom EU presidency (July–December 2005), which emphasizes the costs of health services and their burden on the economy as a whole. At the EU level, there is a new impetus for and a clear acknowledgement of the importance and cost-effectiveness of investing in health.

**Key points raised**

1. Raising political awareness.
2. Changing the culture of health professionals.
3. Bringing research and programmes together.
5. Collaborating across sectors.
6. Strengthening the economic argument.
7. Holding people accountable.
8. Providing public health capacity across sectors.
9. Reaching across the community.
10. Areas of unfinished business:
    - Integrating strategies;
    - Emphasizing the health inequalities agenda;
    - Reaching beyond the health community.

**Parallel sessions**

The meeting split into three groups on:

1. integrated intersectoral action on risk factors and their underlying determinants;
2. strengthening health systems for the improved prevention and control of NCD;
3. systematic integration of action and policy to reduce inequalities in health.
Parallel session 1: Integrated intersectoral action on risk factors and their underlying determinants

England, United Kingdom

In outlining his work at the Department of Health, Dr Feast spoke about his involvement in the preparation of the recent White Paper, *Our health, our care, our say: a new direction for community services (10)*, which aims at a shift towards investment in prevention and the long-term agenda. The recently published *Commissioning Framework for Health and Wellbeing (11)* is an exercise in consulting with health services and local authorities to try to reach a consensus on integrated planning. Specific aims include: health services that are sensitive to the needs and focused on maintaining the independence of the individual; a reorientation towards promoting health and well-being and proactively preventing ill health; and a stronger focus on commissioning for outcomes, across health authorities and local governments, working together to reduce health inequalities and promote equality.

As far as the causes of inequalities are concerned, most major diseases tend to be very strongly correlated with underlying deprivation in a locality. There is much less correlation between the availability of health services, as measured through programme budget spending, and underlying deprivation. The relationship between health outcomes and programme budget spending is also very weak. For example, although there is a very strong correlation between cancer mortality and underlying deprivation, there is currently no significant relationship between cancer mortality and programme budget spending. Furthermore, there is no significant relationship between spending per weighted head of population and deprivation.

Health reform and investment in health have changed the National Health Service. Clinical outcomes have improved and there is much more choice among services, which are being delivered closer to home. There is still work to be done to move towards quality as commissioners tend to buy on the basis of cost and volume and not of what is best or more convenient. At the moment, the focus is on transactional reform (payment according to results), supply side reform (more pluralistic provision, greater provider freedom, work force), demand side reform (choice, voice, commissioning, practice-based commissioning) and system management and regulation (performance management, system rules, commissioning oversight, regulation and assessment of providers). Eight new steps towards more effective commissioning have been proposed:

1. Putting people at the centre of commissioning (voice and choice, self care);
2. Understanding the needs at population and individual levels (a new duty to produce a Strategic Needs Assessment, working across health and local government authorities);
3. Sharing and using information more effectively (myth-busting about what can be shared and provision of better guidance on the benefits of shared data);
4. Assuring high-quality providers for all services (linking licence to operate with standards);
5. Recognizing the interdependence of work, health and well-being (healthy employers, focus on the working age group);
6. Developing incentives for commissioning for health and well-being (across systems, new entrants);
7. Making it happen: local accountability (linking strategic needs assessments with reported actual progress towards agreed goals);

8. Making it happen: capability and leadership (major commissioner development programme across systems).

Primary care clinicians will, therefore, know exactly how much each patient procedure costs, which means that they can budget more effectively, investing in primary prevention rather than paying for complex secondary care. People are being empowered to demand services locally and to contribute to closing the equity gap by, for example, supplying information on their state of health (e.g. do they consider their health to be better or worse than the health of their neighbours?). This is linked to social marketing approaches to identifying the communities with the greatest needs. A primary care clinician will have more choice in referring his patients for treatment, which could be in the private sector or the third sector. The key task is to analyse the impact of each of the health reform mechanisms in order to maximize benefit and minimize risks.

There has been an ambitious system reform programme. Clinical engagement is key. However, the morale of primary care clinicians is low despite increased budgets. The health service should have more democratic characteristics. There are widening health inequalities to address and equality is an issue (age, gender, race, religion and sexual preference).

Future challenges to be addressed include: the role of health and local government authorities; commissioning capability; reduced growth in funding and guidance on decommissioning; the postcode lottery (in connection with variability across communities); the new primary care Quality and Outcomes Framework8 (linked to financial rewards for high-quality care); and gathering evidence for promotion and prevention.

Questions:

• Is the United Kingdom seeking to integrate prevention and care? It was mentioned that there was too much care and that individual choices are still limited; are there incentives in the system for prevention?

The incentives for prevention in the United Kingdom include: (1) the political incentive, which is possible as there is an integrated health service; and (2) financial incentives, so that the bulk of the investment is in primary care. There is quite good evidence that delivering services in primary care is cheaper, as is investment in promotion and prevention. The counter-argument is that seeing many people per hour in a hospital clinic is cheaper than seeing them in the community. They are moving to social accounting to gain an understanding of the value to the individual of being seen at home.

• Does the reported budgeting include funding for health promotion and public health interventions? Is less money going into public health in deprived areas? If so, what is being done to change that?

The 20 programme budgeting categories are not as yet broken down into investment in prevention. A group has been established to look at this, initially with respect to cancer and

coronary heart disease. In addition, a senior academic and political group called "Health England" has been established to advise ministers on the type of investments that are most likely to bring about shifts in public health. At the same time, from 2008 the health authorities will only sign off on investment plans that show a clear shift to prevention and the promotion of health. The problem is that there is no baseline data on original investment levels. Investments to date have been in the long-term conditions, e.g. diabetes, asthma and chronic obstructive pulmonary disease. As yet, there has been no investment in the more social determinants of health. Looking into this will be the next step.

As regards the important issue of how to involve clinicians in health promotion and disease prevention, in the United Kingdom most of the reforms over the last ten years have focused on managerial issues and the goodwill of clinicians has been lost. Clinical leadership is required and there is a strong argument to reinstate more clinicians in management.

**Slovenia**

Recent developments in comprehensive NCD prevention and control in Slovenia came about on the basis of CINDI Programme developments, starting in 1990. The resulting national programme on health promotion and chronic disease prevention was disseminated in 1999.

The demonstration phase, which started in 1998, was characterized by evidence-based advocacy, the promotion of an integrated NCD policy and programme approach, and the many different activities needed to implement such an approach. Supporting resource mobilization and preparing the programme for dissemination were important aspects of the demonstration phase, as was participation in international activities. Other essential areas were capacity-building, education, system development, partnerships and networking, in connection with which work was carried out between 1995 and 2001 when the actual implementation of the national programme started.

Since 1998, much lobbying and advocacy for NCD prevention and control has taken place and this has been successful. The national health council approved the national programme developed by CINDI and the Health Insurance Institute of Slovenia financed the CINDI programme and the implementation of NCD control in primary health care services countrywide. The development of public health policies in the areas of food and nutrition and physical activity started in 1997–1998 when some first steps were also taken to tackle inequalities in health.

There was political change in 2000. With evidence of the burden of NCD in place, the challenge was to develop an integrated approach. Accession to the EU brought along new challenges, such as meeting the standards of the Common Agricultural Policy (CAP)\(^\text{10}\),

A workplan for integrated action on health was developed: one part to tackle the social determinants of health and health inequalities, the other to develop policies related to NCD in individuals and high-risk groups. Although it can be difficult, Slovenia has good experience in working with other sectors, especially those in the areas of food and nutrition and physical activity. Prospective health impact assessment was used for all policies and approaches, always

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with a view to a win-win solution for health development and the goals of other sectors. The result was intersectoral and comprehensive policies.

The investment in health and development approach, which was piloted in the Pomurje region, was developed by the Slovenian Ministry of Health, government and regional public health authorities and many other partners, and supported by the WHO Regional Office for Investment in Health in Venice, Italy. The result was that health determinants became the guiding issue for planning the development and financing of regional programmes. Throughout the pilot programme, the Ministry of Health was coordinator, initiator and supporter, advocator at the governmental and inter-ministerial levels, and lobbyer for an investment-in-health approach.

The outcomes of the programme include a strong partnership in health at the regional level and the inclusion of health in the regional development plan for 2007–2013. This is very important because interdisciplinary and intersectoral work is now ongoing at the regional level. The three main pillars of the programme are healthy community development, healthy food chain development (which will serve rural development and health development), and healthy tourism (mainly agricultural development and natural resources for social, economic and health development). In addition, a health promotion programme was implemented in 50 communities of the Pomurje region. In the healthy food chain development, it is important to note that there is an agreement on the local supply chain between farmers, schools, kindergartens, and hospitals on supporting each other and supporting local development in different settings. These programmes have been evaluated, the two main methods used being the Let’s live healthy programme: the CINDI methodology for a health behaviour survey and the CINDI Health Monitor (12), and both showed that the programme was effective in bringing about healthier lifestyles.

As a result of the experience gained in promoting health in a rural area (pilot project), which has been disseminated throughout Slovenia, it was recommended that NCD be put high on the political agenda and that the Ministry of Health and the Government take an integrated approach. In order to succeed, tools and packages need to be developed to help politicians address the issue.

**Question**

- **Will parallel health promotion programmes be under one umbrella in Slovenia? What about integration?**

One of the problems is that the expertise is with different agencies in the country. Both specific programmes on risk factors and integration at implementation level are needed. Integration has been successful at the programme level whereas it is more difficult at the political level. What is needed is an integrated policy document aimed at bringing together the players at population and high-risk levels.

**Italy**

The Ministry of Health is implementing a coordinated project (Guadagnare Salute) aimed at counteracting four of the main NCD risk factors, namely physical inactivity, poor nutrition, alcohol consumption and tobacco consumption. It is based on an institutional alliance with the regions and municipalities, the food industry, distribution networks and consumer associations.
For example, action to promote a healthy diet includes: encouraging healthy behaviour (e.g. breastfeeding, the Mediterranean diet); introducing healthy foods in schools, hospitals and workplaces; ensuring the availability of healthy foods and encouraging healthy choices (e.g. through agricultural policy, composition of commercially-available foods); encouraging healthy diet (e.g. through education, marketing, access, favourable pricing); providing consumer information; and protecting minors (labelling, advertising).

With respect to the availability of healthy foods to encourage healthy choices, the key players include: the primary producers that play a role in reducing the salt, sugar and total fat content in foods (farmers, the food industry); the Ministries of the Economy and Agricultural Policy that could provide incentives for the production of fruit and vegetables; the Ministry of Regional Development that encourages short production chains, thus improving the local availability of quality products and, as a result, the consumption of fruit and vegetables; the media that promote the traditional Mediterranean diet; and the producers, restaurant owners and consumer organizations,

The project document (Guadagnare Salute) was diffused in January 2007 following agreement at national, inter-regional and municipal levels on allocation of responsibility. A national platform on physical activity, nutrition, alcohol and tobacco was created in May 2007 involving the following sectors: health, education, agriculture, economy, transport, environment, family policy, young people and sports. Evaluation of the project is carried out through the monitoring of activities, which include the surveillance of behavioural risk factors (PASSI: Progress of the health units for health in Italy).

Questions

• In which way did the CINDI programme in Italy influence NCD prevention and control efforts in the country?

The CINDI programme in Italy is based on academic experience and competence, which it endeavours to link to national action.

Austria

Work was started in the 1960s by a family doctors' association. A primary care approach was used, which was possible because the principle of subsidiarity applies in the Province of Vorarlberg. The first public health programme (a vaccination campaign) received the support of the Government. Now Austria is facing the challenge of chronic diseases. Much of the applied prevention and promotion research and many of the programmes are focused on children in order to influence the determination of risk behaviour early in life. There are also programmes targeting adults and older people.

Austria was one of the first countries to join the CINDI programme, in 1986. The primary care approach in the country has been replaced by a network of experts in areas, such as physical activity, nutrition, etc. The achievement of a good working relationship between the experts and the primary care doctors is a challenge that remains.

Austria has an impressive and comprehensive set of data on chronic diseases and risk factors, which have been collected since the 1970s. This is done through CINDI population surveys,
health examination surveys and the cancer registry. The data are used to launch programmes in different settings.

The CINDI programme has been very good for raising the importance of health at the political level. One of the challenges is to determine the true source of health, for example, is it health literacy, health campaigns or smart services?

**Questions**

- *In connection with subsidiarity, now that Austria has moved the focus from infectious diseases to chronic disease, what is the source of funding and is it still allocated under the same principle of subsidiarity?*

Funding is still mainly governmental. A small proportion comes from health insurance firms and national funds, such as the Healthy Austria Fund, which is financed by tobacco taxes and thus controversial. In connection with dependency on government funding, every time the government changes, much of the institutional memory related to public health is lost, which means that public health professionals need repeatedly to advocate the same issues.

- *There are many individual efforts being made to prevent NCD but the approach is not comprehensive. How did Slovenia start the CINDI programme?*

The CINDI programme in Slovenia began in the 1990s in regional demonstration areas and in accordance with the *CINDI protocol and guidelines* (13). All the necessary aspects of the programme were developed in these areas, such as the evidence base, lobbying, advocacy, and capacity building. This preparatory work, as well as a favourable political situation, contributed to establishing the programme at the national level.

**Comments**

- Currently, WHO headquarters are developing a tool to assist Member States in elaborating, implementing and evaluating policies and programmes on the prevention and control of chronic diseases.

- In the United Kingdom, although there is a need to involve the clinicians, a review of the Wanless recommendations has shown that little progress has been made towards having a ‘fully engaged scenario’ so that health services can meet the demand. Although putting more money into treatment and pharmaceutical services will not tackle the basic need to prevent NCD and promote health, this fact is ignored. Allowing the debate to focus on the question of where to find the evidence to apply in a medically-based evidence model diverts attention from the fact that, if health promotion and prevention continue to be ignored at the expense of putting more money into services, the goal of preventing NCD will not be achieved.

- The health promotion–disease prevention difference is also problematic. These two areas need to be integrated as a comprehensive health promotion strategy, which includes disease prevention as a specific action area.

- An interesting aspect emerging from the presentations was the lack of real engagement on the part of employers. Employers have a great opportunity to reach people at the right age, i.e. 16 to 60.
• Another group to engage are the nurses. As there are six million in Europe, they have quite a bit of influence, particularly in disadvantaged areas.

• In 2004, the Ministry of Health of Hungary adopted the National Public Health Programme. However, there has been a lack of enthusiasm at government level. Integration is happening not at government level but at the level of small communities – a bottom-up approach. People in villages and small regions are asking for data in order to make small-scale, comprehensive strategies. It is possible that these small projects will, as in Slovenia, develop into networks and, in turn, into something at the national level. The demonstrated cost of illness is an important argument in convincing government.

• In Greece there is no central coordination of NCD prevention and the private sector is moving ahead. Perhaps the most important risk factor in Greece is tobacco smoking, a very complicated issue because Greece is a tobacco-producing country with an active tobacco industry. It requires very good coordination and support to reduce cigarette smoking. Farmers would have to change their production and support would be required from the EU and WHO. Advertising laws are also needed.

• In the Netherlands there is a new health care system and it is, therefore, difficult to measure its shortcomings and successes at the moment. Incentives are needed in the system, including determination/measurement/monitoring of the cost-effectiveness of prevention.

• In the United Kingdom, some work was done with large American insurance companies on modelling primary, secondary and tertiary prevention. American insurers are happy to invest in primary prevention. Secondary prevention buys extra years of life but rather than saving money for the insurance companies, it costs them more. Tertiary prevention just about pays for itself. For a government, NCD prevention is good value for money because it gives the population more years of healthy life.

• The importance of intersectoral cooperation should be recognized and the role of the health professionals in this type of action should not be underestimated. Furthermore, exchange of experience, for example through global fora on NCD, is extremely valuable.

Parallel session II. Strengthening health systems for improved prevention and control of NCD

Denmark

The key elements in a national NCD strategy are prevention (identification of determinants, focusing on the population level; high risk groups (social, ethnic, behavioural) and individuals with chronic conditions; and control (focusing on the health care system (primary sector), the patient and the community).

In Denmark the approach is based on a vision of public health where the population is equipped with the necessary knowledge to make healthy choices in all phases of life, and where the

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settings for healthy behaviour are in place. Health promotion and disease prevention have become an integrated part of the Danish health care system. They are included in the public agenda and are embedded in other sectors that have an effect on public health. The goal is to increase the mean life expectancy and number of years with a high quality of life, free from disability or illness, and to reduce social inequality in health.

There are two kinds of prevention-oriented interventions under the National Board of Health: (1) patient-oriented prevention, which aims at preventing the further development of illness, complications and relapse; and (2) population-oriented prevention, which aims at keeping citizens healthy, promoting healthy environments, and preventing diseases in the population at large. The interventions of the National Board of Health have four dimensions, namely, risk factors, chronic diseases, target groups and healthy environments. For example, the Danish Risk Factor Study 2004–2006 aimed at quantifying the public health burden of selected risk factors in relevant health outcomes, estimating socioeconomic expenditure related to the same risk factors, estimating the impact of a reduction in the selected risk factors, monitoring the risk status of the population, and focusing on and prioritizing preventive strategies.

The National Board of Health provides guidelines and recommendations (e.g. on the prevention of falls, chronic obstructive pulmonary disease (COPD) rehabilitation, tracking overweight among children); carries out public campaigns (e.g. on alcohol, physical activity and Chlamydia) and monitoring (e.g. of the smoking habits of the Danish population); produces documentation reports; makes overall plans regarding HIV, sexually-transmitted diseases and unwanted pregnancies; and runs model projects as well as network and cooperation projects.

Problems in chronic care include a lack of diagnostic registries in the primary sector, poor adherence to treatment and control, poorly followed evidence-based guidelines, a high readmittance rate, unsupported patient resources, and a lack of active patient involvement.

Thus, the goal is to have a health care system, which supports and activates the patient's own resources and involves him or her in all planning and decision-making. This is done through programmes on patient education in self-management (where patients monitor and self-medicate when appropriate), with a focus on patients and groups with scarce resources. A disease management programme will include a diagnostic registry, risk stratification, clinical guidelines, a multidisciplinary practice team, patient education, pro-active outreach to patients, reminders to patients and carers, feedback to health care professionals, and a case manager, if needed.

Of specific concern are frail patients, characterized by severe disease and/or co-morbidity, health illiteracy, inappropriate use of health care services, low compliance, and inadequate behavioural reactions. This can be responded to by positioning case managers in general practice or municipality services, and through greater cooperation between health care and social services, renewed focus on health education, and multidisciplinary team support.

The goal should be a health care organization that ensures evidence-based, coordinated care for all patients through the full course of disease; disease management programmes for important diseases; organization of the primary health care sector to provide support and care through the full course of disease; emphasis on multidisciplinary action; and activation of competencies.
Questions

• **What is meant by a diagnostic registry?**

This is a list of the more preventive tools that gives a much better picture of what is actually taken care of. In Denmark, the general practitioner (GP) can refer to services other than the hospital, such as different offers within the municipality. These need to be monitored.

• **What incentives are used in Denmark to encourage GPs to work within this scheme.**

Incentives are difficult because they are a political issue. There is at the moment a move towards privatizing the health sector.

• **In relation to the multidisciplinary team model, has Denmark achieved precision with regard to the roles of each player with respect to each condition?**

At the moment this is being described in a manual.

• **What guidelines exist in Denmark? Are they obligatory and, if so, how they are enforced?**

There is a series of guidelines on various issues, such as the early diagnosis of lung disease and how to manage it with the patient. Guidelines are not obligatory but they are norm-setting. The National Board of Health provides guidelines and any doctor, including a GP, who does not follow them should have a very good excuse for not doing so.

A study on caring for people with chronic conditions – a health system perspective

"Caring for people with chronic conditions – a health system perspective" is a study of the experience of six European countries (Denmark, France, Germany, Netherlands, Sweden, United Kingdom), as well as of Australia and Canada, in developing and/or implementing chronic disease management models and strategies. It aims to assess the contextual, organizational, professional, funding and patient-related factors that enable or hinder the implementation of strategies to address chronic illness, to identify best practices, and suggest ways of promoting these practices. The conceptual framework of the study is the Chronic Care Model12, and it is based on the definition that chronic diseases are diseases, “which have one or more of the following characteristics: they are permanent, leave residual disability, are caused by nonreversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care” (14).

The study is based on a series of papers on the following topics: the burden of chronic disease; the economic case of investing in chronic disease management; approaches to chronic care; supporting self-management; delivery systems (human resources); decision support; financing chronic care; policy framework; and facilitators and barriers. In addition, it includes a series of country case studies that were commissioned from Australia, Canada, Denmark, France, Germany, Netherlands, Sweden and the United Kingdom) to present an in-depth assessment of the response to the rising burden of chronic diseases, focusing on three key areas: (1) the current situation; (2) the policy framework and future scenarios; and (3) evaluation and lessons learnt.

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Furthermore, the country case studies discuss the type and format of the approaches to chronic
disease management, the legal, financial and political framework, opportunities and/or challenges related to workforce development (e.g. training, personnel), potential capacity restrictions within the system (e.g. management skills, technical capacity, information technology), plans to change what is currently provided to manage the increasing burden of chronic disease, the drivers and policies behind these plans, and enablers of and barriers to enhancing services.

The preliminary findings indicate that approaches to chronic care vary not only between but also within countries, for example: formal disease-management programmes (Germany, Netherlands); nurse-led clinics (Netherlands, Sweden); health networks (Canada, France); care coordination (Australia); community matrons\(^\text{13}\) (United Kingdom). The involvement of the non-medical profession also differs considerably between countries. For example, Sweden, the United Kingdom and, to a lesser extent, Australia and the Netherlands, make extensive use of nurses but this is not the case in France or Germany where there are legal and professional restrictions on the deployment of nurses outside hospitals. Although the role of self-care is acknowledged as a key component of effective chronic disease management, systems supporting self-care remain relatively weak in many settings. The sustainability of chronic care models faces considerable challenges in all health care settings. These include administrative and financial obstacles to enhancing the coordination and/or integration of health and social/community care services; under- or over-investment in suitable information systems; conflicting policies; focus on cost reduction; and the potential impact of electoral cycles.

The findings of this study will be published in the form of two books, *Caring for people with chronic conditions - a health system perspective* and *Caring for people with chronic conditions – experience in eight countries*\(^\text{14}\) and are expected to be available from spring 2008\(^\text{14}\).

**England, United Kingdom**

The White Paper, *Our health, our care, our say – a new direction for community services*\(^\text{15}\), aims: to achieve better prevention services with earlier intervention; to give people more choice and a louder voice; to give patients a guarantee of registration with a GP practice list in their localities and to simplify the system of doing so; to do more on tackling inequalities and improving access to community services; and to provide more support for people with long-term needs.

Primary care reform has involved GP contracts, ‘fairness in primary care’, the development of quality and outcomes frameworks, pharmacists’ contracts, nurse leadership (other clinicians), practitioners with special (clinical) interests and practice-based commissioning. The National Health Service, in common with healthcare systems worldwide, faces an increasing challenge in treating those with long-term conditions.

The National Health Service and Social Care Long Term Conditions Model\(^\text{15}\) proposes that the infrastructure (community resources, decision support tools and clinical information system, and health and social system environment) supports the delivery system (case management, disease

\(^{13}\) A new type of specialist clinician, usually a nurse.


management, supported self care, promoting better health), creating better outcomes that include empowered and informed patients, as well as prepared and proactive health and social care teams. The Combined Predictive Model\textsuperscript{16} combines both hospital and GP data not only to increase the positive power of prediction but also to inform people who have never been admitted to hospital.

It is estimated that 50\% of people with long-term conditions have not been told about treatment options, 25\% do not have a care plan, 50\% do not have a self care plan, and 50\% of the medicines prescribed are not taken as intended. As a response to such data, the \textit{White Paper LTC} \textsuperscript{17} proposes a range of commitments, including greater emphasis on self care and integration, multidisciplinary teams/networks, universal case management for very high intensity users (VHIUs) personal health and care plans, assistive technology, and a 24/7 single point of contact for people with complex needs.

**Georgia**

There are health inequities between Georgia and high-income countries. Georgia is facing the double burden of both communicable diseases and NCD. In addition, there is a lack of financial resources for and attention to NCD prevention. During periods of economic crises and structural reform, the burden of NCD on society becomes even greater as they have a significant impact on the national economy by disabling and killing the population of working age.

The main points of the Strategic Health Plan of Georgia for 2000–2009 include: emphasis on improving primary and preventive services (rather than on curative care); a shift of resources from hospital services to primary care; and strengthening primary health care by introducing family physicians and developing new primary health care nursing services.

The development and implementation of the concept of health reform in Georgia was supported by many international players and key stakeholders. The development of a family-medicine-based primary health care system has been supported by the Government of the United Kingdom and includes a retraining programme in family medicine, development of professional standards for family physicians, an accreditation system for family physicians and training institutions, and the refurbishment of selected primary health care facilities. Levers for change, incentives and performance management have been identified as:

- establishing a clear mission and goals that focus on improving the training programme for primary care physicians;
- using standards to provide a framework for programme design;
- exerting leadership to make change happen;
- forging relationships to facilitate change;
- mobilizing resources and rewards to support change;
- using information to initiate change and improve programmes over time.

The following action has been taken within the context of the CINDI-Georgia programme: CVD have been defined as a target area; a multifactorial approach to NCD prevention has been adopted; guidelines and methods of intervention have been developed; special attention has been given to situation analysis, coalition building and resource mobilization; and baseline surveys have been conducted. In addition, a national CINDI-Georgia protocol and plan of action have been elaborated.

The above action is particularly important in the light of a recent survey among GPs, which brought to light that about one-third of the respondents did not consider that their salaries covered payment for preventive activities, 95% were not informed about blood cholesterol levels, 55% were not informed about blood glucose levels, only 25% knew the precise definition of elevated blood pressure, over 50% did not have guidelines on prevention in primary care, and only 50% reported carrying out activities to address the risk factors for the main NCD.

Several steps have been taken to address this. The Georgian Societies Joint Committee on Cardiovascular Diseases Prevention is working on approaches towards implementing European recommendations, hosting seminars and workshops, for example, on CVD prevention, and developing practical guidelines. Moreover, an integrated NCD programme at the national level is being tested in a demonstration area.

The current objectives of the integrated NCD programme are:

- to evaluate lifestyles and the principal risk factors for the main chronic diseases;
- to provide appropriate and reliable information on lifestyle changes (diet, physical activity, smoking cessation) to medical professionals and patients;
- to develop clinical tools for the management of hypertension, diabetes mellitus and hyperlipidemia, as the principal risk factors for the main chronic diseases, in accordance with recent evidence-based guidelines;
- to ensure the effective measurement and control of risk factors as a part of routine practice at the primary care level;
- to carry out an assessment of the process, results and outcomes of the integrated NCD programme and to disseminate the findings;
- to detect high-risk individuals and ensure their appropriate referral at the primary care level;
- to carry out laboratory testing (blood glucose; LDL cholesterol and urine analysis (11 parameters)) of all patients at the start and the end of the integrated NCD programme;
- to observe and support screening and interventional measures.

If Georgia is able to achieve a marked improvement in the control of hypertension by means of an inexpensive and effective programme, it would also be possible to do so with respect to the other main chronic diseases.
Questions and comments

- One of the issues in many Canadian provinces is finding ways to encourage physicians to work in low-income areas. Is this also a challenge in England and, if so, what is the approach?

In England, there are fewer problems in this respect in the rural areas than in some areas of the inner cities and the general medical services contract gives increased money to deprived areas. Eighty per cent of the money is for general care and skewed towards poor areas, and because the Quality Outcomes Framework\(^\text{18}\) has a prevalence element (and there are more NCDs in poor areas), it is hoped that there will be a shift. It is still a major challenge.

In Denmark there are regions that are under-doctored. They are working towards shortening the GP specialization process and hope that this will result in more GPs in the rural areas.

In Georgia, the former Soviet Union system is still in use and the new system only partially functioning. This should change in about two years. The old polyclinic system with internists and specialists may continue in the large cities; in the rural areas, there are GPs and family doctors. In terms of distribution after medical school, this was obligatory during the era of the former Soviet Union but is no longer the case. Now family physicians need to have a three years' residency.

A lot of work has been done to ascertain what works for certain populations and where. The Picker Institute\(^\text{19}\) has just published a review on this issue. Denmark was interesting from that perspective because they have highlighted the Stanford model, which is based on a cognitive behaviour theory that involves patient-led support. It was piloted in Denmark to see whether it is applicable in the Danish context. It has worked quite well and is now being rolled out to the whole country. However, as this is short-term, there is no information on follow-up.

- Is there any evidence about which self-care model works best?

There is evidence that the diabetes model for self care is effective.

- Does the European Observatory on Health Systems and Policies have any information on the expenditure connected with NCD?

There are estimates for specific diseases but not for the overall expenditure on NCD.

The comment was made that rather than trying to close the equity gap to countries in western Europe, countries in central and eastern Europe should focus first on levelling inequalities within the country.

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\(^{19}\) [http://www.pickerinstitute.org/about/about.html](http://www.pickerinstitute.org/about/about.html), accessed 24 October 2008.
Parallel session III: Systematically integrating action and policy to reduce inequalities in health.

Norway

Although mortality from coronary heart disease has decreased in Norway, the rates for obesity in adults have been rising steadily since the 1980s. Tobacco use is also decreasing though it is still the cause of a high death toll every year. There are social inequalities in health: the less-educated segments of the population smoke more and have higher rates of obesity, emphasizing that social inequalities in health are a challenge with a gradient. She noted that though inequalities in Norway may seem small compared to those in other countries, addressing them within the country demonstrates Norway’s commitment to addressing them globally.

In order to respond to this challenge, there are two approaches: (1) using population-based strategies (not only for high-risk groups); and (2) directing measures towards the whole causal chain, including the social determinants. There are four priorities for action in Norway related to reducing social inequalities in health:

1. to reduce the social inequalities that contribute to inequalities in health (income, childhood conditions, work);
2. to reduce social inequalities in health behaviour and use of the health services;
3. to target initiatives to promote social inclusion;
4. to develop knowledge and cross-sectoral tools.

School are an important setting for action. They have the potential to reduce inequalities through healthy nutrition, physical activity, tobacco programmes and mental health programmes. Furthermore, inequalities in learning result in inequalities in health, so that early intervention is important. Thus, the health sector and the education sector must be policy partners.

It is important to be persistent in advocating committal action in priority areas and in considering the challenge of reducing inequalities from a cross-cutting perspective, using an integrated approach linked to up-stream determinants and developing policy tools to ensure cross-sectoral approach. With respect to collaboration between countries, it is important to be sensitive to context.

Questions

• How are priorities for action decided in Norway?

This is done through an expert panel on social inequalities in health. Decision-making is grounded in evidence-based principles.

• What is the evidence base for action in schools?

In Norway, the evidence shows that if nutrition and physical activity are given high priority learning capacity is improved.
England, United Kingdom
The work of the Health Inequalities Unit, which is a small team in the Department of Health with cross-government focus, is shaped by a Public Service Agreement (PSA) target to reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth.

The pattern of causes of death contributing to the life-expectancy gap in spearhead areas is broadly similar for both males and females with cancer and circulatory and respiratory diseases, accounting for over 65% in each. Between 2003 and 2005, there were approximately 13,700 additional deaths among 30–59 year olds in spearhead groups as compared to the national average for England. The focus needs to be on reducing early adult death. Action on the overall PSA target to reduce infant mortality will also help deliver the target to reduce the life-expectancy gap. However, early progress demonstrates that three-fifths of the spearhead areas are on track to narrow their gap: 11% of the spearhead areas are on track to deliver both male and female elements, 48% are on track to deliver one element and 41% are off track for both elements. Examples of identifiable action to reduce the gap in infant mortality by at least 10% are:

- targeting prevention to teenagers at risk and providing support for pregnant teenagers and teenage mothers;
- targeting the Time to get back to sleep campaign\textsuperscript{20} and key messages for the target group and maintaining messages for mothers current;
- providing smoking cessation advice as an integral part of service delivery for the whole family during and after pregnancy;
- targeting weight loss programmes (low calorie diet, physical activity and behaviour therapy, drug therapy and surgical procedures);
- providing comprehensive preconception services;
- providing advice/support for “at risk” groups within the target, for example, minority ethnic groups;
- increasing direct access to community midwives;
- providing a round-the-clock direct line for maternity advice;
- implementing National Institute for Clinical Excellence (NICE) antenatal and postnatal guidelines;
- carrying out a health equity audit of women at 12 weeks and more than 22 weeks;
- improving the uptake of immunizations in deprived populations;
- implementing the baby-friendly standard.

Croatia
In Croatia, data collected in 2004 shows that the problem of NCD is increasing among women. Cardiovascular diseases (CVD) are responsible for more than 50% of the total causes of death among women; their prevalence in men is also very high.

NCD constitute a public health priority for both men and women. Although the total mortality rate is higher for women, the hospitalization rate is higher for men.

Interviews carried out with experts in health planning revealed that nearly all of them:

- had noticed an increase in CVD among women;
- found that women first ask for help when the disease is at a more advanced stage than it is in men when they ask for help;
- had noticed that there was a difference in symptomatology between women and men for the same diagnostic entities;
- considered that physicians in Croatia pay more attention to men than to women who complain about pericardial oppression, dyspnoea, vertigo, etc., probably because of the results of previous studies and the belief that estrogens and hormone replacement therapy protect women from CVD;
- were of the opinion that, in planning documents, the measures to be taken with respect to CVD should be defined for men and women separately.

Fifty per cent of those interviewed considered that co-morbidities were more common in women with CVD than in men, and that women were underrepresented in several CVD studies.

In order to raise awareness about these results and about CVD issues related to women, several professional meetings had been held, some of which were multidisciplinary. It was concluded that gender differences should be taken into account in CVD prevention, that guidelines should be elaborated for addressing CVD, with special reference to women, and that they should be adopted and included in governmental health programmes. In addition, mechanisms should be developed to support the implementation of such measures, including guidelines on preventive care, and training should be provided for GPs who need to be better informed.

The Former Yugoslav Republic of Macedonia

CVD and cancers are the leading causes of mortality in the Former Yugoslav Republic of Macedonia and their prevalence is increasing.

After the country became independent in 1991, normative and socioeconomic reforms were implemented. Encouragement of economic growth and employment is a government priority. Twenty per cent of the population lives below the poverty line, which is the result of: (1) the fall in aggregate consumption during the 1990s and after 2000; and (2) the rise in the inequality of its distribution. Economic unfairness can include insufficient housing, education and food, and low chances of employment. About 38% of the population is unemployed, the highest rate in the European Region. The health status is much worse in poor people, as is the prevalence of NCD. There is a connection between deteriorating social and economic conditions and social and economic exclusion, increasing human insecurity and psychosocial stress. The health consequences of unemployment can be observed at the individual, family and population levels. Many national studies show increased risk factors for NCD, such as tobacco smoking.

There are 54 000 Roma living in the Former Yugoslav Republic of Macedonia, representing 2.7% of the total population. They have their own political parties. Furthermore, there are over 30 NGOs working with Roma populations, which are active in issues relating to human rights, culture, education, the environment and infrastructure. The Roma remain the poorest citizens of
the country and have a much lower health status than the rest of the population. Within the national strategy (January 2005), the aim is to integrate the Roma population into mainstream society, address poverty, focus on the long-term development of the Roma community, and fully engage the country in these issues,

Special attention is paid to millennium development goals, including a commitment to reduce poverty, ensure the quality of primary education, ensure environmental sustainability, improve gender balance, reduce infectious diseases and lower maternal and child mortality.

### Developing alliances for NCD

**The World Bank: noncommunicable diseases and injuries – challenges and options in Europe and Central Asia**

In order to improve health conditions in the world, the efforts of international health organizations in the prevention and control of NCD and injuries need to be expanded greatly. Globally, NCD are among the top 20 diseases and CVD alone accounts for nearly 30% of all deaths and 10% of all years of healthy life (YHL) lost to disease. CVD is the number one killer in Europe and Central Asia, causing more than half of all deaths and NCD and injuries account for 85% of all deaths in Eastern Europe and Central Asia. Furthermore, almost 60% of the disease burden in Europe and Central Asia, as measured by disability adjusted life years (DALY), is accounted for by high blood pressure, tobacco, alcohol, high blood cholesterol, overweight, low fruit and vegetable intake, and physical inactivity. These leading risk factors are common to many of the leading conditions in Europe and Central Asia. This results in a significant impact on demographic and health conditions, as well on the economic welfare of the countries, as people who are ill are less likely to stay in work, invest in education and save, and more likely to take sick leave and early retirement.

Ill health impacts labour productivity and supply by significantly reducing hours worked and wage rates. A workday missed because of illness reduces the wage rates by 5.5% for females and 3.7% for males, whereas self-reported good health increases the wage rates by 22% for women and 18% for men, compared to those who are not in good health.

Three plausible future scenarios for adult mortality from NCD and injuries up to 2025 could be: (1) no change in mortality rates; (2) an annual percentage reduction of mortality rates at half the rate of scenario 3; and (3) achieving EU-15 rates by 2025.

From the World Bank’s perspective, in addressing the challenges, the following could be borne in mind:

1. **Healthy Development: The World Bank’s Strategy for Health, Nutrition, and Population Results (16)** was recently approved. It aims to help countries strengthen their health systems to improve the health and well-being of millions of the world’s poorest people, boost economic growth, reduce poverty caused by catastrophic illness, and provide the structural ‘glue’ that combines multiple health-related programmes within client countries.

2. Strengthening health systems may sound more abstract and less important than fighting specific diseases, but well-organized and sustainable health systems are necessary to achieve
results. For example, protecting people from death and illness caused by NCD and injuries calls for strong health systems, as well as control measures at population level.

3. In practical terms, it means putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure that people, particularly the poor, get the good quality health services they need to save and improve their lives.

4. Strengthening health systems is essential but it is not a result in itself. Success in strengthening systems cannot be claimed until the right chain of events on the ground prevents avoidable death and extreme financial hardship due to illness because, without results, strengthening the health system has no meaning. However, until this is done, there will be no results. Working cross-sectorally is imperative to saving lives and improving the quality of health of the world's poor. This means having health ministries, their local departments, and their international aid donors work more closely together with other strategic government ministries to achieve better health results within countries.

5. We need to remember that many of the advances in health status achieved during the 20th century were the result of close synergy among health and other key sectors in the economy, such as those for water and sanitation, environment, transport, employment, education, agriculture, energy, infrastructure, and public administration. Also, good health spurs economic growth and health is often thought to be an outcome of economic growth. Increasingly, good health and a sound health system policy have been recognized as major, inseparable contributors to economic growth.

6. Advances in public health and medical technology, knowledge about nutrition, population policies and disease control, and the discovery of antibiotics and vaccines are widely viewed as catalysts to major strides in economic development, from the Industrial Revolution in 19th-century Britain to the economic miracles of Japan and East Asia in the 20th century. Sound health policy, one that sets the correct incentive framework for financing and delivering services, also has important implications for overall country fiscal policy and country competitiveness.

7. The new World Bank Strategy calls for a greater linkage of health financing with better results. The best way to do this is to connect development aid as directly as possible to achieving health, nutrition, and population outcomes in developing countries. For example, programmes and projects could directly finance targets for vaccination, prenatal care for women or a reduction in the number of deaths from NCD and injuries.

The WHO Regional Office for Europe and the Europe and Central Asia Region of the World Bank are jointly developing an international initiative to meet the challenge of NCD and injuries in Eastern Europe and Central Asia. This will be in partnership with governments and international organizations willing to join and within the framework of the European NCD Strategy (1).

As a first step of this initiative, it is proposed to organize a regional conference entitled, "Meeting the challenge of noncommunicable diseases and injuries in the Commonwealth of Independent States (CIS) countries", in the second half of 2007 in St Petersburg, Russian
Federation. The main objectives of the conference would be: to impress upon senior governmental authorities the importance of addressing the challenge of NCD and injuries in relation to the social and economic development of the country and to promote the issue high on the political agenda; to introduce existing experience to demonstrate the feasibility of effective interventions; to facilitate an exchange of experience and challenges faced among the countries; to stimulate intersectoral dialogue and cooperation across health and social boundaries; to promote international partnership in support of country efforts; and to define the steps necessary to move from knowledge to action. Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan would be invited to participate. Other countries may also wish to participate. The audience for this conference would be senior policy-makers and senior staff of the Ministries of Health, Finance and Social Protection in each participating country. Other Ministries, such as that for transport, would be able to participate at the discretion of their Governments.

The proposed conference would be jointly organized by the WHO Regional Office for Europe and the Europe and Central Asia Region of the World Bank. Other international partners would include the World Bank Institute, the Council of Europe, and the United States Agency for International Development (USAID). Contributions are also expected from policy and academic institutions, such as the European Observatory on Health Systems, the London School of Tropical Diseases, the Johns Hopkins Bloomberg School of Public Health, the Imperial College of London, and the Eurasian Medical Education Program.

**Working in partnership across Europe to improve the prevention and control of NCD: a case study on musculoskeletal conditions**

Musculoskeletal conditions are: (a) common (1–4 adults in Europe are affected); (b) disabling (5% of the adult population have physical disabilities owing to musculoskeletal conditions that cause more functional limitations in adults than any other group of disorders); (c) responsible for 4% of DALYs in Europe; (d) costly (in Sweden musculoskeletal conditions are responsible for 22.6% of the total cost of illness (90% indirect)); and (e) associated with a spectrum of conditions, such as arthritis, back pain, osteoporosis and injuries that are often persistent and progressive, though seldom fatal.

It is important to work on this issue in partnership across Europe. In terms of prevention, the risk factors and determinants of musculoskeletal conditions are common to other NCD. Addressing this issue requires identifying those at particular risk of these conditions or of bad outcomes and ensuring a spectrum of health and social care (community, primary, secondary and tertiary care) and access to integrated multiprofessional, multidisciplinary patient-centred care. The burden and costs of musculoskeletal conditions are great and increasing in all countries. However, this is not reflected in action related to health care, research and education. This has lead to NGO action at the global, European and national levels.

The European League Against Rheumatism (EULAR) represents the patient, health professional and scientific societies of rheumatology of all the European countries and fosters a multitude of activities in the areas of research, patient care and education. It works independently and,
through the Bone and Joint Decade 2000–2010 (BJD)\textsuperscript{21}, with other disciplines (orthopaedics, rehabilitation) to represent all aspects of musculoskeletal health, disease and science, as well as all stakeholders. The BJD aims to improve the health-related quality of life for people with musculoskeletal disorders throughout the world. It provides a framework for international and local action and is supported by over 1000 professional, scientific and patient organizations at national, European and international levels, as well as by 60 governments, the United Nations and WHO. It acts through National Action Networks, which bring together stakeholders, European and international organizations and NGOs. The Bone and Joint Monitor Project (17) is an example of this collaboration.

The European Action Towards Better Musculoskeletal Health Project (18) provides a common policy on preventing musculoskeletal conditions and reducing their impact by dealing with risk factors for musculoskeletal health, identifying high-risk individuals who would benefit most from preventive interventions, and providing the appropriate management of musculoskeletal conditions from the earliest signs, as well as access to appropriate care. The project considers all musculoskeletal conditions in a common framework. It is a partnership between BJD, EULAR, the European Federation of National Associations of Orthopaedics and Traumatology (EFFORT) and the International Osteoporosis Foundation (IOF). It is funded by the European Community.

The type of action necessary varies according to the target population. For example, this could be:

- health promotion, action to promote safe communities (for the whole population);
- the implementation of systems for case finding (for the "at-risk" population);
- the establishment of systems for early diagnosis and timely treatment (for the population with musculoskeletal conditions).

Furthermore, there is a need for the involvement of different stakeholders, including stakeholders at the European political level and the national political level, employers, health and social care professionals, patients/carers, and the public. Alliances between stakeholders working with policy-makers and providers are central to the implementation of the Strategy (1).

In the United Kingdom, action at the national level is carried out through the National Musculoskeletal Services Framework in partnership with the Arthritis and Musculoskeletal Alliance (ARMA) and other stakeholders. ARMA is an umbrella association in the United Kingdom that brings together 28 member organizations representing support groups, professional bodies and research organizations in the field of arthritis and other musculoskeletal conditions. Local groups are being established across the country bringing the relevant stakeholders together and working in partnership with policy-makers towards the implementation of the Musculoskeletal Service Framework.

At the European level, EULAR provides a framework for and actively facilitates collaboration between clinical doctors, allied health professionals and people with musculoskeletal conditions. It supports countries by providing education (courses and bursaries) and training, and by setting standards of clinical practice. EULAR works with the EU, WHO and other relevant NGOs to promote musculoskeletal health through, for example, the European NCD Strategy (1) and the European Charter on Counteracting Obesity (19).

Increased collaboration is needed in Europe to promote musculoskeletal health, in particular alliances with NGOs, which are essential for bringing together stakeholders, experts, researchers, clinicians and users. NGOs can work in partnership with policy-makers and providers of health and social care, supporting evidence-based policy development, best practices and user opinions, and engaging the local level.

The Dutch approach to NCD: opting for a healthy life

The Dutch action programme, *Opting for a healthy life. Public health policy in the Netherlands 2007-2010* (20), covers the issues of smoking, alcohol abuse, overweight, diabetes, and depression. For example, smoking constitutes a significant health problem in the Netherlands and the aim is to reduce the proportion of smokers from 28% (2006) to 20% by 2010. In order to achieve this, the action programme proposes to increase duty on cigarettes, develop a smoke-free catering industry, include graphic warnings on cigarette packets, reduce the number of points for sale of tobacco, carry out a trial on smoking cessation support with (partial) compensation, and provide regular advice to adults about smoking.

In terms of alcohol abuse, the programme aims to reduce the lifetime prevalence of drinking among 12–15 year-olds from 82.4% to 61.3%, and among the population over 16 years from 10.3% to 7.5%. It proposes providing more advice and education for parents, enforcing age limits more strongly, paying more attention to alcohol-related violence, banning television and radio advertising before 21:00 hours, raising taxes on alcoholic drinks, and placing more emphasis on local alcohol policy and early prevention.

Overweight is also a problem in the Netherlands. The action programme aims to respond to this through timely identification, the integration of prevention and care, and healthy living. Specifically, it proposes an overweight partnership, which is a plan involving the integrated action of industry, the hotel and catering sector, supermarkets, health care insurers and sports' organizers. Another initiative is the “Hallo world project”, an innovative form of providing information via the Internet (personal lifestyle advice). Diabetes is related to overweight and this is also an issue to address in the Netherlands. The programme aims to limit the increase of diabetes between 2005 and 2025 to no more than 15%, and to achieve non-development of complications in 65% of diabetes patients through activities related to prevention, screening, disease management, and self-management.

Finally, the prevention of depression is addressed through a partnership between various organizations. It focuses on awareness by introducing clinical guidelines and developing electronic health facilities, and through harmonization and collaboration within the infrastructure.
Panel and plenary discussion

Points raised

• Croatia is attempting to set up partnerships but one of the main problems is financing. An obesity action plan at the national level is being developed, which will involve the sectors for agriculture, sport and others.

• If WHO were to put more emphasis on the budgeting related to NCD, national ministries of health might follow suit.

• The example given in the World Bank presentation highlighted the evidence that was put to politicians in the Russian Federation and the impact of not tackling NCD on sectors, such as those for security and defence, as well as on the economy as a whole. This kind of information could be helpful to countries like Croatia where the health ministry is trying to make the case.

• Denmark has been very cautious about building alliances. So far, the National Board of Health has decided to say no to the private sector and rather build on NGO networks. These are alliances which are not about money but about using an existing collaborative network. Alliances are attractive but countries have to be careful about how they are formed.

• The question was raised as to whether the Dutch policy described set the targets, whether the action programme is developed by the different alliances involved rather than by the ministry and, if so, what mechanisms are used to ensure that the programme is monitored and evaluated. The response was that the alliances are developed by the industry and the health care sector. They are not managed by the Government. The mechanisms used for monitoring these actions are good regulation and political awareness. Everything in the Netherlands is based upon consensus. There is also an inspection mechanism, which controls the programme and reports to Parliament.

• In Armenia, one of the credit lines provided by the World Bank was used to finance a programme on NCD. Also, the national programme is dedicated to building alliances with other institutions and stakeholders, in particular with NGOs and public organizations that have experience in this particular field (health promotion, etc.).

• A question was raised on how to take decision-making forward if the evidence base was not well developed. The point was made that the components of a decision-making triangle are: (1) strong evidence; (2) good theory in the absence of evidence; and (3) value judgements in the absence of good theory. Furthermore, many of the action plans and strategies make sense from a health point of view but not necessarily from an organizational point of view.

• In Finland, one of the success stories is the major change in the diet of the Finnish population over the past 20–25 years, in connection with which one of the key issues has been cooperation with the food industry. Although there are still a lot of problems with the dairy industry, cooperation with the industry has been critical.
• In Lithuania, dietary habits changed very quickly and were sustained over time. So though transition countries may face many challenges, it is a good time for change and new democracies should simply start with this work.

Comments from the panel on how alliances work together

• In terms of health, the World Bank follows WHO as the lead technical agency for health, by helping to bring some of WHO’s recommendations into operation and cost the plans proposed at national level. In the context of HIV/AIDS, the World Bank has worked with countries in assessing the legal implications of the broader definitions of the DOHA declarations, particularly concerning issues of intellectual property rights. The World Bank works closely with and co-finances regional development banks, such as the Asian Development Banks. It has also established partnerships with the EU to push forward a series of initiatives, such as the European Observatory for Health Systems and Policies, and there are different mechanisms for interaction with other organizations, including co-financing. It is important that private and public enterprises are part of the solution and not only part of the problem.

• In the Netherlands, a disease-management approach was built with the involvement of different settings and players, such as industry. The Government intervened only when the different players did not respond.

• The key point in alliances is to develop common messages and common goals.

Conclusions from the parallel sessions

Parallel Session 1: Integrated action on risk factors and their underlying determinants across sectors

Country experience

Austria
The local programme started with the private sector and grew into a prevention programme with public funding. The initial focus was on infection control but the programme is now based on the CINDI approach.

England, United Kingdom
There has been a reorientation of the health system towards an integrated approach at primary care level. The key focus is on patient choice with a view to increasing access to health services. The National Health Service is funded by universal and public means with some private sector involvement.

Italy
WHO strategies were the starting point of the national strategy, which has been drawn up. The key development is the establishment of a national multisectoral platform to give direction to the regions.

**Slovenia**
There is an established national strategy, which is strongly based on the CINDI programme. High-level political involvement was key to achieving integration at national and local levels.

**Successes**
- A partnership approach to tackling all lifestyle factors, including local food chains, and access.
- The CINDI approach (working well in most countries).
- The use of WHO strategies to advocate investment in NCD prevention to politicians and the integration of services to this end.

**Challenges**
- Political will.
- Evidence of effectiveness in convincing politicians and decision-makers.
- The involvement of health professionals at the outset, alongside managers.
- Resources – financial and human.

**Assistance required**
- Guidance on how to start the process.
- Specific tools for implementation (WHO HQ is currently developing tools for use by countries).

**Feedback from plenary**
- Romania has been part of CINDI since 1999 and would like to see greater incentives for the implementation of the NCD Strategy (1).
- In Estonia, new public health and primary care strategies are being developed. A public health strategy would be the umbrella document. The strategy for primary care will reflect the integrated approach and the key focus will be on increasing access to health services.
- The question was raised as to how the focus had been changed from infectious to noncommunicable diseases and who had supported it.
- In Austria, they started compensating the doctors for carrying out preventive activities. Furthermore, they never forgot about feeding back data to the doctors, thus involving them more in the process and making them more conscious about their role.
- In order to stimulate primary health care professionals, there are two important points to address: capacity building and the solid education of all health professionals. NCD need to be high on the political agenda if the Strategy (1) is to be implemented and succeed. Political and professional engagement is a must.
Parallel session 2: Strengthening health systems for improved prevention and control of NCD

The countries presenting were Denmark, Georgia and the United Kingdom. There was also a presentation from the European perspective.

**Primary care capacity**
- Incentives and training.
- Rural versus urban.
- Role of general practitioners, nurses and other health professionals.

**How to make guidelines effective**
- Mandatory versus voluntary.

**Self-management support**
- Patient school, e.g. Denmark.
- Patient-to-patient teaching, e.g. United Kingdom.

**Mobilization and use of resources**
- Making the case in at government level (United Kingdom).
- Achieving good outcomes at low cost (Georgia).

**Working across boundaries**
- Improving patient-centred information.
- Use of targets – emergency readmission.

**Feedback to plenary**
- As regards knowledge in the broad sense of the word, according to the *European NCD Strategy (1)*, it is the task of the national counterparts to get the message across to the health ministries. The elaboration of a separate set of questions pertaining to knowledge, evidence, education and training, and developing protocols was suggested.

- As a result of experience in Lithuania, it is considered important to link primary health care and public health services. In order to do so, however, appropriate training programmes need to be developed.

Parallel Session 3. Systematic integration of action and policy to reduce health inequality

**Experience and examples demonstrated**
- Reducing inequalities – a cross-cutting perspective (Norway).
- Pros and cons of targets (United Kingdom).
- Gender differences (Croatia).
• Problems associated with high levels of unemployment and poverty (the Former Yugoslav Republic of Macedonia).

Successes – what has worked well and why
• Linking the integrated approach with upstream determinants.
• Telling a compelling story – using statistics.
• Targeting spearhead areas (areas of multiple deprivation).
• Including gender perspectives.
• Using quantitative data (breakdown by geography, ethnic group, gender, age, etc.).
• Developing qualitative data.
• Developing national strategy that addresses the needs.

Common challenges
• Developing initiatives at population level.
• Collecting and effectively using more comprehensive surveillance data.
• Addressing the challenge of disadvantaged populations.
• Identifying barriers to greater access to services.

Intervention map for comprehensive strategies
• Social inequality in health is a gradient (higher social equality status = better health);
• Requires a universal approach and selective measures (social reform – upstream; risk reduction – midstream; effect reduction – downstream).

In which connection would countries find assistance helpful?
• In dealing with priority areas.
• In developing policy tools to ensure a cross-cutting perspective.
• In developing collaboration with other countries.
• In improving awareness about CVD risk factors (including gender factors).
• In focusing on specific targets, such as life expectancy, infant mortality rates, etc.
WHO European report on noncommunicable diseases: process and outline

The outline of the forthcoming WHO European report on noncommunicable diseases (European NCD Report) was discussed in April and December 2005 when the value of developing a Europe-specific report on NCD to complement the European NCD Strategy (1) was acknowledged. The rationale behind the decision to prepare the report was that it would support the implementation of the Strategy (1) by promoting the importance of a comprehensive and integrated approach and providing evidence and information about best practice, a baseline for monitoring and measuring progress, and details, illustrations and examples of action.

Three separate modules were proposed, i.e. three products, linked in terms of format and style: (1) The challenge of NCD; (2) Policies and programmes for meeting the challenge; and (3) An illustrated guide to a comprehensive and integrated approach.

Modules I and II were at quite an advanced stage; Module III was still under development. KTL (National Public Health Institute, Finland) had helped with the development of Module I. Module II builds on an analysis of NCD policies and programmes in different countries. Eight of the countries were being examined in more detail in terms of policies and programmes and the conclusions drawn would be used in the preparation of a tool.

In addition to these three substantial products, there would be a summary version.

Re Module I

The development of the first module involves – as a first step – an analysis of the databases available at the European level, such as mortality statistics from the WHO database. However, morbidity statistics are less readily available. For example, only a few countries have a cancer register.

A first working draft has been developed based on a selection of countries. A possibility would be to develop an electronic version of the graphics so that all countries are covered. In terms of the risk factors components: data for smoking and alcohol are available; those for obesity, serum cholesterol and blood pressure are more difficult to obtain. The MONICA23 database is the only one which allows a comparison of the countries. It is, however, becoming outdated. Another source of information would be national surveys.

As regards dietary risk factors, there were some behavioural data and food balance sheets but one of the main difficulties regarding diet is that ideally the nutrient level should be analysed and for that nutrient databases are needed. However, these exist only in a few countries in the Region. The point was made that, although nutrient data are difficult to come by, proxies or markers, such as fruit and vegetables, are good indicators of the intake of several vitamins.

23 MONICA: Multinational MONItoring of trends and determinants in CArdiovascular disease.
Module II

Based on regional balance, eight countries with different types of health systems and at different stages of developing NCD policies had been selected for analysis. These were Albania, Finland, France, Greece, Hungary, Ireland, Kyrgyzstan and Lithuania.

A first draft had been developed through desktop work. The key informants were then interviewed to fill the gaps. The writers focused on the main overall health policy or the health promotion policies in the countries. A first observation was that there are many policies in countries, both overall policies and disease-related policies. Part of the problem was what to include and what to leave out, i.e. how to prioritize. It was agreed that, as a minimum, nutrition and tobacco policies would be included as health risk policies, heart disease policies would be included as diseases policies, and policies relating to older people would be included as population group policies. The results were to be synthesized to see what kind of lessons could be learnt from the case studies. The final part of the module would be a self-assessment tool to encourage discussion about the challenges and about finding solutions to overcome them.

Though NCD strategies do exist, many of them have not been implemented over the past decade, which raises the question of why it should be necessary to create new strategies. One of the aims of the task to hand is to reach a better understanding of the inherent development of European NCD policies. To do so would be a step forward. It is not always easy to find the boundaries between individual biomedical approaches and the social and economic determinants of health. The key is to find common features within the huge diversity of European NCD policy and to develop a practical tool that would stimulate thinking in health policy-making, bearing in mind that the tool should be appropriate for the audience in question.

Comments

- It would be interesting to assess the future burden and to reflect some of the modelling work carried out on the economic consequences of NCD. The financial argument contributes to making the case for addressing NCD.

- There are about 30 CINDI risk factor surveys and health monitor surveys that include data on blood pressure, cholesterol, body mass index (BMI), lifestyle indicators and food-based dietary guidelines. Though these data sources do not cover all countries of the European Region, this information should not be neglected. For example, the risk factor monitoring surveys carried out in Slovenia are based on representative samples and the health monitor surveys are based on national and regional sources.

- A fourth module may be needed on the rationale behind this exercise. The name of the European NCD Strategy is Gaining Health; decision-makers in the key sectors must be convinced about the potential gains of doing so.
Parallel working groups on the European NCD Report

The participants split into three working groups to discuss (1) the overall approach of the European NCD Report, and (2) one of its modules:

1. Working group on Module 1: Challenges of NCD
2. Working group on Module 2: Policies to meet the challenge
3. Working group on Module 3: Illustrated guide

Working group on Module I: Challenges of NCD

Summary of working group discussion

- There was support for the suggestion made to add a fourth module on the future burden of disease with the aim of encouraging political will.

- It was considered best for all modules of the report to be released together. This would be more appropriate for communication purposes and would ease WHO's task of disseminating the publication.

- The importance of identifying the appropriate audience was underlined.

- It could be dangerous to have a module aimed at both communication and research. There are three major questions to address: (1) what is known and needs to be communicated; 2) what is known but needs to be better understood; and (3) what is still to be understood. Mortality figures cannot be the markers of effectiveness or the lack thereof.

- It would be important to monitor and evaluate progress made in implementing the Strategy (1) in order to show politicians what has been done. To this end, it is necessary to identify universal indicators. The question is whether evaluation should be included in Module I or in the proposed fourth module.

Feedback from the Working Group on Module I

Comments on the overall approach of the European NCD Report

- Two additional modules were proposed: one to motivate decision-makers in all key sectors about the potential gains of implementing the Strategy (1); and one on monitoring and evaluation with a list of indicators reflecting the situation in the European Region.

- Two versions of the report should be produced: a short version for communication purposes and a detailed version.

- All modules of the report should be released at the same time, as a package.
**Overall comments on the proposed outline of Module I**

The outline was supported in principle bearing in mind that:

- data should be presented in a way that was easily understood by politicians;

- data analysed at subregional level would best reflect the differences that exist between groupings and countries.

**Additions/changes proposed**

- Include information on health systems.
- Draw on information from country examples.
- Include available data on health behaviour.

**Contributions from countries**

- Analysis of mortality data to assess social determinants, behaviours and risk factors.
- Regarding determinants of health: use groupings; include behavioural and socioeconomic data (assistance sought from Norway); use the CINDI database.

**Challenges**

- Establishment of joint projects (joint effort), e.g. joint project on monitoring and evaluation.
- Inequalities and development of policy to tackle them.
- Collection and presentation of data to initiate and support action.

**Comments from plenary on Module I**

- The point was stressed that there have been discussions about the importance of developing good surveillance systems and that to be able to assess the effectiveness of interventions, which is difficult, it is necessary to have data not only on mortality and morbidity but also on risk factors. In this connection, the participants were reminded about the forthcoming 5th International Behavioural Risk Factor Surveillance Conference, Rome, Italy, 24–26 October 2007.

- One way to approach surveillance and monitoring could be through case studies as has been done, for example, by the CINDI Programme. Participants were reminded that statistics should be used to tell the story.

- It might be useful to include examples of inequalities from two or three countries. The Regions for Health Networks use maps in a convincing way, for example, mortality rates versus gross domestic product (GDP). They help to tell the story.
Working Group on Module II. Policies to meet the challenge

Summary of working group discussions

- Module II comprises five parts: (1) Introduction, summary and approach; (2) History of NCD policy development in Europe in recent decades; (3) Case studies – eight countries; (4) Analysis and conclusions; (5) Self-assessment tool (there was still work to be done on this part).

- In analysing the case studies of the eight selected countries, the aim is to move, if possible, towards a typology of different NCD prevention policy developments and eventually produce a practice tool.

- It is important to keep the target audience in mind (i.e. decision-makers, high-level civil servants or politicians). The tools are of course fundamental to this part of Module II, and a starting point may be the strategy framework, i.e. advocacy, regulations, etc, and the more operational tools, such as health impact assessment.

- The point was made that a part on the inequalities dimension seemed to be missing in Module II. It was clarified that this had been taken into consideration by the writers but that it was sometimes difficult to identify the boundaries between prevention policy and the more overall issues of tackling the social and economic determinants of health without focussing explicitly on health.

- In terms of the audience, it is strategically important to identify the right people (decision-makers). For example, there are problems in targeting the top level in ministries of health. Firstly, from a strategic point of view, disease prevention spans a period far beyond the electoral cycle of 4–5 years, which does not help to attract political interest in prioritizing this area. Another problem is related to negative information presented in the press about health financing, hospital management, deficits in care, etc. This also weakens negotiation. Policy-makers do not expect to be educated, and more importantly, their decision-making position is defined by the dilemmas to be managed and the structure of interest at all levels.

- In Romania, there is a crisis in relation to drugs. Though the health budget has increased, the availability of funding for drugs is decreasing. The reason for this is that after 1990 a massive infusion of high technology and expensive drugs meant that funds for the provision of basic services were limited. Romanian policy-makers used this as an argument to shift the focus to prevention and the early detection of diseases. If this has been the experience in other eastern European countries, perhaps this is the argument that policy-makers need to start thinking about and designing NCD prevention policies. It is difficult for the government to impose guidelines.
Feedback from the Working Group on Module II

Comments on the overall approach of the European NCD Report

- The audience would be decision-makers, not only in ministries of health but also in other sectors (a changing public health), at international, national and local levels.
- To be of interest to a varied audience (especially politicians), the report needs to reflect flexibility.
- Perhaps there should be two versions of the report (long and short).
- Material should be provided on training, capacity-building, etc.

Overall comments on the proposed outline of Module II

- Hints should be included about structures that would help to make awareness-building more permanent (channels of communication).
- The focus should be on the future rather than the past; include history only to give an understanding of the present.
- Mainstream tendencies should be described.
- Care should be taken with regards to policy analysis. In the case studies, we have the opportunity to triangulate through interviews with different people.

Additions/changes proposed

- Inequalities may not be sufficiently highlighted.
- Apart from the eight country case studies, other specific examples and significant experience should be included.
- Some of the work carried out in Canada could complement the case studies.
- Part 4 of Module II seems to focus too much on the health sector.
- Use examples from pioneers.
- Public health infrastructures? For example, having a “public health minister”.

Contributions from countries

- Include specific examples, such as the Norwegian experience with a ministerial breakfast meeting.
- Consider how to use the network to gather other examples.

Training and capacity building

- Include something short and catchy on training packages for politicians and health professionals.
- The logical framework approach24 could be useful, for example, to health professionals and others.

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Comments from plenary on Module II
There were no comments on Module II.

Working group on Module III: Illustrated guide
Summary of working group discussions

- A comment was made on the necessity of including morbidity at the same level as mortality in order to show that conditions other than cancer and heart disease are connected to high morbidity.

- It was not clear whether any results had come out of the WHO global survey conducted in 2001 through health interviews to assess national capacity for NCD prevention and control but such data may be useful. There are also a couple of EU initiatives on the burden of chronic disease, e.g. the EU Public health Programme Project, Global Report on the Health Status in the European Union (EUGLOREH 2007), which was coordinated by a group in Italy, and supported by the Public Health Directorate. Furthermore, the WHO European Health report 2005 focused on DALYs, whereas years lived with a disability (YLD) are probably a better reflection of conditions with high morbidity. Also, risk factors and determinants like health-seeking behaviour need to be taken into account even if there are not many data thereon.

- The importance of assessing the future burden of chronic disease was stressed as this would be a convincing argument for policy-makers.

- A point was made about remembering to include CINDI data and, when addressing health inequalities, to look at various modelling approaches. With respect to risk factors and behaviour, it was also considered important to decide on the indicators to be used. If not all of the countries have the indicators, they would need to develop them. Nutritional indicators also need to be taken into consideration.

- The point was made that it was essential to focus on the economic aspects of NCD. Being able to demonstrate costs saved to governments would help give NCD priority.

- The question was raised as to whether there was a case for prioritizing key data in those countries that have no data at all. The data presented need to be sufficient to justify the argument for working towards NCD prevention. It is also important to have trend data and disease registers in order to be able to provide sufficient amounts of accurate data.

25 www.who.int/chp/about/global_forum/en/
Comments from plenary on Module III

Overall comments on the approach of the European NCD report

- There seems to be an overlap between Modules II and III. It was suggested that they be merged.
- Coordination between the different modules is very important.
- The target audience should be defined for each module, the content of which should be appropriate to the audience.
- The timeline is ambitious.
- Morbidity data should be included as well as mortality data.
- Modelling or proxy data should be used when data are not available.
- Trend data are very important for monitoring progress.
- Existing databases (STEPS, Infobase and others) should be used.
- Comparable data are lacking; guidelines are needed for monitoring and evaluation.
- Individual country data are needed for advocating to governments (appendix).
- Consideration should be given to linking up with the EUROSTAT project. WHO might consider supporting countries that are not included in this project.

Comments on the proposed outline of Module III

- Suggestions for the introduction:
  - Argue the case.
  - Explain the purpose of the module.
  - Mention the target audience.
  - Include briefing on how to use the module.
  - Link to other ongoing activities.
- Case studies:
  - There is an overlap with Module II.
  - Small boxes are not sufficient: add links to details.
  - There should be recommendations as a checklist of the core elements of a national NCD action plan.
  - Monitoring and evaluation need to be included.
  - Guidelines need to be specific to national and local levels.
  - WHO coordination is needed and countries should report progress regularly.
Country contributions to Module III

• Technical assistance from: Croatia; Ireland; Norway; United Kingdom (Heart of Mersey); EULAR; WHO headquarters.
• All countries will have the opportunity to comment during course of development.

Training and capacity

• CINDI experience.
• Experience of Heart of Mersey.
• EULAR.

Comments from plenary on Module III

In response to a point made about absolute mortality or avoidable mortality, it was specified that it had been agreed that mortality would be separated as such.

Slovenia would be willing to support the work on Module III.

Summary of discussions on the European NCD report and the way forward

The feedback had been tremendously helpful. The timeline is ambitious and review meetings will be necessary.

It was very important that the full breadth of the data be used to make compelling arguments and help countries position themselves to make the case. This is part of a long-term process.

There are still two gaps to be filled: (1) the empowerment of people should be emphasized; and (2) community support should be addressed.

Reflections on the WHO Action Plan for the implementation of the European NCD Strategy

An outline was presented of the different aspects to be considered in developing the action plan for the implementation of the European NCD Strategy (1). Comments were requested

Governance

• Internal advisory group
• External advisory group
• Network of national NCD counterparts (as requested by the Regional Committee in Resolution EUR/RC56/R2 (2)).
• Joint meetings of national counterparts (new ways of working across technical areas, such as nutrition and tobacco).
• WHO planning.
Comments

The importance of involving the network of national counterparts (across risk factors) was stressed. Their expertise is rich and should be linked to Part 10. Also, it would be worth naming the WHO networks, such as Healthy Cities, as they are one of WHO’s biggest strengths.

Alliance

- Maximizing synergies between existing international alliances – e.g. with the World Bank.
- Developing a European forum with major partners – supporting existing alliances.
- Promoting the development of country alliances.

Comments

- The collective experience of CINDI should be taken into consideration since the type of expertise existing in the programme might be helpful in speeding up implementation. In this connection, there are several entry points: individual contributions within countries; individual examples of good practice, and relevant experience to be shared, irrespective of source.
- Strategic positioning could be highlighted in Part 10, which talks about strategic networks and their collective contribution.
- There could be more emphasis on collaboration between the countries and joint projects (e.g. on monitoring and evaluation).
- An explanation could be added on the code of communication between countries and WHO.
- Using networks at the EU level and the WHO level would be much more efficient than using individuals at country level. The umbrella of the strategy implementation and existing networks should be used because there is a power in their functioning.
- The World Bank is ready to respond to government requests to estimate costs and assess financial gaps in connection with implementation of the Strategy (I).

Communication

- Communication plan.
- Dissemination of the European NCD Strategy (I).
- Development of publications/materials.

The objectives, target audiences, concepts and messages had not been identified and a reflection of the importance of message-testing and evaluation was missing. A communication plan would be useful for clarifying the aim of the report and the audience.
**Integrated work packages**

Over the next two years, work would be started in different areas, based on discussions in countries regarding:

- integrated NCD policy;
- disease-specific programmes;
- essential effective interventions;
- social determinants of health and health inequalities;
- chronic care;
- primary care development.

**Comments**

- It was suggested that “universal access to disease prevention and health care” be mentioned as a priority area.
- It would be good to review the consistency between the priority areas and monitoring and evaluation and perhaps develop performance indicators.

**Monitoring and evaluation**

- European NCD policy integrated platform: there are databases for tobacco and nutrition/obesity risk factors. There is a need for a platform where all these issues come together.
- European NCD risk factor surveillance.
- Strengthen health information systems to support NCD prevention and control.

**Research and development**

- Identification and support of new areas of research.
- Strengthening research on intervention and implementation.

**Training and capacity-building**

- Knowledge transfer strategy.
- Review of existing training mechanisms.
- Development of new capacity-building mechanisms.
- Country support.

*Comment:* The health impact assessment should be explicitly mentioned here.

**Resource mobilization**

- Generation of new resources.
- Reorientation of existing resources.
- NCD consultants.
• Communities of practice/knowledge networks.
• WHO collaborating centres.

Comments
• The question of including budget in the action plan was raised. This had not yet been done but budget outlines had been drawn up for different sections, bearing in mind that resources are not only financial but also human, such as technical expertise, etc. Part 10 of the action plan is about the possibility of finding additional resources or making better use of existing funds. There is an assumption that a basic package from WHO would be available.

• Some resources could be allocated to help develop strategies and support start-up implementation activities. This is a decision for the governments to make.

Next steps
The comments made were important to the development of a focused effort to help countries. There will be opportunities to bring groups of countries together and efficient ways of working together will be investigated. The NCD report will be strengthened and made clearer before being submitted to the Standing Committee of the Regional Committee in May 2007. Thereafter, a report on the development of the document will be submitted to the Regional Committee in September 2007. It was important that countries and individuals be actively involved in contributing to these efforts.

Closure of the meeting
In his closing remarks, Dr Nikogosian recalled similar efforts in relation to other conditions or risk factors, such as obesity and tobacco and encouraged countries to link with these areas in their NCD prevention efforts and support integrated action. The exchange of experience during the meeting was very rich and created a pool of knowledge, which will help analyse the situation across the Region. The discussion on alliances was encouraging because these will not only create international coordination but also stimulate an intersectoral approach to NCD prevention, as well as inter-agency dialogue.

The discussion on the forthcoming European NCD report showed an understanding of and agreement about the document. The main comments received will be taken into consideration.

Dr Nikogosian thanked the participants for their time, commitment and excellent contributions to the work. He also thanked the Government of the United Kingdom for graciously hosting the meeting and providing excellent technical and financial contribution to the work.

In closing the meeting, Ms Rae paid tribute to Dr Adshead as a leader in NCD prevention. She thanked WHO on behalf of the Government of the United Kingdom for leading the work on the implementation of the European NCD Strategy (1) in such an effective manner and pledged the United Kingdom’s continued commitment and support to the Strategy (1) and to the WHO Regional Office for Europe.
References


Annex 1: Programme

Wednesday, 2 May 2008

09:00 hours Opening of the meeting
Welcome and introduction
Department of Health, United Kingdom
WHO Regional Office for Europe
Appointment of Officers
Adoption of programme
Report on developments since endorsement of the European Strategy for the Prevention and Control of Noncommunicable Diseases

10:00 hours Challenges and priorities I
A comprehensive and integrated approach to NCD prevention and control
The experience of England, United Kingdom
The experience of Canada
Facilitated discussion

11:15 hours Challenges and priorities II
Progress and challenges faced by countries
The experience of Ireland
The experience of Georgia
Facilitated discussion

14:00 hours Parallel sessions
Integrated intersectoral action on risk factors and their underlying determinants
Strengthening health systems for the improved prevention and control of NCD
Systematic integration of action and policy to reduce inequalities in health

16:00 hours Developing alliances for NCD
International and country perspectives
Presentations followed by panel and facilitated discussion
Thursday, 3 May 2007

09:00 hours  Feedback from parallel sessions
             Conclusions
             Progress and challenges faced by countries

09:45 hours  WHO European report on noncommunicable diseases
             Process and outline
             Plenary discussion

11:00 hours  Working groups on the WHO European report on NCD
             Parallel working groups focusing on different aspects of the report
             Reports of the working groups
             Plenary discussion
             Summary and way forward

15:00 hours  Implementation of the European Strategy on NCD
             Reflection on the WHO action plan
             Facilitated discussion
             Summary

16:00 hours  Conclusions and recommendations
             Closure of the meeting
Annex 2. List of presentations and presenters

Developments since endorsement of European Strategy for the Prevention and Control of Noncommunicable Diseases (Dr Jill Farrington, Coordinator, Noncommunicable Diseases, WHO Regional Office for Europe)

A comprehensive and integrated approach to NCD prevention and control:
- **The experience of England** (Dr Fiona Adshead, Deputy Chief Medical Officer, Health and Social Care Standards and Quality Group, Department of Health, United Kingdom)
- **The experience of Canada** (Dr Sylvie Stachenko, Deputy Chief Public Health Officer, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada)

Progress and challenges:
- **The experience of Ireland** (Dr John Devlin, Deputy Chief Medical Officer, Department of Health and Children, Dublin, Canada)
- **The experience of Georgia** (Dr Levan Baramidze, Head, Public Health Department, Ministry of Labour, Health and Social Affairs of Georgia)

Integrated action on risk factors and the underlying determinants across sectors:
- **England, United Kingdom** (Dr Steve Feast, Senior Adviser, Health and Wellbeing, Health Improvement Directorate, Department of Health, London, United Kingdom)
- **Slovenia** (Dr Jozica Maucec Zakotnik, Director of the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) Programme in Slovenia, Bratislava, Slovenia)
- **Italy** (Dr Paulo D'Argenio, Director of the IX Office, General Directorate for Prevention, Ministry of Health, Rome, Italy)
- **Austria** (Dr Günter Diem, Director, Arbeitskreis für Vorsorge- und Sozialmedizin Gemeinn. Betriebs Gesmbh, Bregenz, Austria)

Strengthening health systems for improved prevention and control of NCD:
- **Denmark** (Dr Else Smith, Director, National Board of Health, Ministry of Interior and Health, Copenhagen, Denmark)
- **A study on caring for people with chronic conditions – a health system perspective** (Dr Ellen Nolte, Senior Lecturer, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, London, United Kingdom)
- **England, United Kingdom** (Dr David Colin-Thomé, National Clinical Director for Primary Care, Department of Health, London, United Kingdom)
- **Georgia** (Dr Revaz Tataridze, Vice-President, Department of Internal Medicine, Georgian Medical Association, Tbilisi State Medical University)
Systematically integrating action and policy to reduce inequalities in health

- **Norway** (Dr Dr Gunn-Elin Aa. Bjørneboe, Director-General for Public Health, Directorate for Health and Social Affairs, Oslo, Norway)
- **England, United Kingdom** (Ms Maggie Rae, Head, Health Inequalities Unit and Local Delivery Units, Department of Health, London, United Kingdom)
- **Croatia** (Dr Vlasta Hrabak-Zerjavic, Head, Epidemiology of Chronic Diseases Service, Croatian National Institute of Public Health, Zagreb, Croatia)
- **The Former Yugoslav Republic of Macedonia** (Professor Dodro Donev, Associate Professor, Director, Institute of Social Medicine, Joint Institutes, Faculty of Medicine, Skopje, The Former Yugoslav Republic of Macedonia)

Developing alliances for NCD


Working in partnerships across Europe to improve the prevention and control of NCD. A case study: musculoskeletal conditions

(Professor Anthony Woolf, Department of Rheumatology, Royal Cornwall Hospital, Truro, United Kingdom)

The Dutch approach to NCD. "Opting for life"

(Mr Erik Koster, Policy Coordinator for Chronic Diseases, Ministry of Health, Welfare and Sport, The Hague, Netherlands)

WHO European report on noncommunicable diseases: process and outline

(Prof Dr Jill Farrington, Coordinator, Noncommunicable Diseases, WHO Regional Office for Europe)

Implementation of the European Strategy for the prevention and control of noncommunicable diseases

(Prof Dr Jill Farrington, Coordinator, Noncommunicable Diseases, WHO Regional Office for Europe)
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