



WORLD HEALTH ORGANIZATION

FIFTY-FIFTH WORLD HEALTH ASSEMBLY
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Ministerial round tables: risks to health

Report by the Secretariat

1. Four ministerial round-table discussions on risks to health were held concurrently on 14 May 2002, during the Fifty-fifth World Health Assembly. Ministers of health exchanged information and experiences on risks to health and their prevention in their respective countries. The main issues raised in the round tables are summarized below.

FOCUSING ON RISKS AND PREVENTION

2. A new emphasis on risks to health and hence on prevention raised considerable support among ministers. Many reported that, while most of their resources are currently devoted to treatment or palliative services, more need to be committed to prevention. They welcomed the initiative to focus on the major risks that are the leading causes of disease and injury. For many, not only was finding the best balance between prevention and treatment a major challenge, but so also was ensuring that preventive efforts were applied to the major risks to health. They recognized the need for reliable and locally-relevant assessments of a range of risks to health, using consistent methods and comparable health outcomes. Without such assessments, priorities might be set ad hoc on the basis of historical precedence, vested interests, or uncommon but newsworthy dangers. Ministers strongly supported the efforts of WHO in creating a scientific framework for making reliable and comparable assessments, and welcomed initial estimates of the likely magnitude of major risks to health in order to target prevention programmes better.

3. Numerous ministers provided examples of risks that were important in their countries. Although the number of potential risks is almost infinite, they also recognized the need to prioritize actions continuously so that ministries can focus their efforts in areas where health can be improved most, and to evaluate risks that are most likely to be a major cause of disease burden. Generally, they supported the selection of risks to be assessed in the forthcoming issue of *The world health report*. Ministers suggested additional attention on some factors that particularly affect developing countries, including injury (for example, through motor vehicle crashes or at home) and mentioned that some risks are modified (for instance, tobacco chewing and home brewing of alcohol) or different (such as chewing arica beans) in some such countries. They noted that initial estimates by groups of countries should be updated as information becomes available, and ideally amplified with, for example, information on local risk profiles. The ministers urged WHO to provide technical assistance for evaluating the impact of risks at country level, measuring risk factors and their trends, and building capacity to monitor exposures and to survey outcomes. The rapid change in age structure of many populations was raised as an important factor that will lead to changing risk profiles in the coming decades.

4. There was support for assessing risks under the broad headings of the environment, occupation, consumption or use of alcohol, tobacco and other addictive substances, nutrition, reproduction and sexual behaviour and violence. Several ministers noted that such an inclusive approach would mandate an intersectoral approach to prevention strategies. Reducing major risks to health would often require cooperation with many influential agencies, such as ministries of agriculture, environment, education and finance, and partnerships with communities, nongovernmental organizations, local government and private-sector organizations, where appropriate.

POVERTY DETERMINES MANY RISKS AND SHAPES OUR RESPONSES TO THEM

5. A recurrent theme was poverty as a major risk to health, indeed an underlying determinant of most if not all the risks discussed in the round tables. Poverty affects disease patterns between and within countries, with continuous gradients between levels of poverty and risks. Several ministers referred to the important role of other aspects of socioeconomic status, particularly education for women.

6. The realities of poverty present serious obstacles to reducing the risks to vulnerable groups who have little or no capacity to lessen their or their family's exposure. Changing the environment – in its broadest sense, including the policy environment – was seen as important to reducing risks in all countries, but essential in developing countries in which many individuals have less autonomy.

GLOBALIZATION CAN LEAD TO GLOBAL RISKS

7. Global trade has been championed as a strategy to reduce poverty, but, liberalization of trade can both benefit and harm health; in some instances it has led to globalization of risks. A prime example is tobacco, whose use has become in recent years an established or rapidly emerging risk to health in all developing countries. Its use was the risk to health most commonly cited by ministers, who uniformly recognized the need for more stringent control in their countries, with measures including increased taxation, bans on advertising, introduction or expansion of smoke-free environments and expansion of cessation programmes. Consumption of alcohol was another commonly cited and increasing risk to health. Increasingly globalized risks were also seen for conditions to which diet was a major component, such as diabetes, obesity and hypertension, even in countries with coexistent undernutrition.

COST-EFFECTIVENESS ANALYSIS IS CRUCIAL IN CHOOSING STRATEGIES TO TACKLE MAJOR RISKS

8. Every country has major risks to health that are known, definite and increasing, sometimes largely unchecked, for which cost-effective interventions are insufficiently applied. The main concern for all ministers was how best to manage their scarce resources to tackle the major risks once they had been identified. Many ministers noted that the budget allocated to health was neither adequate to continue existing activities nor sufficient to deal with new risks to health. Cost-effectiveness was a critical measure for decision-makers to identify which interventions provide the best value for money. The unavailability of cost-effective options to lower serious risks to health should trigger major international investment in research to identify such interventions.

9. Several ministers requested technical assistance in identifying packages of interventions that were appropriate to their resource setting. Additionally, they recognized the need for technical assistance in implementing, evaluating and refining these packages.

10. Ministers widely recognized the great need to increase the application of proven cost-effective interventions against major risks to health. Developing health policy that achieves this and maintains a good balance between prevention and treatment services remains one of their predicaments. The chain of causality, from socioeconomic through environmental and community to individual behaviour, offers many different entry points for prevention. Ministers echoed the need for mixes of interventions that tackle background environmental (e.g. indoor air pollution) and distal (e.g. sanitation) risks, as well as more proximal risks such as physical inactivity and alcohol abuse.

GOOD COMMUNICATION ABOUT RISKS IS INTEGRAL TO GOOD MANAGEMENT OF RISKS

11. Several ministers noted the importance of communication about risks as part of the process of managing risk, and recommended an open approach between all concerned parties, even when there were unpalatable messages or scientific uncertainty, so as to maintain trust. Loss of trust and openness was seen as likely to jeopardize other communications about risk and hence prevention strategies. How risks are described, who are the scientific spokespersons, how dialogue and negotiations take place, and whether uncertainties are adequately conveyed, all have a substantial influence on successful communication. The management of unknown or highly uncertain risks can present particular difficulties. Ministers would welcome guidance on strategic choices between continued surveillance, commissioned research, further scientific and public dialogue, or action. Some noted that strengthening the public health infrastructure (surveillance structures, epidemiological laboratories, and planning and communication capacity) provides increased capacity for controlling current communicable diseases.

COUNTRY NEEDS AND INTERNATIONAL RESPONSES

12. For the international health community, tackling major risks to health at a global level means focusing on countries with highest disease burden, such as most African countries and many in south Asia. Not only are the risks particularly frequent in these countries, but there is increasing evidence that they are highly concentrated. Much of this large burden (and most of the world's infectious-disease and childhood-disease burden) is due to comparatively few risk factors, such as malnutrition, unsafe sex, unsafe water, indoor smoke and interpersonal violence.

13. The ministers noted also the need for international and national efforts to combat the widely distributed risks to health – high blood pressure, tobacco use, consumption of alcohol, physical inactivity, obesity and high cholesterol concentrations, which are now major threats throughout the world and causes of much of the disease burden in developed countries. In middle-income countries, these risk factors already contribute to the double burden of risks to health, and these same risk factors are also of growing importance in low-income countries. With ageing populations and current trends in disease rates, exposure to these risks is likely to assume increasing importance. Without early introduction of preventive measures, with initiatives such as those envisaged in the WHO framework convention on tobacco control, the low- and middle-income countries will suffer a vast increase in the number of premature deaths from noncommunicable diseases.

14. Many ministers reported considerable successes in tackling major risks. Benefits were gained within just a few years, for example, with large reductions in the prevalences of HIV/AIDS and cardiovascular disease. In some cases, substantial benefits had resulted from moderate but population-wide reductions in major risk factors, such as blood pressure and high cholesterol levels. Ministers recognized a crucial role for WHO in fostering the evaluation of prevention programmes and disseminating the results. Sharing other countries' successes and learning from their predicaments will improve prevention in many different settings, especially in rapidly developing countries where healthy transition is an important goal.

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