WHO REGIONAL COMMITTEE FOR EUROPE

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Agenda item 5 (a) 2. Promoting intersectoral and interagency action for health and well-being in the WHO European Region, with special focus on social determinants and health, health literacy: links and coherence between health, education and social policy.

The stratification of social determinants and the capacity to disaggregate communities by risk categories to target relevant interventions are not trivial activities. They entail radical re-orientation of services and, most of all, of health workers. Their attitude need to change and our medical schools must incorporate the new paradigm in their curricula.

We need to identify determinants and anticipate our interventions as early as possible in the chain of promotion, prevention and cure.

To do this we have established population surveillance systems capable to generate data and information not immediately available from the HIS. They have enabled us to monitor risk behaviours and assess outcomes in school children, in adults and in the elderly. Moreover we are now completing the analysis of the first decade of data collected from a sample of 1.5 million people representative of our population.

We have knowledge and relevant tools, such as genomics and epigenetics, that are telling us how foetal programming may be critical and predictive of how individuals interact with family and social environment.

We also know from toxicology how external physical environment impacts on health profiles and predicts morbidity and mortality.

We know that education levels more than income can contribute to health (not well-being, though, for which financial income thresholds apply).

We believe that communication is an essential public health tool that may orient individual choice towards healthy habits, providing a socially balanced marketing contrasting much wealthier and intrusive commercial advertising.

We are currently targeting pre-primary and primary schoolchildren in order to make them health literate adults.

Literacy should be extended and be inclusive. Our targets are those who are marginal in the system, by education, income, age, semantics and language. In my country we also face a reversal gradient between rural (with best health records) and urban area (the worst performing, for cities

with more than a quarter million residents), where slums are easily, and sometimes inevitably, formed. It is exactly in urban slums and deprived peripheral areas that we see a concentration of avoidable morbidity and mortality.

It is very easy to recommend people to eat properly, have a balanced diet, have physical activity set daily, avoid smoking and substance abuse. But are people able to get the message and practice? Are they equipped to practice? Do they have enough knowledge and the minimal financial resources needed to break the vicious circle of ignorance, misery, disease? Our mission is exactly to find out and act accordingly to break this circle, providing our people, who are our shareholders, with the needed resources and tools. And we constantly fight with competing priorities to make sure budget does not decrease as we are already at less than 7% GNP invested in the sector.

Thank you Chair.