Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Diseases Prevention and Control

17–18 March 2011
Seoul, Republic of Korea
Regional High-Level Meeting on Scaling up Multisectoral Actions for Noncommunicable Disease Prevention and Control

World Health Organization Western Pacific Region

17-18 March 2011 Seoul, Korea
REPORT

REGIONAL HIGH-LEVEL MEETING ON SCALING UP MULTISECTORAL ACTIONS FOR NONCOMMUNICABLE DISEASE PREVENTION AND CONTROL

Convened by:

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NOTE

The views expressed in this report are those of the participants in the Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Disease Prevention and Control and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Disease Prevention and Control, held in Seoul, the Republic of Korea, from 17 to 18 March 2011. Financial support was provided by the Korea Foundation for International Healthcare (KOFIH).
SUMMARY

Noncommunicable diseases (NCD) are a significant public health concern for countries and areas in the Western Pacific Region and have been identified as one of the four priorities of the Regional Director. The Regional Action Plan (2008-2013) is guiding NCD prevention in the Region.

There is renewed interest in NCD at the global level with a United Nations General Assembly Resolution leading to a High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011. All WHO regions are organizing high-level NCD meetings in the run-up to a United Nations high-level meeting on NCD. NCD prevention and control efforts have to be scaled up in the Western Pacific Region Member States through high-level political commitment, multisectoral actions and health systems strengthening in addition to resource mobilization for NCD prevention and control.

The meeting of senior policy-makers from ministries of health, finance and planning and foreign affairs from Member States along with experts was organized in Seoul, the Republic of Korea, from 17 to 18 March 2011.

The objectives of the meeting were:

1. to strengthen high-level political commitment and to place NCD prevention and control as a top priority in the national health and development plans;
2. to promote health in all policies and identify key policy intervention areas in health and nonhealth sectors, which have a strong impact on lifestyle and NCD risk factors for populations;
3. to identify key areas in health systems strengthening based on the values and principles of primary health care with a focus on health promotion and NCD prevention and control; and
4. to strengthen partnerships for NCD and to identify opportunities for mobilizing resources for NCD prevention and control.

The Regional High-Level Meeting on Scaling Up Multisectoral Actions for Noncommunicable Disease Prevention and Control consisted of six sessions. The first session set the scene on the WHO Western Pacific regional situation and its strategic response to NCD; economics of the worldwide obesity epidemic; and the health and socioeconomic burden of NCD (challenges and opportunities), including presentations and discussions on the economic burden of NCD in the world. The second session included presentations and panel discussions on the national strategic response to NCD on national policies and programmes. The third session included presentations and panel discussions on multisectoral actions for comprehensive and integrated approaches to reduce major risk factors and social determinants.

The fourth session was comprised of country presentations and panel discussions on health systems strengthening to address NCD prevention, treatment and care. The fifth session tackled partnerships for NCD, including presentations on NCD alliance, promoting NCD in the development agenda and a panel discussion on partnership for strengthening national capacity and improving service delivery and research.
The sixth and final session included deliberations on the draft Seoul Declaration and endorsed it. Mechanisms for communicating with the United Nations General Assembly High-Level Meeting on the outcome of this meeting were discussed.

The key recommendations from the meeting are contained in the Seoul Declaration. It is the desire of the participants at the meeting that this declaration be disseminated widely and taken forward to the forthcoming First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in April 2011 and possibly to the United Nations High-Level Meeting on the Prevention and Control of NCD in September 2011.
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**Keywords**

Noncommunicable diseases – prevention and control / Risk factors / Partnership
1. INTRODUCTION

1.1 Background

Noncommunicable diseases (NCD) are a significant public health concern for countries and areas in the Western Pacific Region and have been identified as one of the four priorities of the Regional Director. The Regional Action Plan (2008-2013) is guiding NCD prevention in the Region.

There is renewed interest in NCD at the global level with a United Nations General Assembly Resolution leading to a High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011. All WHO regions are organizing high-level NCD meetings in the run-up to a United Nations high-level meeting on NCD. NCD prevention and control efforts have to be scaled up in the Western Pacific Region Member States through high-level political commitment, multisectoral actions and health systems strengthening in addition to resource mobilization for NCD prevention and control.

A meeting of senior policy-makers from ministries of health, finance and planning and foreign affairs from Member States along with experts was organized in Seoul, the Republic of Korea, from 17 to 18 March 2011. Pacific island countries consulted in February in Nadi, Fiji, and produced the Nadi statement on the NCD crisis in Pacific island countries and areas as their collective voice.

1.2 Objectives

The objectives of the meeting are:

(1) to strengthen high-level political commitment and to place NCD prevention and control as a top priority in the national health and development plans;

(2) to promote health in all policies and identify key policy intervention areas in health and nonhealth sectors, which have a strong impact on lifestyle and NCD risk factors for populations;

(3) to identify key areas in health systems strengthening based on the values and principles of primary health care with a focus on health promotion and NCD prevention and control; and

(4) to strengthen partnerships for NCD and to identify opportunities for mobilizing resources for NCD prevention and control.

1.3 Participants

The meeting was attended by 31 participants, temporary advisers and resource people from 16 countries and areas in the Region, namely: Australia, Brunei Darussalam, Cambodia, China, Hong Kong (China), Japan, Kiribati, the Lao People's Democratic Republic, Macao (China), Malaysia, Mongolia, New Zealand, the Philippines, the Republic of Korea, Singapore and Viet Nam. Observers from 17 organizations and agencies also were present.
Five WHO staff from the Western Pacific Regional Office and one from WHO Headquarters in Geneva, Switzerland, served as the Secretariat.

The list of participants, temporary advisers, resource people, observers and members of the Secretariat is presented in Annex 1 and the programme of the meeting is presented in Annex 2.

1.4 Organization

The Regional High-Level Meeting on Scaling Up Multi-sectoral Actions for Non-communicable Disease Prevention and Control consisted of six sessions. The first session set the scene on the WHO Western Pacific regional situation and its strategic response to NCD; economics of the worldwide obesity epidemic; and the health and the socioeconomic burden of NCD (challenges and opportunities), including presentations and discussions on the economic burden of NCD in the world. The second session included presentations and panel discussions on the national strategic response to NCD on national policies and programmes. The third session also included presentations and panel discussions on multi-sectoral actions for comprehensive and integrated approaches to reduce major risk factors and social determinants.

The fourth session was comprised of country presentations and panel discussions on health systems strengthening to address NCD prevention, treatment and care. The fifth session tackled partnerships for NCD, including presentations on the NCD Alliance, promoting NCD in the development agenda and a panel discussion on partnership for strengthening national capacity, improving service delivery and research.

The sixth and final session included discussion and finalization of the draft Seoul Declaration, the mechanism for communicating with the United Nations General Assembly High-Level Meeting on the Prevention and Control of Non-communicable Diseases.

1.5 Opening ceremony

The meeting was opened by Dr Chin Soo-Hee, Minister of Health and Welfare, the Republic of Korea, and Dr Shin Young-soo, WHO Regional Director for the Western Pacific. Dr Shin’s opening address is attached as Annex 3.

The meeting commenced with a video keynote address by Dr Ala Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health, WHO Headquarters, in which he stressed the importance of addressing the common risk factors for NCD to reduce disability, morbidity and premature death. NCD are a threat to economic development and impede poverty-reduction initiatives, including achievement of the Millennium Development Goals. There is a need to accelerate national and global actions against NCD. He also shared with the meeting the global response to NCD by WHO which will culminate in the United Nations High-Level Meeting on the Prevention and Control of NCD (UN HLM) in September 2011.

2. PROCEEDINGS

The meeting continued with a brief introduction and a discussion of the draft Seoul Declaration, which is one of six regional declarations leading up to the UN HLM on NCD.
It was followed by the presentation of the Nadi Statement on the NCD crisis in Pacific island countries and territories by Dr Kautu Tenaua, Minister of Health and Medical Services, Kiribati, attached as Annex 4.

The meeting was briefed on the issues faced by the Pacific islands and the response agreed to in the Nadi Statement endorsed in February 2011. The key point from this declaration is the concern of Pacific nations on the health and economic burdens imposed by the rapidly developing epidemic of NCD at the individual, family, community and national levels.

In view of the NCD crisis, and the inadequate response to date, the following urgent actions are required in the Pacific: political leadership at the highest level to take responsibility for and address the crisis at national and regional levels; the right multisectoral policy environment to mainstream the response; support for priority cost-effective interventions and monitor their implementation and expand the evidence base through research and surveillance; adequately resource and sustain the response; ensure full accountability of all sectors for their respective contributions; significantly strengthen advocacy and community engagement to maintain a focus on the NCD crisis; and strengthen health systems to effectively respond to the crisis.

2.1 Session 1 – Health and socioeconomic burden of NCD: challenges and opportunities

2.1.1 The WHO Western Pacific regional situation and its strategic response to NCD

The presentation outlined the NCD burden in the Region. A key finding is that the death rates from NCD are now higher in the low- and middle-income countries than in the high-income countries in the Region. The major risk factors are prevalent in the Region, especially tobacco use among men, and high body mass levels in most the countries. The comprehensive WHO/Western Pacific Regional Office response was summarized and the roadmap towards and after the UN HLM outlined. The Regional Committee Meeting in October will be preceded by a regional forum on NCD, which will focus on post-UN HLM issues.

2.1.2 Economics of the worldwide obesity epidemic

This presentation reviewed the global and regional obesity situation and the opportunities and difficulties in responding to the obesity pandemic. The high rates of obesity in the Region were described and the need for (sub) region-specific cut points stressed. It was proposed that the obesity epidemic is the result of technological advancements that have changed the relative costs of food consumption (decreasing) and physical activity (costs increasing, especially the opportunity costs). There is not enough information about the health costs of obesity in the Region. Addressing obesity will require strong government action since the private sector inevitably under-invests in prevention.

It was proposed that not enough is known about the causes of the obesity epidemic. Successful strategies will need to change the costs and/or benefits of obesity-related behaviours and will need to be multidimensional (and likely include drugs and devices). Incentives and disincentives may have a role, but more research is needed and the best chance of success may be to focus on youth and even earlier.

2.1.3 Economic burden of NCD in the world

This presentation summarized the reasons for the World Economic Forum placing such importance on NCD as a global economic threat and the actions taken in response by the forum. Costs are major, both direct and indirect, but not yet clear. There is a lack of data from different regions. Most studies are disease-specific, making them difficult to compare and to argue for
NCD at large. There is also a lack of strong evidence of costs incurred outside the health sector and direct links to major global risks savings. There is a need for a costs and savings rationale that speaks to business and government.

The discussion emphasized a need to ensure that healthy foods and beverages and physical activity make commercial sense as well as having a public health rationale. The focus on the health and well-being of children is based on the long-term goal of prevention, even though it does not have a purely economic justification.

2.2 Session 2 – National strategic response to NCD: national policies and programmes

2.2.1 NCD prevention and control – Australia's perspective

This presentation reviewed the disease and risk factor burdens in Australia and the national response which has had notable successes, especially in tobacco control, although obesity, health inequalities and the ageing population present significant problems. The National Health Reform Agenda (2011) provides an opportunity to reduce the lifestyle risks in Australia.

2.2.2 Strategic response to NCD epidemic in China

The key challenges are the high rates of NCD and the high prevalence of risk factors, especially smoking, and, increasingly, obesity. Various programmatic responses are in place across the full range of strategies although the response is in need of urgent strengthening.

2.2.3 National policy and programme on NCD prevention and control in Mongolia

The burden of NCDs is high in Mongolia and risk factors prevalent, especially heavy alcohol consumption and low fruit and vegetable intake. A feature of the response is the new Health Promotion based on a 2% tobacco tax (2007) and, recently, a 1% tax on alcohol and a 2% VAT on imported drugs. Progress is hampered by the influence of the alcohol and tobacco industries.

2.2.4 A national policy and programme on NCD prevention and control in Viet Nam

The burden of NCD is high and the response has, until recently, been organized in a vertical fashion. A more integrated approach is under development.

2.2.5 Discussion

The discussion emphasized the challenges of more effectively responding to the NCD, especially in low resource settings where both finance and human resources are scarce. The importance of win-win strategies involving multiple partners was emphasized and the need for a regulatory response in many situations. Innovative financing will be a useful option and should be considered more widely. Local priorities will vary but key strategies are cheap and affordable, e.g. tobacco control and salt reduction, and should be part of a coherent, funded and planned response.

2.3 Session 3 – Multisectoral actions: comprehensive and integrated approaches to reduce major risk factors and social determinants

2.3.1 Multisectoral action for behaviour change and health promotion foundations
The health sector has a key leadership role in the response to NCD across the full range of strategies. Health promotion foundations are an important financing mechanism and the evolving regional experience with these foundations is encouraging. Multisectoral action is critical and there are good regional examples of success; bisectoral approaches are a useful starting point. However, barriers to more effective action are strong, e.g., obesity, especially in childhood, and are a result of "commercial successes and market failures". The auto industry is a key factor in the obesity epidemic. International multisectoral action and global networks will strengthen local resolve. In summary, national development is difficult without controlling NCD and it will not be easy to control NCD without the ownership and participation of development agencies.

2.3.2 Promoting a healthy lifestyle – Singapore’s experience

Singapore has a relatively young population with good health indicators. There is a focus on prevention although obesity is increasing and there is concern that a tipping point might soon be reached which could lead to escalating rates of obesity. Both top-down and bottom-up approaches are required and are in place. The successful "Mee Rebus" story (healthy noodles with brown rice) was described; it involved a response from the 3Ps – private sector, people and the public sector (whole-of-government approach).

2.3.3 Healthy diet and physical exercise – Hong Kong experience

NCDs are the main health issue in Hong Kong and the burden will increase as the population continues to age. A full range of strategies has been developed and implemented. Multisectoral actions are in place, e.g. involving health and education sectors. The major challenges include maintaining political will; the sustainability of current efforts; and the coordination of multiple partners and stakeholders, all with a different agenda.

2.3.4 Discussion

The question of what works in low resource settings was posed by the chair. The answers include the need for environmental policies and mechanisms to integrate medical and preventive services; capacity-building; social mobilization and promotion; engagement of all partners, especially the public; support from international partners; and extra resources. A small number of performance targets, as used in New Zealand, will be helpful and monitoring progress is essential. The overall aim is to develop an environment which facilitates healthy behaviour choices. The importance of being alert to possible tactics of the food and beverage industries was stressed. They will build on the experience of the tobacco industry, which continues to influence tobacco control policies. The public health community needs to develop criteria for working with industry.

2.4 Session 4 – Health systems strengthening to address NCD prevention, treatment and care

This session had presentations by Dr Hendrik Bekedam, Professor Li Liming, Dato' Dr Hasan Abdul Rahman and Dr Mark Jacobs on strengthening health systems for NCD and by Professor Soonman Kwon on sustainable financing for NCD.

2.4.1 Health systems and NCD

There are differences in the requirements for management of communicable and noncommunicable diseases, and resources and capacities for NCD vary in the region. There is a need to move towards integrated services for all common conditions, regardless of cause. Most Member States in the Region have NCDs as part of a national health plan but not all have a strong national political commitment and not all are funded. The ultimate goal is to provide a mix of population-based and individually-based services across the NCD risk continuum. In addition,
there is a need for patient-centred and a continuum of care; treatment at the appropriate level; a
shift towards multidisciplinary teams; empowerment of patients and peers; and cost control.
Above all, to get started, NCD must be included in the costed national health plans based on
capacities and resources.

2.4.2 Strengthening primary health care for NCD prevention and control

Integrated community-based NCD Prevention and Control began in 1997 based on an
integrated community hospital-based diabetes project and a national community-based
hypertension project (reduction in hypertension). Healthy cities provide valuable practice for
NCD prevention and control.

2.4.3 Sustainable financing for NCD

Health systems financing, including the amount and mix of health care financing, varies
among Member States in the Region. It is rare to have a financing scheme targeting NCD. An
unresolved issue concerns the optimum amount of spending; this depends on health expenditures
and health outcomes. Most low- and medium-income countries face high out of pocket (OOP)
payments, which discriminate against the poor, especially if the prices of medicines are high. The
benefit package needs to cover both medical care and pharmaceuticals and there is a need to
monitor the level and amount of spending. Innovative additional sources of NCD financing are
available, e.g. increases in the tobacco tax that have a major impact on smoking and in generating
extra revenue for prevention and service delivery.

2.4.4 Health systems strengthening and NCD – Malaysia’s experiences

There are two components of the health system: public (majority of patients) and private
(majority of facilities). Efforts to strengthen NCD management at the primary health care level
began in the 1990s based on a National Strategic Plan for Prevention and Control of Diabetes as
an entry point for health systems strengthening. The next approach is 1 Care (blueprint in 2013),
which aims to integrate public and private services, where payments are linked to the performance
of doctors.

2.4.5 Improving NCD service delivery: quality, access and coverage – Experience from
New Zealand

NCD services cover the full spectrum of activities, from population-based approaches to
individually targeted care. There have been improvements in quality, access and coverage though
significant health inequalities remain. NCD risk factor trends vary – obesity increasing, tobacco
and cervical cancer decreasing. Approaches to improving NCD service delivery include national
health performance targets. Three of six relate to NCD: shorter waits for cancer treatment, better
help for smokers to quit and better services for cardiovascular diseases and diabetes mellitus.
Other measures for NCDs include fruit in schools – one piece of fruit for each of 100 000 students
in low socioeconomic areas; green prescriptions for physical activity, now extended to 5-18 years;
"care plus” – improved management of patients with complex problems; regional cancer control
networks; and Let’s Beat Diabetes – long term sustainable change to prevent or delay
complications, especially for Maori and Pacific people using the life course approach. Key aspects
to success include continuity of care for NCD, a mix of national, regional and local programmes,
involvement of service providers and providing information, including monitoring and evaluation.
2.4.6 Discussion

Challenges include scaling up of nonhealth sector involvement; engagement of communities; building political support; sustainability of health care financing; establishing country-specific targets and tools; creation of enabling and a positive environment for a healthy lifestyle; and addressing reliance on food imports, especially processed food. Health information systems need strengthening in all countries.

A fundamental question is whether NCD are really on national agendas; not all participants are convinced.

2.5 Session 5 – Partnerships for NCD

2.5.1 NCD Alliance

The NCD Alliance was established in 2009 and was made up of four international nongovernmental organizations (NGOs), 900 associations with strong partnerships and networks. It is the recognized leader in civil society with the important task of producing disease-specific and NCD indicators and targets and to foster leadership and to persuade donors and philanthropic organizations to invest in NCDs. The NCD Alliance has published its suggestions for the outcome document for the UN HLM on NCD (see NCDA website (http://www.ncdalliance.org/).

2.5.2 Promoting NCD in the development agenda

Development of an integrated NCD prevention and control programme in the Philippines started in 2000, culminating in an administrative order, the National Policy on the Prevention and Control of Chronic Lifestyle-Related Noncommunicable Diseases. Challenges include adoption by the national government and localization by local government units; mobilization of human and financial resources and development of an appropriate financing mechanism; organization of health delivery systems (strengthening primary care); development and standardization of performance indicators and information systems for NCD; and strengthening partnerships with professional organizations, NGOs and international agencies.

2.5.3 Discussion

The discussion focused on the role of the Union for International Cancer Control, the Southeast Asia Tobacco Control Alliance, the Framework Convention Alliance, the United Nations Economic and Social Commission for Asia and the Pacific, the World Economic Forum, the Asian Development Bank and the World Bank. All agencies are active in NCD prevention and control and wish to increase their engagement. There is a need to coordinate these actions.

Selected presentations are attached as Annex 5.

2.6 Session 6 – Seoul declaration and next steps

The main outcome of the meeting was the Seoul Declaration on Noncommunicable Disease Prevention and Control in the Western Pacific Region. A draft was available to participants and was discussed on two occasions at the meeting before the final version was presented, revised again and then endorsed by all participants.
The Seoul Declaration will be distributed widely and discussed by Member States and other interested stakeholders. It is expected that the declaration will be presented at the forthcoming First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control to be held in Moscow, Russia, from 28 to 29 April 2011.

SEOUl DECLARATION ON NONCOMMUNICABLE DISEASE PREVENTION AND CONTROL IN THE WESTERN PACIFIC REGION

Recognizing the serious and rapidly increasing adverse impact of NCD, including cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, on individuals, families, communities, health systems and national economies, and the high prevalence of the risk factors, the countries and areas of the WHO Western Pacific Region participating at the Regional High-Level Meeting on Scaling Up Multisectoral Action for Noncommunicable Disease Prevention and Control, declare their commitment to:

(1) provide strong and sustained high-level political support for NCD prevention and control programmes to reduce premature NCD death and disability and health inequalities;

(2) ensure a supportive multisectoral whole-of-government policy environment and a coordinating process to mainstream the response to NCD involving all stakeholders, including civil society and, where appropriate, the private sector to protect health and to ensure that healthy choices are the easier choices;

(3) reduce the common NCD risk factors (tobacco use; diets high in total fat, saturated and or trans-fats, salt and sugar; the harmful use of alcohol; and physical inactivity); and

(a) in line with WHO action plans and using the full range of options, including legislation, regulation, fiscal measures and healthy public policies and, in particular, accelerate towards the full implementation of the Framework Convention on Tobacco Control; and

(b) by addressing the social determinants of health and by leveraging the power of local governments and civil society actions;

(4) strengthen and integrate health systems, based on primary health care to ensure that NCD prevention and control is part of a funded, coherent, balanced, realistic and comprehensive health planning process that is financially feasible and to:

(a) deliver services for NCD and their risk factors using team-based care and the most appropriate health professional for the patient’s needs and including affordable and cost-effective drugs, technologies and services to support evidence-based priority interventions; and

(b) work towards continuity of quality care from prevention to palliative care across the whole health system and promote a people-centred approach with synergies with other programmes;

(5) prioritize human and financial resources and infrastructure to ensure equitable coverage of priority evidence-based NCD programmes; and
(6) provide integrated but practical monitoring and accountability systems based on strengthened health information systems and, as appropriate, a small number of quantified and timed targets and indicators to assess progress nationally to be reported publicly and to WHO and, if appropriate, to the United Nations General Assembly.

In support of these commitments, participating countries and areas request the global community, through the United Nations High-Level Meeting on the Prevention and Control of NCD, to act in a coordinated way to support global and national multisectoral efforts by:

(1) raising the priority of NCD on their agendas;

(2) strengthening synergies between NCD programmes and other development priorities, including the Millennium Development Goals and the future global development agenda; and

(3) mobilizing additional resources and supporting innovative approaches to financing NCD prevention and control.

3. CONCLUSIONS

The meeting emphasized the pressing health, social and economic burdens imposed by NCD in all countries in the Region. Although there have been many successes in reducing NCD death rates at all ages in several countries, their response is still inadequate. WHO has led the development of a full range of strategies to respond to the main risk factors for NCD, notably the Framework Convention on Tobacco Control (FCTC), which has been ratified by all countries in the Region, and global and regional strategies for diet and physical activity and to reduce the harmful effects of alcohol. To date, implementation of these strategies has been incomplete at the national level. For example, tobacco use remains high in many countries, especially among men, and the key elements of the FCTC are not yet being fully implemented.

There are many positive examples of national NCD prevention and control programmes, including bisectional and multisectoral programmes, from which important lessons can be learnt for all countries in the Region. Explicit and transparent approaches to working with the food and beverage industry towards independently monitored targets require discussion and agreement.

A key requirement is that national NCD prevention and control programmes are an integral, and costed, component of national health plans. The cost of implementing key NCD interventions is relatively low -- for example, for tobacco control and salt reduction programmes and primary health care-based strategies to reduce the risk of NCD, especially cardiovascular diseases.

Most countries would benefit from extra resources and innovative funding mechanisms such as health promotion foundations in place in several countries in the Region. They generally have been successful in reducing harmful consumption and raising extra revenue.

Strengthening health systems to respond to all priority conditions regardless of cause is an outstanding challenge in all countries. A stepwise approach may be useful beginning at the primary care level and, for example, training existing staff in cardiovascular risk assessment and management and in simple tobacco cessation approaches.
There is considerable support available for national prevention and control activities from regional and international agencies, including from WHO. The NGO community is a valuable partner for national and regional efforts.

Evaluation and monitoring are essential components of all NCD programmes with attention to learning lessons and modifying approaches as appropriate.

The key recommendations from the meeting are contained in the Seoul Declaration. It is the desire of the participants at the meeting that this declaration be disseminated widely and taken to the forthcoming First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in April 2011 and possibly to the United Nations High Level Meeting on the Prevention and Control of NCD in September 2011.
## LIST OF PARTICIPANTS, TEMPORARY ADVISERS, RESOURCE PERSONS, OBSERVERS AND SECRETARIAT

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</tr>
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<td><strong>PHILIPPINES</strong></td>
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<tr>
<td><strong>REPUBLIC OF KOREA</strong></td>
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<tr>
<td><strong>VIET NAM</strong></td>
<td>Dr NGUYEN Son Tuong, Deputy Director, Department of Labor, Culture and Social Affairs, Ministry of Planning and Investment, No. 6B Hoang Dieu Street, Ba dinh District, Ha Noi. Telephone: +8491 359 6898. Facsimile: +0084 804 4577. E-mail: <a href="mailto:tuongson66@hotmail.com">tuongson66@hotmail.com</a> / <a href="mailto:sonnt@mpi.gov.vn">sonnt@mpi.gov.vn</a></td>
</tr>
</tbody>
</table>
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## PROGRAMME

### DAY 1: 17 March 2011 (Thursday)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speakers</th>
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<tbody>
<tr>
<td>08:30 – 09:00</td>
<td>Registration</td>
<td></td>
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<tr>
<td>09:00 – 09:20</td>
<td>Opening session</td>
<td>Dr Shin Young-soo, RD/WHO/ WPRO Minister Dr Chin Soo-Hee, Republic of Korea</td>
</tr>
<tr>
<td>09:20 – 09:35</td>
<td>1. Opening address</td>
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<tr>
<td>09:35 – 09:45</td>
<td>2. Welcome address</td>
<td></td>
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<tr>
<td>09:45 – 10:10</td>
<td>Election of Co-Chairs: adopt agenda</td>
<td></td>
</tr>
<tr>
<td>10:10 – 10:45</td>
<td>Keynote address (video presentation)</td>
<td>Dr Ala Alwan, ADG/NMH/WHO/HQ</td>
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<tr>
<td>10:45 – 11:00</td>
<td>Coffee break and group photo</td>
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</tr>
<tr>
<td>11:00 – 11:15</td>
<td>NCD prevention and control: introduction of draft Seoul declaration</td>
<td>Professor Robert Beaglehole</td>
</tr>
<tr>
<td>11:15 – 11:30</td>
<td>1. WHO-Western Pacific regional situation, strategic response to NCD</td>
<td>Dr Han Tieru, DHP/WHO/WPRO</td>
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<tr>
<td>11:30 – 11:45</td>
<td>2. Economics of the worldwide obesity epidemic</td>
<td>Dr Eric Finkelstein, Duke-NUS</td>
</tr>
<tr>
<td>11:45 – 12:00</td>
<td>3. Economic burden of NCD in the world</td>
<td>Dr Eva Jane-Llopis, WEF</td>
</tr>
<tr>
<td>12:00 – 12:30</td>
<td>Discussion</td>
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<td>12:30 – 13:30</td>
<td>Lunch break</td>
<td></td>
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<tr>
<td>13:30 – 13:45</td>
<td>Session 2 – National strategic responses to NCD: national policies and programmes</td>
<td>Ms. Jenny Hefford</td>
</tr>
<tr>
<td>13:45 – 14:00</td>
<td>1. NCD prevention and control – Australia's perspectives</td>
<td>Dr Kong Lingzhi, China</td>
</tr>
<tr>
<td>14:00 – 14:15</td>
<td>2. Strategic response to NCD epidemic in China</td>
<td>Dr Jadamba Tsolmon, Mongolia</td>
</tr>
<tr>
<td>14:15 – 14:30</td>
<td>3. National policy and programme on NCD prevention and control in Mongolia</td>
<td>Dr Truong Dinh Bac, Viet Nam</td>
</tr>
<tr>
<td>15:15 – 15:30</td>
<td>Coffee break</td>
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### Session 3 – Multisectoral actions: comprehensive and integrated approaches to reduce major risk factors and social determinants

<table>
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<tr>
<th>Time</th>
<th>Content</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>15:30 – 15:45</td>
<td>1. Multisectoral action for behaviour change and Health Promotion Foundations</td>
<td>Professor Rob Moodie, Australia</td>
</tr>
<tr>
<td></td>
<td>2. Promoting healthy lifestyle – The Singapore experience</td>
<td>Mr Ang Hak Seng, Singapore</td>
</tr>
<tr>
<td>15:45 – 16:00</td>
<td>3. Healthy diet and physical exercise – Hong Kong (China) experience</td>
<td>Dr Lam Ping-yan, Hong Kong (China)</td>
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<tr>
<td>16:00 – 16:15</td>
<td>Panel discussion</td>
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**Moderator:** Professor Rob Moodie  
**Discussants:** China, Malaysia, New Zealand and Republic of Korea

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### DAY 2: 18 March 2011 (Friday)

### Session 4 – Health systems strengthening to address NCD prevention, treatment and care

<table>
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<th>Speaker(s)</th>
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<tbody>
<tr>
<td>09:00 – 09:15</td>
<td>1. Health systems and NCD</td>
<td>Dr Hendrik Bekedam, DHS/WHO/WPRO</td>
</tr>
<tr>
<td></td>
<td>2. Strengthening primary health care for NCD prevention and control</td>
<td>Professor Li Liming, PUMC</td>
</tr>
<tr>
<td>09:15 – 09:30</td>
<td>3. Sustainable financing for NCD</td>
<td>Professor Soonman Kwon, SNU</td>
</tr>
<tr>
<td>09:30 – 09:45</td>
<td>4. Health systems strengthening and NCD – Malaysia's experiences</td>
<td>Dato' Dr Hasan Abdul Rahman, Malaysia</td>
</tr>
<tr>
<td>09:45 – 10:00</td>
<td>5. Improving NCD service delivery: quality, access and coverage-Experience from New Zealand</td>
<td>Dr Mark Jacobs, New Zealand</td>
</tr>
<tr>
<td>10:00 – 10:15</td>
<td>Panel discussion: strengthening health systems for NCD</td>
<td></td>
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</tbody>
</table>

**Moderator:** Professor Myongsei Sohn  
**Discussants:** Professor Li Liming, Brunei Darussalam, Hong Kong (China), Mongolia, Philippines and Viet Nam

**Coffee break**

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>10:15 – 10:30</td>
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10:30 – 12:00 | 6. Panel discussion: strengthening health systems for NCD                                      |                                                              |

### Lunch break

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### Session 5 – Partnerships for NCD

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:00 – 13:15</td>
<td>1. NCD Alliance</td>
<td>Professor Ruth Colagiuri, IDF (NCD Alliance)</td>
</tr>
<tr>
<td></td>
<td>2. Promoting NCD in the development agenda</td>
<td>Dr Mario Villaverde, Philippines</td>
</tr>
</tbody>
</table>
| 13:30 – 14:30| 3. Panel discussion: Partnership for strengthening national capacity, improving service delivery and research                                        | **Moderator:** Professor Ruth Colagiuri  
**Discussants:**  
Professor Susan Henshall (UICC)  
Professor Ruth Colagiuri (IDF)  
Dr Duk Hyon LEE (Korea CDC)  
Dr Shi Xiaoming (China CDC)  
Dr Eva Jane-Llopis (WEF)  
Mr Gerard Servais (ADB)  
Mr Shiyong Wang (World Bank) |
|              |                                                                                                                                                                                                        |                                                                              |
| 14:30 – 15:00| **Coffee break**                                                                                                                                                                                        |                                                                              |
| 15:00 – 15:45| **Session 6 – Seoul declaration and next steps**                                                                                               | **Co-Chairs**                                                                |
|              | **Discussion, finalization and adoption of the draft Seoul declaration**  
Discuss the mechanism for communication with the United Nations General Assembly High-level Meeting on the Prevention and Control of Noncommunicable Diseases | **Facilitator:** Professor Robert Beaglehole                                  |
|              |                                                                                                                                                                                                        |                                                                              |
| 15:45 – 16:00| **Closing session**                                                                                                                            | Dr Shin Young-soo, RD/WHO/WPRO  
Dr Jong-Koo Lee  
Director/Deputy Minister  
Korea Centers for Disease Control and Prevention, Republic of Korea               |
ANNEX 3

OPENING REMARKS OF THE DR SHIN YOUNG-SOO WHO REGIONAL DIRECTOR FOR THE WESTERN PACIFIC AT THE REGIONAL HIGH-LEVEL MEETING ON SCALING UP MULTISECTORAL ACTIONS FOR NONCOMMUNICABLE PREVENTION AND CONTROL 17 MARCH 2011 SEOUL, REPUBLIC OF KOREA

HONOURABLE MINISTER DR CHIN SOO-HEE, MINISTRY OF HEALTH AND WELFARE, REPUBLIC OF KOREA, DISTINGUISHED PARTICIPANTS, REPRESENTATIVES OF PARTNER AGENCIES, AND DIPLOMATIC CORPS.

Good morning, and welcome to this Regional High-level Meeting on Scaling Up Multisectoral Action on Noncommunicable Disease Prevention and Control. I would like to thank the many senior officials, including ministers and vice-ministers of health, finance and planning, who traveled here to help us consider what perhaps is the most stubborn public health challenge facing Western Pacific Region—and that’s the rising tide of noncommunicable diseases.

I also would like to thank the Ministry of Health and Welfare of the Republic of Korea and the Korea Centers for Disease Control and Prevention for their support in co-hosting this important meeting and for providing this wonderful venue for our discussions.

First of all, I would like to take this opportunity to express my sincerest condolences to the people of Japan, who lost their families, relatives and friends, and those who are suffering so much from unimaginable scale of disasters. I simply hope that the Japanese people can recover from these ordeal as soon as possible.

Throughout history, changes in the ways we live, the foods we eat and the work we do have evolved slowly, allowing our bodies to adapt. But changes over the past few decades—particularly rising urbanization, an increasingly sedentary lifestyle, and the aggressive marketing of foods unnaturally high in fat, salt and sugar—have occurred so rapidly that the human organism has not had time to adapt.

As a result, noncommunicable diseases—cancer, cardiovascular diseases, chronic respiratory conditions and diabetes—are rising rapidly and now affect every country in our Region.

Today, in the Western Pacific Region—home to nearly 1.8 billion people, a quarter of global population—noncommunicable diseases are responsible for four out of every five deaths. Nearly 30 000 people in our Region die every day due to diseases that can and should be prevented.

Tobacco alone claims 3000 lives in the Western Pacific Region every single day, according to WHO estimates.

WHO’s global data show that overweight and obesity are responsible for 44% of all diabetes cases. And physical inactivity is estimated to cause between 15% and 25% of breast and colon cancers, and is responsible for 30% of the heart disease burden worldwide.
The rising tide of noncommunicable diseases is already straining our health systems. Unlike communicable diseases that tend to affect people quickly, noncommunicable diseases generally progress much more slowly, creating complex health needs that are expensive to treat and can overwhelm already stressed health systems. Developing nations do not always have the resources to facilitate extended care for chronic noncommunicable diseases, leaving the patients in the care of their families.

And we are only seeing the tip of the iceberg. Globally, deaths due to cancer are projected to rise by more than 60% in the first 30 years of this century, according to the latest WHO projections. And deaths due to cardiovascular disease are expected to rise more than 70% over the same period.

It's usually the poorest people in our Region who have the highest burden of noncommunicable disease, as they often have greater exposure to risk factors and less access to preventive and therapeutic services.

Noncommunicable diseases are claiming victims at increasingly younger ages, even during childhood, depriving many of our citizens of their most productive years. These premature deaths not only devastate families by claiming the lives of primary wage-earners, but they weaken communities and national economies, making it more difficult to achieve equitable and sustainable development.

To the uninitiated, noncommunicable disease sounds like a "health issue" that can only be solved by the health sector. But as medical doctors, public health specialists, and government and community leaders, we know that by the time people enter the health system with noncommunicable diseases, it's often too late to offer much help. The battle really needs to begin at a much earlier stage.

If we want to win the battle against noncommunicable diseases, the health sector must join hands with other sectors—agriculture, education, the environment, the food industry, trade, transportation and others. And that's why we were very careful in choosing the title for this meeting, making sure the words "Multisectoral Action" were included.

We need a "whole-of-government" approach that engages all sectors. The private sector—those involved in producing, marketing and trading food—can take important steps to make our food healthier, while still enjoying healthy profits. Actions can be taken by city planners and transportation officials to create urban environments that promote healthier and more active lifestyles.

Our goal is to make it easier for all of our people to make healthier choices.

We are gathered here today so that our collective voice can be heard when world leaders gather in New York in September for a High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases.

Working together over these next two days, we hope to agree on a Seoul Declaration on Noncommunicable Disease Prevention and Control in the Western Pacific. This document, which many of us have worked on in draft form, lays out a road map for prevention and control in the Western Pacific and will allow us to raise our voices as one on the global stage at the NCD Summit at the United Nations in September.

We should not let ourselves think the problem is too big or too complicated.
In the Western Pacific Region, we have seen real progress in controlling tobacco, one of the major risk factors for noncommunicable diseases. All the countries in our Region have ratified the WHO Framework Convention on Tobacco Control and now have laws designed to reduce tobacco consumption. As a result, many countries in the Western Pacific are reporting declines in smoking prevalence.

We must mount similar efforts against unhealthy diets, physical inactivity and other NCD risk factors. There is an urgent need to push these issues higher on the public health agenda of countries in the Region, where public awareness of these problems is still low.

The Seoul Declaration and the United Nations high-level meeting in September are significant steps in mounting an effective, comprehensive and sustained response to noncommunicable diseases.

We know what needs to be done. Now we have to do it.

Thank you.
Pacific Steering Group on Revitalising
Healthy Islands (focusing on NCD)
Organised by The World Health Organization
3-5 February, 2011

Nadi Statement on the NCD crisis in Pacific Island Countries and Areas (PICs)

Pacific Island countries are in crisis due to the rapid build-up of the overwhelming NCD epidemic. The burden of NCD in the region ranks amongst the highest in the world (up to three in four adults are obese and up to four in five adults smoke). Already our children are at risk of dying before their parents.

This crisis is impacting adversely on the social development and the economic aspirations of PICs and is a barrier to achieving the vision of Healthy Islands as articulated in the 1995 Yanuca Declaration and the MDGs.

...too little but not yet too late!

The aspirations of the people of the Pacific are to:
1. Reduce premature death and disability due to NCDs;
2. Improve the health and well being of all people;
3. Prevent the emergence of NCDs in children and in future generations; and
4. Reduce the economic impact of NCDs on individuals, families and national economies.

In view of the NCD crisis, and the inadequate response to date, to achieve these aspirations, the following urgent actions are required:
1. Demonstrated political leadership at the highest level to take responsibility for and address the crisis at national and regional levels;
2. Ensure the right multi-sectoral policy environment to mainstream the response;
3. Support priority cost effective interventions, monitor their implementation and expand the evidence base through research and surveillance;
4. Adequately resource and sustain the response (human resources, infrastructure, financial, technical);
5. Ensure full accountability of all sectors for their respective contributions;
6. Significantly strengthen advocacy and community engagement to maintain a focus on the NCD crisis; and
7. Strengthen health systems to effectively respond to the crisis.
WHO-WPR regional situation and strategic response to NCD

Dr. Han Tieru
Director, Division of Building Healthy Communities and Populations,
WHO Western Pacific Regional Office, Manila

Estimated Proportional Mortality (%)
WHO WPR, 2004-Males

Estimated Proportional Mortality (%)
WHO WPR, 2004-Females

NCD Deaths under age 70
(Percentage of all NCD deaths)

Noncommunicable Diseases
Age-standardized Death Rate (per 100,000)

Economic impact of NCD in selected countries

Table 2: Estimates of effect of heart disease, stroke and diabetes on the economy.

| Region | Cancer | Diabetes | Stroke | Total | GDP lost | % of GDP
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>-5.7</td>
<td>-5.0</td>
<td>-3.0</td>
<td>-13.7</td>
<td>-0.13</td>
<td>-1.5</td>
</tr>
<tr>
<td>Canada</td>
<td>0.3</td>
<td>-3.5</td>
<td>-0.5</td>
<td>-4.3</td>
<td>-0.21</td>
<td>-1.6</td>
</tr>
<tr>
<td>China</td>
<td>10.3</td>
<td>-5.0</td>
<td>-3.0</td>
<td>-18.3</td>
<td>-0.37</td>
<td>-2.2</td>
</tr>
<tr>
<td>Japan</td>
<td>1.5</td>
<td>-3.0</td>
<td>-1.5</td>
<td>-6.0</td>
<td>-0.10</td>
<td>-0.5</td>
</tr>
<tr>
<td>Korea</td>
<td>-1.0</td>
<td>-2.0</td>
<td>-1.0</td>
<td>-4.0</td>
<td>-0.10</td>
<td>-0.5</td>
</tr>
<tr>
<td>Mexico</td>
<td>-4.0</td>
<td>-2.0</td>
<td>-1.0</td>
<td>-7.0</td>
<td>-0.11</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

Source: Delo'Anguille, Oxford Economics WHO 2008

The estimated economic loss caused by chronic diseases in Vietnam in 2008 was about US$20.0 billion (0.933% of annual national GDP).
Top 10 risk factors for DALYs for working age (age group 25-65):

- High blood pressure
- High blood cholesterol
- Low birth weight
- Low dietary fruit
- Diabetes
- High body mass index
- High body mass index
- Low dietary fruit
- Low dietary fruit
- High body mass index

Cumulative GDP loss (US $ billions) by 2015:

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>13.61</td>
</tr>
<tr>
<td>India</td>
<td>16.63</td>
</tr>
<tr>
<td>Indonesia</td>
<td>4.18</td>
</tr>
<tr>
<td>Philippines</td>
<td>0.62</td>
</tr>
<tr>
<td>Thailand</td>
<td>1.49</td>
</tr>
<tr>
<td>Vietnam</td>
<td>0.27</td>
</tr>
</tbody>
</table>

Source: Biyani D, Khurana SC, Jain T, Drory A, Shen H, Lalani N.

Medical costs for NCDs are 75% of healthcare costs, but productivity losses account for four-fifths total NCD costs.

Direct social costs of alcohol to Europe: €125bn

- Health €22bn
- Crime €44bn
- Lost productivity €69bn

Source: Antouna S, Bunting SC.
Economic costs per head (2007 SUS PPP) attributable alcohol by cost category

Global cancer rates expected to increase by 50% to 15 million by 2020

Projected % increase in new cancer cases from 2009 to 2020

Total costs in US$ million for new cancer cases, first year after diagnosis alone 2009

Components of total cost of new cancer cases in year 1, 2009

Top 5 cancers (incidence) by region, 2009
Total costs ($bn) of new breast cancer cases, by geographic region, 2009

- Europe: US$ 8.742bn
- Asia: US$ 1.323bn
- Americas: US$ 17.221bn
- Africa: US$ 756m
- Oceania: US$ 481m

Global economic burden of breast cancer in 2009 = US$ 228bn

1 in 4 of us will have a mental health problem

Impact of poor mental health on employers in the UK (2007)

- Mental illness: 30%
- Musculoskeletal disorders: 12%
- Accidents and other illnesses: 9%
- Absenteeism

Leading cause of workplace disability/costs
Economic costs to UK £50 billion/year

Prevention and treatment can largely reduce costs

2% yearly extra reduction in mortality would save 10% of expected income loss

Total returns on investment: economic pay-offs per £1 expenditure

- £12 return
- £9 return

Source: Kruse et al., Lancet (2009)
Calculate return on investment: conversation starter

Challenges to make economic case for NCDs

- Costs are large both direct and indirect yet not clear
- Lack of data from different regions: US/Afro global data
- Most studies are disease specific: difficult comparability and argument for NCDs at large
- Lack strong evidence of costs incurred outside health sector and direct links to major global risks - savings
- Need for a costs/savings rationale that speaks to business and government, understand what figures would make the argument stronger

Thank You
Multi Sectoral action for behaviour change

Rob Moodie
Neosal Institute for Global Health,
University of Melbourne, Australia
WPRO
March 17 2011

The rationale for multi-sectoral action

The battle needs to begin well before people get to hospital – and with other sectors - Dr Shin Young Soo

Our behaviour happens within the complex context of a community, a nation, the globe - Minister Chin Soo-Hee

The role of health sector

As leaders
As sounder of the alarm
As guardian
As role model
As educator and promoter
As service provider

Tobacco

Legislators/Attorney General/Law
Finance/ Treasury
Education
Agriculture
Communications
Workplaces, Sport
Hospitality industry
Insurance industry

Health Promotion Foundations
VicHealth, ThaiHealth, TongaHealth, Swiss Health and Mongolia!!

By nature these are evolving
Original model: dedicated tobacco tax
ThaiHealth: alcohol and tobacco surcharge
SwissHealth: excise on social insurance
Mongolia: Tobacco, alcohol and imported drugs
<table>
<thead>
<tr>
<th>Health Promotion Foundations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ThaiHealth:</strong></td>
</tr>
<tr>
<td>Board of Governance: High level, multi sectoral</td>
</tr>
<tr>
<td>Innovating, designing, implementing, funding cross sectoral programs in tobacco, road trauma, alcohol harm, mental health</td>
</tr>
</tbody>
</table>

| S. E. Asian Tobacco Control Alliance (SEATCA) |
| S. E. Asian Initiative in Tobacco Taxation (SIIT) |
| Indonesia – increasing excise tax to approx 57% |
| > Price of one pack of 10 cigarette sticks will be US$1.65 |
| > Will result in a 12.6% decline in cigarette consumption |
| > Estimated to save 1.04 million premature deaths |

| Vietnam - a 50% rise in excise tax is predicted to result: |
| > 12.4% decline in consumption – a WIN |
| > 6.5% decline in prevalence – a WIN |
| > 55.2% increase in excise revenue – a WIN |

<table>
<thead>
<tr>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police/Crime prevention</td>
</tr>
<tr>
<td>Attorney General/Law</td>
</tr>
<tr>
<td>Finance/Treasury</td>
</tr>
<tr>
<td>Workplaces</td>
</tr>
<tr>
<td>Hospitality/Tourism industries</td>
</tr>
<tr>
<td>Insurance industry</td>
</tr>
<tr>
<td>Alcohol industries</td>
</tr>
<tr>
<td>NGOs</td>
</tr>
</tbody>
</table>

| Physical Activity |
| Urban planning and infrastructure |
| Conservation/Environment/Parks |
| Police/Crime prevention |
| Attorney General/Law |
| Finance/Treasury |
| Education |
| Workplaces |
| Sports and active recreation |
| Insurance industry |

| Healthy nutrition |
| Agriculture |
| Communications |
| Attorney General/Law |
| Finance/Treasury |
| Education |
| Workplaces |
| Sports and active recreation |
| Insurance industries |
| Food and beverage industries |
| NGOs |

| Operationalisation |
| Health In All Policies |
| Multi-sectoral groups – e.g. Presidents/Prime Minister’s taskforces, health promotion foundations |
| Work out what the “common project” is |
Operationalisation

Needs leadership
And funding . . . .

Look for creative partnerships - careful selection of which relationships/partnerships are important

Operationalisation

Bi-sectoral action

Health working with other sectors on common projects
No need for everyone to be in the "same room"

International Multi-sectoral action

WHO
World Bank, Regional Development banks (ADB), UNDP, WTO, FAO, UNICEF,
UN General Assembly
World Economic Forum
Industries (Alcohol, Food and Beverage, Pharmaceutical, Tobacco)
NCD Alliance
International development NGOs

What stops other sectors getting involved?

- Conflict of interest – e.g. economic development (profit) v health outcomes
- Obesity is a commercial success
- Car industry v active transport
- Alcohol availability v health outcomes
- Unclear purpose: why am I here?
- Lack of ownership: it’s not my problem

International Multi-sectoral action

We can't effectively support national development without controlling NCDs

We can't control NCDs without the ownership and participation of development agencies

We need global networks to work with (and sometimes against) global industries that have far more resources
Working with Industries

Working on what we can agree on

Alcohol – drinking culture – yes
Promotions, advertising, taxation – very unlikely

Food – reformulation yes and no
Promotions to children, taxation – very unlikely

Pharmaceutical – decreased costs of relevant drugs – ??

Tobacco – nothing they have so degraded themselves

Effective multi-sectoral action on NCDs requires

public health lawyers, political scientists, economists, development experts, advertisers, business analysts, urban planners, transport specialists, psychologists and........

.........our own lobbyists!

There is no place for the faint-hearted
Sustainable Financing for NCD

WHO WPRD
March 18, 2011

Soonmen Kwon, Ph.D.
Professor of Health Economics
School of Public Health
Seoul National University, Korea

1. Amount and Mix of Financial Resources

Rate to have a financing scheme, targeting NCD
- Exception: SHI for long-term care, tax on risk factors resulting in NCD (tobacco tax, fat tax)

Difficult to determine the optimum amount of health expenditure
- Criteria: health expenditure and health outcomes

System of resource allocation (health care financing mechanism) -> not only how much, but also how (how effectively) to spend on health care (or invest in health)
- Resource generation, pooling, purchasing

WPRO & SEARO
Per Capita Health Expenditure (at average exchange rate)

<table>
<thead>
<tr>
<th>Below 50 USD</th>
<th>50-100 USD</th>
<th>100-500 USD</th>
<th>Over 1000 USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Bhutan</td>
<td>China</td>
<td>Australia</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Mongolia</td>
<td>Cook Islands</td>
<td>Japan</td>
</tr>
<tr>
<td>China</td>
<td>Singapore</td>
<td>Jordan</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Solomon Islands</td>
<td>Kuwait</td>
<td>Norway</td>
</tr>
<tr>
<td>Lao People's Democratic Republic</td>
<td>Sri Lanka</td>
<td>Malaysia</td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Timor-Leste</td>
<td>Mongolia</td>
<td>Singapore</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Vanuatu</td>
<td>Marshall Islands</td>
<td>South Africa</td>
</tr>
<tr>
<td>Nepal</td>
<td>Viet Nam</td>
<td>Marshall Islands</td>
<td>Spain</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Thailand</td>
<td>Tonga</td>
<td>Togo</td>
</tr>
<tr>
<td>Russia</td>
<td>Tunisia</td>
<td>Tuvalu</td>
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</tr>
</tbody>
</table>

Source: WHO, World Health Statistics 2010

High OOP Payment for Health Care

In most of the low-/middle-income countries, high OOP (out-of-pocket) payment for health care means that health care is like a market commodity (different from developed countries)

- The poor cannot afford to pay and may give up treatment (problem in access)
- High OOP results in catastrophic expenditure and impoverishment due to illness

WPRO/SEARO Health Expenditure as a % of GDP

Role of Medicines

Access to medicines is important in NCD
- Benefit package needs to cover both medical care and pharmaceuticals, especially outpatient benefit package including medicines
- Adequate funding level and rational allocation of funds to medicines needs to be closely monitored. Neither under-funding to medicines, nor cost inflation due to medicines. -> Rational use, increasing role of generics is important

High OOP for Medicines in low-income countries
- The poor tend to rely more on drugs (than medical care)
- Price of medicines is high in those countries
- Availability of medicines in public facilities is very low
- Pharmaceutical expenditure often becomes a source of catastrophic payment for health care

Table: OOP Payment for Health Care in Asia

<table>
<thead>
<tr>
<th></th>
<th>Lao PDR</th>
<th>Malaysia</th>
<th>Philippines</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>% OOP in HI Consumption</td>
<td>11.9</td>
<td>5.3</td>
<td>8.2</td>
<td>6.8</td>
</tr>
<tr>
<td>% OOP in Non-subistence HI Consumption</td>
<td>22.3</td>
<td>8.3</td>
<td>17.1</td>
<td>14.2</td>
</tr>
<tr>
<td>% OOP in Total Health Exp</td>
<td>61.7</td>
<td>40.7</td>
<td>54.7</td>
<td>54.8</td>
</tr>
<tr>
<td>% Pharmaceutical Spending in OOP</td>
<td>47.8</td>
<td>28.8</td>
<td>50.2</td>
<td>37.0</td>
</tr>
</tbody>
</table>

II. Public Financing: Tax and SHI

1. Challenges of SHI in low-income countries
- Problem of income assessment and premium collection for the self-employed or informal sector
- Compliance/participation is an issue in the formal sector. OOP
- Employer requirement to pay half of the contribution
- Covering the formal sector first and extending to the informal sector may not work in low-income countries
- Informal sector is too big
- Cross-subsidy by the formal sector does not work
- Without government subsidy, covering the informal sector through SHI is very difficult

2. Challenges of Tax-based Financing in Low-income Countries
- Mobilizing sufficient amount of tax revenue for health care is not as easy as in high-income countries
- Direct tax (income tax) in low-income countries is not as geographically equitable due to the lack of adequate tax-sharing mechanisms
- Equity of tax-based health care financing in low-income countries also depends on - Availability: delivery system in disadvantaged areas; - Quality and responsiveness of the public delivery system
3. Tax vs. SHI: What is a right perspective?

How resources are pooled is as important as which types of resources is used

- Crucial role of purchasing/fund pooling

  **Mixed Financing**: neither pure tax-financing nor pure SHI in Asia
  - Tax-financing: not as universal as Europe, targeting the poor, the better-off rely on the private sector (e.g., Sri Lanka, Malaysia)
  - SHI: full tax-subsidy to the poor and at least partial subsidy to the self-employed (e.g., Japan, Korea, Taiwan, China)

  e.g., Thailand: greater role of tax-financing in terms of financing mix, but with a strong role of purchasers

S. Korn ICD Financing

---

4. How to Mix/Combine Tax and SHI?

- Tax subsidy for the SHI premium of the poor and informal sector
  - Tax financing for primary care (guaranteed/free access) and SHI for secondary and tertiary care?
  - Early detection and promotion saves future cost
  - Tax financing for catastrophic care/expenditure?
  - Improve financial sustainability of health insurance
  - SHI for specific sectors?
  - Pharmaceuticals, long-term care (LTC)

S. Korn ICD Financing

---

III. Service Delivery, Payment, Benefits

Payment system for providers:
- Crucial impact on the efficiency and equity of health care financing because health providers play a key role in health care resource allocation (due to information asymmetry)
  - Fee-for-service: increase amount and intensity of care
- Capitation for primary care is crucial in NCD

S. Korn ICD Financing

---

Benefit Design

- Financial protection requires
  - Exemption for the poor and vulnerable population (e.g., elderly)
  - Ceiling on the (cumulative) amount of copayment for a given time period
  - Discounted coinsurance rate for chronic and catastrophic cases (e.g., cancer)

To strengthen primary care and encourage rational utilization
- Improve the quality of primary care
  - Higher copayment is needed for cases without referral letter (i.e., when patients visit secondary, tertiary care providers directly)

S. Korn ICD Financing

---

IV. Tobacco Tax

(Slightly?) different perspectives between public health and public finance (economics):
- Impact on smoking vs. Revenue generation
  - Amount: big increase (to affect consumption) vs. incremental increase (e.g., linked to consumer price index)
  - Ear-marking: stable fund flow (avoiding chronic under-funding) vs. inefficiency of ear-marking

Potential (negative) impact on equity
- Different responses to price change among different SES
- Brand switching

S. Korn ICD Financing

---

**Figure 4.33. Tobacco tax and consumption**

-axe to the right: 1999 dollars purchasing power exchange rate US/IMF

V. Long-term Care (LTC) Insurance

Why Separate LTC Financing from Health Insurance? (E.g., Germany, Japan, Korea)

a. Pros
   - Foreclose the spillovers of medicalization, dominant role of physicians, and cost-increasing practices of health care financing
b. Cons
   - Transfer beneficiaries to the other fund
   -> Coordination between health care and social care can be more difficult

Beneficiaries of LTC Insurance in Korea

a. Long-term care for the elderly (+65), and
b. Age-related long-term care of the younger (<65 years)
   -> will be very few

Political compromise:
   Everybody should pay contribution, and everybody eligible when he/she has LT care needs due to age-related health problems
   Those certified to be eligible for the benefits in 2010: 5.7% of the elderly
   Service users: 4.8% of the elderly in 2010

Financial Sustainability

Composition of expenditure paid by LTC insurance in 2009:
   - Institution-based (43.3%), Home-based (56.7%)

Average service days per user of LTCI benefits in 2009:
   - Institution-based (229.5 days), Home-based (157.1 days)

Rapid increase in LTCI contribution:
   - 4.05% of health insurance contribution (2006)
   -> 4.78% (2009) -> 6.55% (2010)

THANK YOU !!!

Prof. Soonman Kwon
kwons@snu.ac.kr (Seoul National Univ.)
http://plaza.snu.ac.kr/~kwons (Homepage)
Non-Communicable Diseases (NCDs)
4 diseases – 4 key risks

Four NCDs cause > 60% of global mortality
- Cancers
- Cardiovascular disease
- Chronic respiratory disease
- Diabetes

Fuelled by four common key risk factors:
tobacco use, unhealthy diet, physical inactivity, harmful alcohol use

NCDs: The Magnitude of the Mortality

- Biggest global killer: 60% of estimated annual deaths
- 4 out of 5 now in developing countries
- One third NCD deaths occur prematurely (before age 60)
- Over 300 million people with diabetes now - 500 million by 2030
- Worldwide 300 million people with asthma
- Global CVD deaths are 17.1 million
- 70% of all global cancer deaths occur in LMICs – where cancer claims 5.3 million lives each year.

NCDs: The Cost

Macro-Economic Impacts:
- Lost economic growth: every 10% rise in NCD mortality rates reduces annual economic growth by 0.5% - In 2009 and 2010 WHO rated NCDs among the top global risks
- High healthcare expenditure – EU estimates that diabetes caused USD378 billion in global healthcare in 2010

Individual/household impacts:
- Costs of NCD morbidity and mortality and lost income push vulnerable’s families into destitution
- Poverty breeding ground for NCDs, NCDs can cause poverty

NCDs: The Health & Development Paradox

- NCDs impede achievement of MDGs, yet are not part of the global development agenda
- NCDs receive > 3% of the $22 billion health ODA
- Violating Paris Declaration of Aid Effectiveness
- NCDs are a national priority for development LMICs

The NCD Alliance formed in 2009
4 NGO federations made up of
900 associations in 170 countries
What We Do: The Leadership Vehicle for Civil Society

- Global to Local Advocacy
- Technical Expertise
- Health Service Delivery in LMCs
- Patient support

NCD Alliance: Established Partnership Structures and Networks

- UN Summit Supporters: 4 major NGOs
- Common Interest Group (CIG): 240 NGOs
- Private Sector supporters
- Allies: WHO, PAHO, WEF, Lancet, govts.......
- Website: 60,000 hits

NCD Alliance: Recognised Leadership for Civil Society

- WHO recognise the Alliance as the main NGO partner for the UN HLM
- Recognised by UN, private sector and governments
- Invited to cosponsor high-profile events
- Invited to author papers in prominent journals
- No similar NGO NCD organising network

Where We Are Now?

- Happy with UN HLM Modalities Resolution
- Raising awareness/mobilising/making the case
- Engaging with WHO and UN consultations, and Moscow meeting
- Lobbying Heads govt/state to attend UN HLM
- Producing disease specific and NCD indicators/targets
- Technical work: health systems, essential medicines/tech, FCTC, economics, evidence, guidelines and clinical protocols

But Time is Ticking...

With only six months to go, we have a limited window of opportunity to maximise this unique global political opportunity

UN High Level Meeting on NCDs:

- Leveraging Assets
- Investing in Enablers
1. UN Processes & Mechanisms

- Appoint a high-level focal point for NCDs within UN New York
- Strong leadership across UN system
- Strong participation of civil society in the Summit:
  - a Civil Society Taskforce under the Office of the President of the General Assembly
  - NGOs included in all consultations
  - representation of civil society in national delegations
- Mobilisation of parliamentarians: who is leading with IPU?
- Talking to private sector about their engagement/contribution

2. Clear ‘Asks’ for the UN HLM

1. Governments accountable and measured on NCD plans
2. A global commitment to prevent the preventable
3. Framework Convention on Tobacco Control fully implemented
4. Resources to deliver NCD interventions
5. Agreed approaches to NCD treatment & care
6. NCDs in the MDG successor goals

3. Four Pillars of Leadership

1. UN – WHO as the lead organisation and co-ordination across whole UN system
2. Governments – NCD champions; implement recommendations and outcomes
3. Private Sector – employers, producers, influencers, innovative and affordable NCD medicines and technologies for LMICs
4. Civil Society - Global to local advocacy; technical expertise; health service delivery in LMICs; academia/research

4. Long term view

- UN HLM won’t provide all the answers – first step to global solution
- NCDs need long term view by everyone – UN Decade of Action on NCDs:
  - focus on activities and policies that ensure long-term sustainable change
  - periodic review meetings
- Private sector instrumental in adoption of long term view

5. Accountability structures

Good Practice - Commission on Information and Accountability for Women’s and Children’s Health:
- Dec 2010 – set up by UNSG following Global Strategy on Women and Children’s Health
- May 2011 - propose an accountability framework and an action plan for global reporting, oversight and accountability on women’s and children’s health
- Headed by well-positioned leaders from the developed and developing worlds and has a role for civil society
- Should be integrated at the start of UN HLM

Gap Analysis:
What Seems to be Missing?

- Neutral space for govt/NGO/private sector dialogue
- Visioning the really big questions:
  - how do we address obesity/change behaviour?
  - how will we fund this?
  - radical thinking new technology, m-health, e-health
  - what WHO/UN system do we need post UN HLM?
  - post HLM leadership vehicle UN/govt/private sector/NGOs
What can we all do individually and collectively?

- Foster leadership: UN, govt, private sector - NGOs are ready!
- Ensure Heads of State and Government attend the UN HLM
- Include NGOs in country delegations
- Persuade donors/philanthropic organisations to invest in NCDs
- Message NCDs and the UNHLM to govs and the public
- Inform and educate International media on NCDs
- Support NCD diagnosis, prevention and management especially access to essential medicines/techs
- Promote the rights of people with NCDs

UN HLM  2011:
Our generation’s chance to change the future

www.ncdalliance.org