

## H. CONCLUDING PANEL DISCUSSION

A concluding panel discussion attempted to summarize the main implications of the deliberations carried out during the Symposium. Panelists stressed the importance of doing comparative research and of disseminating the findings of such research so that countries could learn from the experience of one another. The framework provided by the mortality, epidemiological and health transitions was considered a useful point of reference for such research. However, it was recognized that since general overviews of trends in a group of countries tended to focus on the similarities between them, there was the danger of disregarding the distinctive experiences of particular countries. In Central and Eastern Europe, for instance, the experience of different countries had been far from uniform although the main trait was shared by all: they had all experienced a long hiatus in the transition between high and low mortality. Developing countries might derive some fruit-ful lessons from such experience. The importance of social conditions in fostering or hindering change was one of them. However, although the full set of mechanisms leading to the stagnation of mortality was not yet well understood, action should not be delayed. Enough was known about high-risk behaviours, such as cigarette smoking, to validate concerted action aimed at modifying them.

It was also recognized that, although general frameworks or theories regarding changes in mortality and morbidity helped to explain overall trends, they often did not fit well the experience of specific countries. Furthermore, trends in period measures might be "reversed" because of changing cohort experience. It was suggested that projections about likely mortality levels should take into account the prevalence of high-risk factors among different cohorts. Thus, the fact that in certain developed countries cigarette smoking was more common among younger cohorts of women than among older cohorts suggested that female mortality might stagnate or even rise in the future. Similarly, in countries where cigarette smoking was increasing among younger adults, whether male or female, mortality declines would be less likely in the

future. That was the case of China, where smoking had increased markedly, and it might also affect Japan, where mortality from lung cancer was rising.

The need to consider cohort experience was further validated by current biomedical evidence about the influence that exposure to certain conditions early in life might have on morbidity and mortality at a later stage. In this respect, the distinction between some infectious and chronic diseases was becoming somewhat blurred, as it was found that exposure to certain infectious pathogens could trigger a chronic condition. Similarly, the effects of diet and nutritional status acted over the long-run and, because of changing conditions, might affect differently the various cohorts. Behavioural changes were also likely to be more common among certain cohorts than among others, since the diffusion process would tend to reach peers first. Furthermore, interventions were often more successful if aimed at particular age groups. Children, for instance, should be a key target of programmes aimed at reducing smoking because it was easier to prevent a habit-forming behaviour than to stop it once dependence had taken hold.

Considerable emphasis was put on the scarcity of funds to improve health. In sub-Saharan Africa, for instance, one of the effects of structural adjustment had been the reduction of subsidies for health care and education that had forced many people to do without both, thus limiting their chances to improve their health and living conditions over the long run. In Latin America, the reduction of birth rates was leading to an aging population that was more likely to experience non-communicable diseases. Yet the health systems of countries in the region were not geared to provide long-term care for a larger number of elderly persons. Given the scarcity of resources, priorities needed to be set. However, priorities could not be set on the basis of objective criteria when information on health status and morbidity was mostly lacking. The importance of raising awareness about the urgent need for more data collection efforts and analysis in developing countries was underscored.

It was agreed that a key element to improve health and reduce mortality was the mobilization of social resources by

empowering people to opt for behaviours that could reduce the risk of illness and death. Providing education was a major component of such mobilization, since it was a means of ensuring people's commitment to live longer and better lives by adopting health-promoting behaviours. It was also necessary to provide the means of enacting such behaviours and to avoid inconsistent policies. Proclaiming the deleterious effects of smoking, for instance, while at the same time reducing the price of cigarettes was not likely to reduce smoking.

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NOTE

<sup>1</sup>It should be noted that in this volume, the papers are presented in a slightly different order.

