World Health Organization

Dr Margaret Chan
Director-General

Address to the Regional Committee for Europe, sixtieth session
Moscow, Russian Federation, 14 September 2010

Madam President, honourable ministers, distinguished delegates, Ms Jakab, ladies and gentlemen,

Let me begin by expressing my warm wishes to your Regional Director, Ms Jakab, as this first regional committee of her administration gets under way.

This is a time of reckoning, and this is a fragile time. Public health must be smart, strategic, and resourceful as never before.

I welcome the initiatives, described in your documents, for making this regional office more responsive to the needs of its Member States and the expectations of its citizens. As noted, some traditional solutions, and some traditional ways of thinking, no longer match the complex realities of today's public health landscape.

The environment for health in Europe is changing, and so is the global environment. It is good to see that strengthening the European contribution to global health, also through foreign policy, is among the top priorities for the future.

For decades, this region has been the bellwether for health trends and challenges that eventually affect the rest of the world. As such, you have pioneered policies and approaches that serve public health everywhere. The Tallinn Charter, for example, is a landmark achievement with relevance well beyond Europe.

European countries are also leading the quest for a coherent global health policy. Doing so makes sense. The public health community counts European countries as among its most generous, and frankly, its most innovative and forward-looking donors. This leadership was particularly evident at the European Union's high-level conference on global health held in June. In seeking policy coherence, European countries expressed commitment to universal coverage and emphasized capacity-building in developing countries as a foundation for sustainable solutions, self-reliance, and more effective aid. I was particularly heartened by the importance given to strengthening health systems.

I have no doubt that the Tallinn Charter helped give health systems this high place on the political agenda. I am equally certain that the Charter will serve this effort well as an action-oriented policy instrument.

The need for a coherent global health policy becomes all the more important given the diverse and complex health challenges facing public health. These days, politics must be the bedside manner of health officials if they want to get results. Risks that have

been present throughout history have become much larger, and more universally disruptive, in a highly interdependent and interconnected world.

Threats to health are increasingly created, or amplified, by policies made in non-health sectors. To tackle many root causes of ill health, officials need to diagnose causes and consequences in a language that speaks to the core interests of these non-health sectors.

The importance of doing so is explicitly acknowledged in the recent Parma Declaration on Environment and Health. That document recognizes the increasingly critical role of economic arguments in developing sound policies across all sectors.

The phrase "health is wealth", that could have been copyrighted by this regional committee, has an important corollary. Not only does investment in health contribute to national wealth. Policies that fail to consider the impact on health can backfire. They can create or aggravate costly health problems that cancel out any net gains for human progress.

This need to take the health impact into account pertains to policies at the international as well as the national level. More and more, health is the unwitting victim of policies made in the international systems that tie countries, economies, commerce, trade, and foreign affairs together. This is the new source of setbacks for health in the 21st century.

Let me illustrate with a single set of policies, for food, and a single disease, diabetes.

The industrialization of food production has, up to now, made it possible to feed the world's growing population, and this is good. But this trend, combined with the globalization of food marketing and distribution, has brought processed foods, rich in fat, sugar, and salt, yet low in essential nutrients, into every corner of the world, including cities throughout the developing world. These are, of course, the foods that contribute to the rise of chronic diseases.

Mounting evidence shows that obesity and type 2 diabetes, strongly linked to unhealthy diets, have reached epidemic proportions in Asia, where the nutritional transition has been exceptionally rapid. People in that part of the world are developing diabetes in greater numbers and at a younger age than diabetics in industrialized countries, and unfortunately they are dying sooner. Diabetes is an especially costly disease: costly for societies, costly in terms of chronic care, and extremely costly in terms of hospital bills for well-known complications.

Some economists have described this rising prevalence of obesity and diabetes as a "side effect of progress", a consequence of economic development. But I would raise one question: is this progress at all? What is the net gain when economic development sets health development backwards?

Ladies and gentlemen,

This is a time of reckoning, and this is a fragile time. Deadlines are looming. The bills for past extravagance are falling due.

The current economic downturn is global. It is the worst seen in a generation. It is by no means over. And it was seeded by greed, compounded by a failure of risk management at every level of the financial system.

Climate change is the price being paid for policies that favoured the growth of economic wealth over the protection of ecological health.

Multiple global crises, on multiple fronts, reshaped the first decade of a century that began with so much promise, especially for public health. The Millennium Development Goals boosted international health development. The past decade saw the creation of numerous global health initiatives, new funding mechanisms, and new financial instruments. Commitments of official development assistance for health more than tripled.

The results tell us clearly: investment in health development is working. Finally, we are coming closer to reaching one of the most elusive goals in public health: scaling up of coverage with life-saving interventions.

The number of under-five deaths dipped below 10 million for the first time in nearly six decades, and then dropped again to under 9 million. Later this week, UNICEF and WHO will issue new estimates showing another decline of nearly 1 million deaths.

The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200,000 in late 2002 to well over 5 million today, an achievement unthinkable just a decade ago.

The number of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, data from sub-Saharan Africa suggest that the steadily deteriorating malaria situation might be turned around. Countries that have achieved high coverage with recommended interventions are seeing malaria deaths decline by more than 50%. Research is now documenting related drops in all-cause young-child mortality of 60% and higher.

Tomorrow, WHO will release, jointly with UNFPA, UNICEF, and the World Bank, new estimates indicating a significant worldwide drop in maternal mortality, with the greatest declines, of around 60%, reported in Eastern Asia and Northern Africa.

Progress in all these areas is significant and very welcome. But progress is also fragile, for reasons largely beyond our control.

The first decade of the 21st century may very well go down in history as the time when nations came face to face with the perils of interacting in a world of radically increased interdependence.

Sceptics who doubt the reality of climate change would do well to look closely at recent events in China, Pakistan, and here in the Russian Federation. The downpours, mudslides, floods, heat waves, drought, wildfires, and ruined crops match closely the predictions of climate scientists. These scientists have repeatedly warned the world to

expect an increase in the frequency and intensity of extreme weather events, and this is what we are seeing.

More and more, these events are being described as the worst on record, or the worst in the entire history of a country. Records are being broken a record number of times.

The stress is felt internationally. The United Nations has struggled to secure emergency funds on a scale that matches the magnitude of suffering and loss in Pakistan, and the very real threat of epidemics. As a matter of fact, I was working till 2 a.m. discussing with New York how to respond to this situation. Grain prices on the international markets already reflect the huge crop losses in that country and in the Russian Federation. Russia is the fourth largest wheat exporter and Pakistan is in the top ten. We have to anticipate another global crisis of soaring food prices that will hit poor households the hardest.

The future of financing of WHO is on your agenda, as is the proposed programme budget for 2012–2013. Countries in this region have suffered disproportionately from the economic downturn, and your budgets are under close scrutiny.

Money is tight and public health is feeling the pinch. It is being felt at levels ranging from national health budgets, to commitments of official development assistance, to funds available to support the work of the Global Fund, the GAVI Alliance, and other global health initiatives.

I can assure you: the austere economic outlook is also affecting WHO. The aspirations set out in the proposed programme budget may need to be adjusted in line with the reality of the global economic situation.

Ladies and gentlemen,

Good will and commitment remain steadfast. The momentum continues to build, especially for reducing maternal and neonatal mortality. But, as I said, money is tight.

Initiatives such as the Global Fund and the GAVI Alliance have done great good and are widely praised as models of success. These initiatives introduced the principle of results-based funding. And yet despite their own excellent, measurable results, they are now strapped for cash.

Other initiatives speeded the development of new vaccines to prevent pneumonia and diarrhoeal disease, the two biggest killers of young children in the developing world. Yet the introduction of these life-saving vaccines into routine immunization programmes is now in jeopardy because of funding shortfalls. A shortage of funds likewise threatens to curtail introduction of a powerful new conjugate vaccine for reducing epidemics in Africa’s meningitis belt.

What will it mean if a financial crisis, seeded by greed, cancels out fragile health gains made possible by so much good will and innovation? Does the worst in human nature win over the best? These are big-picture issues, and they need to be raised.

Two weeks ago, at a conference in Australia, Michel Sidibe, the Executive Director of UNAIDS, expressed his view that the world has grown numb to HIV/AIDS. The response, including financial support, no longer matches the reality of 7,400 people becoming infected every day.

As you will be discussing during this session, the 2010 target set for eliminating measles and rubella and preventing congenital rubella syndrome will almost certainly not be met. Though perfectly feasible from a technical perspective, prospects for elimination have been dampened by political and public complacency, including unfounded concerns among parents about the safety of vaccines.

Progress towards polio eradication is likewise fragile, as underscored by the recent importation of the poliovirus into Tajikistan, jeopardizing this region's polio-free status. Your Regional Director has updated you on the current situation.

We have to fight for money, but we also have to fight against complacency and fatigue. In times of economic austerity, a dangerous calculus can emerge. How many lives can be saved, how much poverty can be reduced, by a finite amount of money? We have to be very careful about shifting priorities. Antiretroviral therapy for HIV/AIDS is a life-line for a lifetime. The only ethically acceptable exit strategy is to prevent new infections from occurring in the first place.

And there are other challenges.

Aided by new communication technologies and social media, public demand for good quality health care is rising everywhere. While this is a welcome trend, can health systems afford to meet these expectations?

Moreover, decisions that affect health and health care are now subject to a new form of electronic scrutiny, whereby individuals draw instant information from a range of different sources. They make their own decisions about which information to trust and which advice to follow. They develop their own expertise. The days when public health can issue advice, based on the best scientific evidence, and expect the public to comply may be coming to an end.

We experienced this with the MMR vaccine, and we experienced this during the influenza pandemic.

Ladies and gentlemen,

WHO is under scrutiny for its response to the 2009 influenza pandemic. To some, response measures now look excessive compared with the moderate impact of the pandemic. Such scrutiny is understandable, and these concerns are being addressed.

We are grateful for the moderate impact. Had the H1N1 virus mutated to a more deadly form, we would be under scrutiny of a different kind, for having failed to protect large numbers of people.

Response plans, put together during years of nervously watching the highly lethal H5N1 avian influenza virus, prepared the world to anticipate a much more severe

event. Scaling down these plans proved difficult, in part because no one could answer, with certainty, a fundamental question. Is it safe to do so? Are we sure? Do we dare?

The phased approach to pandemic alert, introduced in 1999 as a strategy for reducing public anxiety, actually had the opposite effect. It dramatized the steps leading to the declaration of a pandemic in the eyes of the public and the media. Adjusting perceptions to match a much less severe event proved problematic.

The finite capacity and long production times of vaccine manufacturers reduced the flexibility of the response. Orders had to be placed before data were available to support evidence-based projections of need. For example, some orders were based on the assumption that two doses would be needed. The procedures for getting donated vaccines to developing countries proved far more cumbersome and timely than anticipated. You may need to hear that the vaccine deployment process will benefit 83 countries that would not otherwise have vaccines. I thank many of your countries for this, as well as partners.

There are many things that could have been done better. I am relying on the findings of the Review Committee, set up under the International Health Regulations, to advise WHO on necessary changes.

I do not want to prejudice the outcome of this review, which is being conducted very rigorously and taken very seriously. But I can respond to at least one burning question. Was WHO influenced by ties to the pharmaceutical industry?

I was, of course, deeply involved in the discussions that led WHO to announce phase changes. I can assure you: never for one moment did I see a single shred of evidence that pharmaceutical interests, as opposed to public health concerns, influenced any decisions or advice provided to WHO by the experts. Never did I see a shred of evidence that financial profits for industry, as opposed to epidemiological and virological data, influenced WHO decisions.

I will have an opportunity, later this month, to present my views to the Review Committee, together with the full records, both public and confidential, of all WHO deliberations and decisions. We kept meticulous records. As I have said, we welcome this scrutiny as an opportunity to improve our performance. The 2009 influenza pandemic will not be the last public health emergency requiring an international response.

Ladies and gentlemen,

As I mentioned, this is a time when public health must be smart, strategic, and resourceful as never before.

Smart means using economic arguments to make the case for investing in health, as you are doing here in Europe. While the basic right to health is enshrined in the WHO Constitution, economic arguments are likely to carry greater weight in times of austerity.

Strategic means getting the priorities and the policies right. One level of strategic engagement is what the international community has been doing over the past decade: delivering life-saving interventions on a massive scale. I thank the countries of this region for their financial support in this effort, and for the innovative initiatives they helped spearhead.

A higher level of strategic engagement involves the strengthening of fundamental capacities and infrastructures, like procurement and delivery systems, the health workforce, information systems, financing systems, and regulatory capacity. This is where the engagement of the European Region and the European Union is especially appreciated.

Arguably, the highest level of strategic engagement aims to influence the policy environment, as shaped by all relevant sectors. It aims to create the opportunities, and the conditions that favour better health, and thus address the root causes of ill health as far upstream as possible. This is an area where European health ministries have done some of their greatest pioneering work, long before the Commission on Social Determinants of Health issued its report. As Dr Jo Asvall liked to say, in his typically sharp way: creating such a policy environment makes healthy choices the easy choices.

Resourceful means finding innovative ways to finance health development, but also cutting waste and inefficiency.

The financial sustainability of health systems is cited as one of seven main challenges faced throughout the region. Again, what European countries are experiencing is a trend seen around the world. Though resources available to invest in health care are vastly different, the main health problems facing wealthy and developing countries are becoming remarkably similar. All around the world, people are living longer, and the technologies that prolong life and improve its quality are increasingly costly.

The year’s World Health Report, on health systems financing, offers a menu of options for raising sufficient resources and removing barriers to access, especially for the poor. The emphasis is firmly placed on moving towards universal coverage.

In a key achievement, the report estimates that from 20% to 40% of all health spending is currently wasted through inefficiency. It points to ten specific areas where better policies and practices could increase the impact of health expenditures, sometimes dramatically. At a time of economic austerity, cutting waste and inefficiency is a far better option that cutting health budgets.

The report will be launched in Berlin in November. I hope it can work, hand-in-hand with the Tallinn Charter, to improve the financial sustainability of health systems, in this region and elsewhere.

Thank you.