Dr Margaret Chan Director-General -Report by the Director-General to the Executive Board at its 130th Session Geneva , Switzerland, 16 January 2012

Mister Chairman, distinguished members of the Executive Board, excellencies, ladies and gentlemen,

You have before you a strong and challenging agenda at a time when the world at large is in very bad shape.

Given the state of world affairs, public health can be proud of its achievements since the start of this century, proud of its ability to take a long-term perspective, and proud of its willingness to take on increasingly complex problems.

We have stayed the course, steadfast and surefooted.

WHO and its Member States can be especially proud of their consistent ability to reach agreement on global governance instruments that provide collective protection against shared threats.

Like tobacco. Like outbreaks and other causes of abrupt illness that can spread internationally. Like influenza pandemics and the need to be prepared, with equitable distribution of benefits.

Recent governance instruments also provide ways of meeting shared needs.

Like the need to manage intellectual property rights in fair ways, for industry, but most especially for public health.

Like the need to track aid for health development and ensure that it is used in accountable ways. That means: ways that bring measurable results, but also build capacity to measure results in the first place.

Since the start of this century, you have reached agreement in all of these difficult areas, with negotiations determined to carve out a path to better health, with a quest for fairness as the driving force, and with a square deal for everyone.

This is an outstanding achievement at a time when international negotiations keep breaking down in so many other areas.

All too often, policies considered vital in terms of long-term benefits, such as maintaining agricultural self-sufficiency or curbing global warming, lose out if thought to threaten a fragile economy.

Not for public health, as the record shows so clearly since the start of this century. This says much about the high priority genuinely given to health.

The steadfast determination of public health to keep moving forward is all the more impressive when we look at the odds.

Ladies and gentlemen,

Few will disagree with my statement: our world is in very bad shape.

The turmoil experienced during the previous decade, when the world was beset by one global crisis after another, recurred in concentrated form throughout 2011.

That was a year of unprecedented numbers of extreme weather events, of floods, droughts, windstorms, ice storms, a tsunami and a related nuclear accident, of hunger and starvation in the Horn of Africa, and of humanitarian crises made even more complex by conflict and severe security challenges.

That was a year of deepening financial austerity, growing unemployment, and economic misery, especially for the middle classes, the ordinary people.

That was a year of unprecedented protests and uprisings that spread nearly everywhere like a dense fog of social malaise.

In fact, 2011 may well go down in history as the time when politicians, economists, and the mass media paid attention to inequality as a threat to social stability and world security.

The protests that toppled some governments were a quest for democratic and economic reforms. Protestors sought basic human rights, dignity, and a chance to get jobs with wages they can live on.

Numerous analysts interpreted these uprisings as a protest against inequality, especially inequality in income levels and in opportunities, most notably for youth.

This is understandable. In some of these countries, GDP grew steadily, year after year, while more and more people fell below the poverty line, year after year.

Last year also saw a new statistic. In some wealthy countries, the difference in the quality of life between the older generation and today's youth is the greatest ever recorded.

Last year was a time when many countries realized they were losing their middle classes, the very foundation of democracy and economic productivity.

According to a recent report from the Organization for Economic Cooperation and Development, income inequality in wealthy nations has reached the worst levels seen in nearly 25 years.

That report further concluded that societies with the least inequality had the best health outcomes, regardless of the levels of spending on health.

In other words, money alone does not buy better health. Good policies that promote equity have a better chance.

Public health has known this for ages. It is tempting to feel vindicated by this sudden high-level attention to social inequality as a disruptive force strong enough to undermine security and topple governments.

WHO and its Member States have long been concerned about equity, fairness, and social justice, and the interplay between social conditions and health outcomes.

This has been true since at least the Declaration of Alma-Ata in 1978. More recently, we have argued that health systems are social institutions. Properly managed and adequately funded, health systems contribute to social cohesion and stability.

Let me remind you. Universal health coverage is a powerful equalizer. Changes in health status are a powerful indicator of overall social and economic well-being.

At the start of this century, the Millennium Declaration and its Goals breathed new life into the values of equity and social justice. That Declaration set out a straightforward social contract for reducing human misery and introducing greater balance into our lopsided world.

As stated: “Those who suffer or who benefit least deserve help from those who benefit most.”

This is not at all what has happened, especially in well-off nations. As documented in numerous reports, social inequality in wealthy nations is actually increasing.

In contrast, in large parts of the developing world, the picture looks very different. In these countries, vast inequalities also exist, expressed as vast differences in health status and in access to care.

But misery, for many groups, for many diseases, is actually going down. Those who benefit least are getting help from those who benefit most.

Public health can be proud. We were ahead of the game. We got the policies and the priorities right. Our long-standing quest for equity and social justice is bringing measureable results.

Ladies and gentlemen,

In my view, the agenda for this session supports a mood of pride in accomplishments and qualified optimism for the future. We have a better understanding of what works in public health, and how to triumph despite the odds.

For public health, 2011 was a year of convergence, a gathering of lessons learned, and a regrouping of forces to take on new challenges. That was also a year of high-level meetings on health challenges, and ways to address their root causes, that will guide our work for some years to come.

Looking at the technical items on your agenda, I believe we can make four general observations about the state-of-the-art in public health.

The MDGs are on your agenda, as are maternal, infant, and young child nutrition, the consequences of early marriage and teenage pregnancies, a global action plan for vaccines, the elimination of schistosomiasis, and the eradication of polio.

These items support my first observation. We see how commitment to a limited number of time-bound goals has improved health outcomes in measurable and often significant ways.

And we also see how this commitment has left a powerful legacy of innovations. Like financing instruments, like ways of securing money from new sources. Like a new breed of strategic R&D partnerships that are bringing to market innovative products tailor-made to tackle diseases of the poor.

In the first decade of this century, the epidemics of HIV/AIDS and tuberculosis peaked and began a slow decline. The deteriorating malaria situation has been turned around.

Young child mortality dropped below 10 million for the first time in nearly six decades. Compared with 12 million under-five deaths in 1990, the figure for 2010 was 7.6 million, a drop of more than 40%. In sub-Saharan Africa, under-five mortality is now being reduced at double the rate seen between 1990 and 2000, and continues to accelerate.

Worldwide, the number of maternal deaths, the starkest statistic in public health, has finally begun to decline.

In 2009 alone, an estimated 800 million people received preventive chemotherapy for at least one of the neglected tropical diseases. As you will be discussing during this session, some of these ancient companions of poverty could actually be eliminated in the near future.

Polio eradication is also on your agenda. Authoritative bodies, like the Independent Monitoring Board and the Strategic Advisory Group of Experts on immunization, tell us: we must stay the course.

Should commitment falter, polio will come roaring back. Should our resolve waver, this will be the most expensive failure in the history of public health.

You will be considering a draft resolution that proposes declaration of the completion of polio eradication as a “programmatic emergency for global public health.” I urge you to consider this resolution with utmost urgency.

Implementation of the International Health Regulations is on your agenda, as are the framework for Pandemic Influenza Preparedness, and the Commission on Information and Accountability for Women’s and Children’s Health.

These items support my second observation. We see the success of WHO and its Member States in developing and implementing novel instruments for global health governance.

Let me comment on two.

The negotiations that culminated in the framework for Pandemic Influenza Preparedness were the most difficult and potentially explosive that I have ever witnessed in my 35 years in public health. But the spirit of consensus and fair play eventually won, and we got a square deal for everyone, including the pharmaceutical industry.

This tells us that countries really want risks to be proactively managed. They want rules of proper conduct, with clearly assigned responsibilities, and they want fairness, a square deal for everyone.

The framework for information and accountability is part of a chain of innovative mechanisms and instruments linked to the Global Strategy for Women’s and Children’s Health.

The Commission’s sharp, smart, and lean recommendations are now supported by a detailed workplan for translating these recommendations into action. The workplan greatly facilities

rapid action, especially to develop systems for vital registration, by identifying existing instruments, methodologies, guidelines, and best practices that can be used immediately or easily modified to fill gaps.

Oversight, which includes identifying the best value-for-money approaches, has been assigned to an independent Expert Review Group. The Group was established in September of last year and held its first meeting two months later.

With these developments, public health breaks new ground by tackling a long-standing need. That is: to build national capacity to generate and analyse basic health data.

Without information, at country level, we can never have accountability. Without information, we can never know what a “best” or a “wise” investment really means. Without information, we are working in the dark, pouring money into a black hole.

This is totally unacceptable at a time when every dollar counts, and both donors and recipients must be held accountable.

Ladies and gentlemen,

You will be looking at the outcomes of two high-level meetings held last year, namely the meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases, held in New York in September, and the World Conference on Social Determinants of Health, held in Rio de Janeiro in October.

Reports on these meetings, both of which were highly successful, support my third observation. Public health must address pressing new challenges, beyond the MDGs, like chronic noncommunicable diseases.

And we must do so by tackling their root causes, namely through a social determinants

approach that engages the whole of government and the whole of society.

For ages, the mindset of public health has been geared towards the prevention and control of infectious diseases. It has been geared towards episodes of acute illness, and not towards long-term care or towards prevention that requires efforts well beyond the health sector.

This mindset must change, and that will not be easy.

The impact of NCDs comes in waves. What we are seeing now in much of the developing world is a first wave. This is marked by growing numbers of people with raised blood pressure, raised cholesterol, and the early stages of diabetes.

The growing prevalence of obesity and overweight, seen nearly everywhere, is the warning signal that big trouble is on its way.

The second wave, which is yet to come, will be much more horrific. One statistic tells the story.

Of the estimated 346 million people worldwide who suffer from diabetes, more than half are unaware of their disease status. For many of these people, the first contact with the health services will come when they start to go blind, need a limb amputation, experience renal failure, or have a heart attack.

The September political declaration on NCDs assigns a number of roles and responsibilities to WHO. I can assure you: we are giving these obligations the highest priority.

My final observation is this. WHO reform is on your agenda, and no one questions the need to change the way WHO works.

The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach.

I thank all of you for your engagement, often passionate engagement, in the November special session of the Executive Board on WHO reform. The outcome exceeded our highest expectations.

As I often say, what gets measured gets done. During the special session, the Board worked hard to measure the right things to make sure the right things get done.

I count on your guidance now, and that of all Member States during the May Health Assembly, as we work together to equip WHO to respond to the challenges I have mentioned and many others, known and unknown.

As you have agreed, changes in governance and management are needed, but also in programmes and the way priorities are set.

I ask that you think about reform as you consider other items on the agenda, and particularly the one on WHO's response to the growing demands of health in humanitarian emergencies. This is a good way to see some practical problems WHO faces and how specific reforms might help solve these problems.

My final comment is brief.

As you have stated, the reform process starts from a position of multiple strengths.

I fully agree: multiple strengths for WHO, but also for public health.

Thank you.