Address to the Sixty-seventh World Health Assembly
Geneva, Switzerland, 19 May 2014

Mister President, Excellencies, honourable ministers, distinguished delegates, ambassadors, ladies and gentlemen,

On 5th May, I declared the international spread of wild poliovirus since the start of this year a public health emergency of international concern. I did so on the advice of an emergency committee convened under the International Health Regulations.

That declaration included recommendations for vaccination certification of travellers from three countries known to be seeding outbreaks elsewhere. No travel restrictions were imposed.
Two years ago, the international spread of polio virus had nearly ceased. Not anymore. At end-2013, 60% of polio cases resulted from international spread, with strong evidence that adult travellers were playing a role. The trend has continued this year, during the low-transmission season for polio, a situation described by the emergency committee as “extraordinary”.

What accounts for this change? Armed conflict that flies in the face of international humanitarian law. Civil unrest. Migrant populations. Weak border controls. Poor routine immunization coverage. Bans on vaccination by militant groups. And the targeted killing of polio workers.

Two years ago, polio was on its knees, thanks to committed political leadership, better strategies and tools, and the dedication of millions of polio workers.

The factors responsible for this setback are largely beyond the control of the health sector. They are only some of several dangers for health in a world shaped by some universal and ominous trends.

In just the past few months, social inequalities, within and between countries, have attracted the attention and deep concern of leading economists and development banks. They have issued a spate of warnings about the disruptive effects of rising inequality and economic exclusion on social cohesion and stability, about the damage done to economies and the risks to future prosperity.

Wealth does not trickle down. Some economists argue that the past practice of equating growth in GDP with overall progress is outmoded. These views carry weight and should be taken seriously.

Signals about what human activities have done to the environment are becoming increasingly shrill. Our planet is losing its capacity to sustain human life in good health.

In March, the Intergovernmental Panel on Climate Change issued its most disturbing report to date, with a strong focus on the consequences for health.

Also in March, WHO revised its estimates of the health effects of air pollution upwards. In 2012, exposure to air pollution killed around 7 million people worldwide, making it the world's largest single environmental health risk. These estimates coincided with crippling episodes of air pollution in several parts of the world.

Changes in the way humanity inhabits the planet have given the volatile microbial world multiple new opportunities to exploit. Confirmation of an Ebola outbreak in Guinea brought to four the number of severe emerging viruses that are currently circulating, including the H5N1 and H7N9 avian influenza viruses and the Middle East Respiratory Syndrome coronavirus.

Parts of the world are quite literally eating themselves to death. Other parts starve. Hunger and undernutrition remain an extremely stubborn problem. Over the past twenty years, the global prevalence of anaemia has barely budged, dropping only slightly.

At the other extreme, we see no good evidence that the prevalence of obesity and diet-related noncommunicable diseases is receding anywhere. Highly processed foods and beverages loaded with sugar are ubiquitous, convenient, and cheap. Childhood obesity is a growing problem with especially high costs.

The 2014 World Cancer Report, issued by WHO's International Agency for Research on Cancer, provoked considerable alarm. The number of new cancer cases has reached an all-time high and is projected to continue to rise. Developing countries now account for around 70% of all cancer deaths. Many of these people die without treatment, not even pain relief.

Estimates for 2010 indicate that cancer cost the world economy nearly $1.2 trillion. No country anywhere, no matter how rich, can treat its way out of the cancer crisis. A much greater commitment to prevention is needed.

The same is true for heart disease, diabetes, and chronic lung diseases. In some middle-income countries, diabetes treatment alone is now absorbing nearly half of the entire health budget.

Not only has the disease burden shifted since the start of this century. The poverty map has changed.

Today, around 70% of the world's poor live in middle-income countries. As more and more countries graduate to middle-income status, they also graduate from eligibility for support from the Global Fund and GAVI, and for concessional prices for medicines.

We need to ask some questions.

Will economic growth be accompanied by a proportionate increase in domestic budgets for health? Will countries put polices in place to ensure that benefits are fairly shared? If not, the

world will see a growing number of rich countries full of poor people.

International trade has many consequences for health, both positive and negative. One particularly disturbing trend is the use of foreign investment agreements to handcuff governments and restrict their policy space.

For example, tobacco companies are suing governments for compensation for lost profits following the introduction, for valid health reasons, of innovative cigarette packaging.

In my view, something is fundamentally wrong in this world when a corporation can challenge government policies introduced to protect the public from a product that kills.

Some Member States have expressed concern that trade agreements currently under negotiation could significantly reduce access to affordable generic medicines.

If these agreements open trade yet close access to affordable medicines, we have to ask: Is this really progress at all, especially with the costs of care soaring everywhere?

Ladies and gentlemen,

All of these trends are certain to increase the world's inequalities even more. They define the tremendous job that lies ahead for public health. They also shape expectations for the performance of WHO, and the support countries, and the international community, will need from this Organization.

Health has an obligatory place on any post-2015 development agenda. I think this is clear.

The global strategies and action plans recently approved by Health Assemblies are already giving the health-related Millennium Development Goals a second life. The Global Vaccine Action Plan aims to exceed the target set for reducing child mortality. During this session, you will be considering some highly ambitious new goals for tuberculosis and neonatal mortality.

We can move forward on very solid ground. Pursuit of the MDGs has saved many millions of lives and spared untold human misery. Health is blessed with a legacy of lessons, best practices, and innovative instruments for securing funds, purchasing life-saving interventions, and developing new products for diseases of the poor.

The Global Fund, GAVI, UNITAID, multiple partnerships for product development, and the International Health Partnership Plus are part of this legacy.

We learned that high ambitions pay off. The response to AIDS proved that seemingly impossible goals are entirely feasible. Who could have imagined, at the start of this century, that well over 12 million people would be receiving antiretroviral therapy today?

The WHO consolidated guidelines for the treatment and prevention of HIV put the response on a solid footing that readily accommodates even higher goals for the future. India's eradication

of polio tells us there is no such thing as impossible.

We learned that health is a smart investment. It brings measurable results, sometimes remarkable results. In fact, last year's Lancet Commission on Investing in Health shows that the returns on health investments are even higher than previously calculated.

We learned that markets cannot sell something to people who cannot pay. Childhood immunization programmes deliver vaccines at no cost to recipients. The massive free distribution of bednets coincided with dramatic drops in malaria cases and deaths.

The bottom billion receive medicines for neglected tropical diseases at no cost. Universal health coverage goes hand-in-hand with financial risk protection, especially for the poor.

But we also learned that policies matter as much as money. Countries with the same level of resources achieve strikingly different health outcomes. The right policies, especially when they make equity an explicit objective, make the difference. This underscores the decisive role of domestic leadership, and is one reason why appreciation for country ownership has deepened.

We learned, too, how much the world needs an organization like WHO. Within the framework of our leadership priorities, WHO is shaping the health agenda as needs evolve, and using multiple mechanisms and partnerships to meet these needs. If anything, the relevance of this Organization has increased.

WHO leads in line with need. The leadership role given to WHO by the 2011 UN political declaration on NCDs came with a number of time-bound responsibilities, which we continue to fulfil.

Much of our work has direct relevance in countries. We identified "best buys" for NCD prevention and control. We used our authority to alert the world to the need to reduce daily sugar consumption, based on evidence of the association with dental caries and obesity.

We continue to support the health needs of the elderly: their need to stay in their homes as long as possible, their need for people-centred care that looks after co-morbidities, including mental problems like dementia.

WHO shapes policies. The growing commitment to universal health coverage can act as a counterweight to many of the trends I have described. UHC is one of the most powerful social equalizers among all policy options.

The World Bank is now a welcome partner in helping countries make their health systems more inclusive. This engagement sends a strong signal that UHC is financially feasible and makes good economic sense.

WHO gets the prices of commodities down, helping countries and donors get more from their investments. The prequalification programme makes supplies of medical products more plentiful, predictable, and affordable. Pooled procurement gains economies of scale.

WHO facilitates negotiations with industry for concessional prices. For drugs for diseases of the poor, WHO negotiations have cut prices by as much as 90%. For the neglected tropical diseases, WHO negotiates and manages very large drug donations from multiple industry partners, amounting to 900 million doses last year. This is a huge undertaking with huge benefits.

WHO constantly monitors evolving trends and sounds the alarm when needed. For communicable diseases, one of the most alarming crises is the rise of antimicrobial resistance, which WHO documented in a report last month. This is a crisis that now affects every region of the world, and it is only getting worse. The new report on adolescent health is another alert to neglected needs.

WHO takes up the cause for orphan problems, and gives them a home. When I took office, I was told that strengthening health systems has zero appeal, zero glamour for donors, and low priority on the development agenda. This has thankfully changed.

We are now arguing for similar attention to regulatory capacity. Countries must have well-functioning regulatory authorities to protect their populations, whether from tainted food, unsafe medical products, tobacco, drink-driving, air pollution, notifiable infectious diseases, or the marketing of unhealthy foods and beverages to children.

Countries also need well-functioning information systems. The new accountability frameworks for results-driven initiatives depend on reliable information.

Overall, only around one third of all deaths worldwide are recorded in civil registries along with cause-of-death information. Think about what this means: we are investing in black holes. WHO has repeatedly stressed the urgent need to tackle that data gap and make systems for civil registration and vital statistics a top priority.

Fortunately, some Member States with excellent civil registries have taken a leadership role in making this happen elsewhere. It is this spirit of solidarity that makes me proud to work for WHO and contributes to my optimism about the future.

Ladies and gentlemen,

For health, the previous century largely relied on the technology-driven medical model to combat communicable diseases. With NCDs now the biggest killers worldwide, this century must be an era where prevention receives at least as much priority as cure.

Last year, I attended an international conference that looked at strategies for a tobacco end-game, that is, strategies that could end tobacco use altogether.

Thirty years ago, who could have imagined that health could take such a firm stand against such an economically and politically powerful industry?

Given the importance of prevention to protect healthy human capital, we will need to argue for

the supremacy of health concerns over economic interests with other industries. This will not be easy.

As recent experience shows, even the very best scientific evidence can have less persuasive power than corporate lobbies.

For the post-2015 agenda, I see many signs of a desire to aim ever higher, with ambitious yet feasible goals. Many more end-games are already on the table. End preventable maternal, neonatal, and childhood deaths. Eliminate a large number of the neglected tropical diseases. End the TB epidemic.

We have at our disposal a host of strategies for pursuing ever higher goals. Some of these strategies have been refined by two large programmes that are marking their 40th anniversaries this year: the Expanded Programme on Immunization, or EPI, and the Special Programme for Research and Training in Tropical Diseases, or TDR.

From the outset, EPI has been a paradigm of prevention and a pathfinder for universal access to services. EPI showed how a constant simplification of operational demands on programmes promotes country ownership. In other words, make things easy to own. This was done through several innovations, including profiles of ideal products that encourage the pharmaceutical industry to develop and package new vaccines that are easy to use under harsh conditions.

The establishment of GAVI in 2000 helped launch the most innovative EPI decade to date. Tomorrow, GAVI is meeting development ministries of the European Union to launch a drive to extend access to vaccines even further. I join fellow GAVI partners in offering my full support to this launch and a successful GAVI replenishment.

In recent years, TDR has moved away from its initial focus on product discovery and development to concentrate more on implementation research for communicable diseases of the poor. TDR now uses the tools of scientific investigation to understand why good drugs, good diagnostic tests, and good preventive strategies fail to reach people in need. In other words, to find the barriers to access and break them down.

TDR also innovates to help countries get the most out of their resources. One example stands out. The original strategy of community-directed treatment to deliver ivermectin for river blindness was expanded to support integrated delivery of a range of critical health interventions.

Coverage more than doubled, also for malaria interventions, at lower costs than conventional parallel delivery systems. Success draws on the great desire of communities to manage their own priority health problems, taking us back to the basics of the primary health care approach.

Health also benefits from WHO's ability to tap the world's best expertise. I am deeply concerned by the increasing prevalence of childhood obesity in every region of the world, with the increase fastest in low- and middle-income countries. In the African region alone, the number of overweight children increased from 4 million in 1990 to 10 million in 2012. This is

worrisome. As the 2014 World Health Statistics report bluntly states, “Our children are getting fatter.”

To gather the best possible advice on dealing with this crisis, I have established a high-level Commission on Ending Childhood Obesity. Fortunately, science defines several opportunities for intervention.

What I expect from the Commission is a state-of-the-art consensus report on which specific interventions, and which combinations, are likely to be most effective in different contexts around the world. I have asked the Commission to deliver its report to me in early 2015 so that I can convey its recommendations to next year’s Health Assembly.

Ladies and gentlemen,

As I conclude, let me thank Member States, the owners and shareholders of this Organization, and their Geneva missions, for taking us so far on the road to WHO reform. The two financing dialogues held to date proposed solutions to problems that have hindered our performance for years.

Given the challenges that lie ahead, and the high expectations for health, WHO’s dedicated and committed staff will need to perform better than ever. We are well-motivated to do so.

Better health is a good way to track the world’s true progress in poverty elimination, inclusive growth, and equity.

Thank you.