A55/3

ADDRESS
BY
DR GRO HARLEM BRUNDTLAND
DIRECTOR-GENERAL
TO THE
FIFTY-FIFTH WORLD HEALTH ASSEMBLY

GENEVA,
MONDAY, 13 MAY 2002

Agenda item 3 **A55/3**

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Mr President, ministers, distinguished delegates, ladies and gentlemen,

For years we have all been striving to get health in its proper place.

All of us in this hall know that health for all is vital for human security.

Now, advocacy for health has moved beyond circles of health professionals.

Prime Ministers and Presidents, rock singers and sports' stars, business leaders, share our position.

Put simply – unless people are healthy, we will not see economic growth; we will not see stability; we will not see human dignity, or fulfilment of human rights; we will not be at peace.

I do not mean that health is everything. But most of the world's leaders now recognize that good health is essential for the secure future of our planet.

They have agreed on a set of development goals for the millennium. Many of these goals are concerned with health. The Commission on Macroeconomics and Health has presented them with a road map for how these health goals can be achieved.

At the Monterrey Conference on Financing for Development in March, several of them agreed to scale up their investments in achieving the Millennium Development Goals. A growing portion of such investment is being earmarked for health.

This increased emphasis is much needed and most welcome. And we should not be too modest. We have all been instrumental in making this happen.

The dreams that inspire us at the annual World Health Assembly, our calls for action and our carefully crafted resolutions – all of this has a broader meaning. We have triggered a change. Now we are taking it forward. A hearty welcome to you all. I would like to specially greet the Minister of Health of Afghanistan, who is with us here today. That our colleague is a woman is all the more welcome and itself an encouraging sign that Afghanistan is on its way to recovery.

Colleagues,

In a world where we tend to focus on shocking inequities and crises, and indeed there are many, let us not forget what has been achieved in the last few years.

- We are well down the road to poliomyelitis eradication with a dramatic reduction in the number of cases detected over the last year;

- We have agreed targets – and clear strategies – for confronting AIDS, tuberculosis and malaria;

- We are seeing a real increase in available resources through a new global fund to fight these conditions;

- Millions more children are being vaccinated against common childhood illnesses, and immunization coverage is increasing;

- Mental illness is now being addressed as a major cause of suffering and disability;

- Nations are united in initiatives to control tobacco marketing and reduce its use, the forthcoming soccer world cup is smoke free, many countries have banned cigarette advertising, and many more have increased tobacco taxes; and

- All over our world, these results are being achieved by under-funded health systems, often through joint efforts by the public sector and civil society.

I salute the thousands of dedicated health workers who have made these achievements possible. All of you here today have built on these achievements and worked hard to make health a real development issue. Your work enables me and my WHO colleagues to speak out – confidently – and call for greater investments. I thank you.

Now is the time to chart the way ahead for the next few years. As I reflect on the increased public interest in health, three big challenges stand out.

First: we need to speak out about the threats of ill-health in different societies and the potential for tackling them. Systematic work on "risks to health" is vital: it will be the focus of our discussions at this Assembly.

Second: we need to invest in better health systems everywhere – bringing benefits to those who need them, responding to needs and expectations, and fairly financed.

And, third: we must sustain the momentum in the fight against diseases of poverty, empowering affected communities – and countries – to take action for health equity.

We cannot speak out about risks to health unless we know clearly what they are. This year's world health report on risks to health, to be published in October, will be a wake up call to the global community. It represents an intensive effort by WHO – one of the largest projects it has ever undertaken. It tries to quantify some of the most important risks to health, and to assess the cost-effectiveness of measures to reduce them. The ultimate goal is to help governments of all countries lower these risks, and raise the healthy life expectancy of their populations.

The picture that is taking shape from the research on the report gives an intriguing – and alarming – insight into current causes of disease and death and the factors underlying them. It shows how human behaviour is changing around the world, and the impact of these changes on people's health.

At one end of the risk factor scale lies poverty, undernutrition, unsafe sex, unsafe water, poor sanitation and hygiene, iron deficiency and indoor smoke from solid fuels. These are among the 10 leading causes of disease. All are much more commonly found in the very poorest countries and communities.

At the other end of the scale we see unhealthy consumption.

High blood pressure and high blood cholesterol, strongly linked to cardiovascular and cerebrovascular diseases, are also closely related to excessive consumption of fatty, sugary and salty foods. They become even more dangerous when combined with the deadly forces of tobacco and excessive alcohol consumption. Obesity, a result of unhealthy consumption, is itself a serious health risk.

All of these factors – blood pressure, cholesterol, tobacco, alcohol and obesity, and the diseases linked to them are well known to wealthy societies. They dominate in all middle- and upper-income countries. The real drama is that they are becoming more prevalent in developing communities, where they create a double burden on top of the infectious diseases that always have afflicted poorer countries.

The world is living dangerously:

– either because it has little choice,

– or because it is making wrong choices about consumption and activity.

Let me put it another way. Six billion people co-existing on our fragile planet. On the one side are the millions who are dangerously short of the food, water and security they need to live. On the other side are the millions who suffer because they use too much. All of them face high risks of ill-health.

Unhealthy choices are not the exclusive preserve of industrialized nations. They have consequences for global security and individual destiny everywhere. We all need to confront them.

In order to improve world health, we all have to tune up our policies for managing risks of ill-health. Countries need to be able to adapt these policies to their needs. We know that risks like unsafe sex and tobacco consumption will increase global deaths substantially in the next few decades. They will continue to do so until they are brought under better control.

Individual behaviour is frequently governed by the circumstances in which people live and work. It influences their level of exposure to individual risk factors.

We have effective means to reduce these risks. The critical question is: How do we implement these measures on a wide scale and ensure better health outcomes?

We must never forget what lies behind the figures and statistics. Every day, every hour and every minute, a fellow human being is suffering, and approaching an early death. Families are coming to terms with tragedy. We have to respond in ways that reflect the realities of people's lives. This calls for concerted and evidence-based action.

WHO's mandate is to get the evidence right and to see to it that the world uses this evidence to become a healthier place.

Our first priority must be the children and the young. They are particularly vulnerable to physical and emotional risks. Two-thirds of all diseases in later life can be traced back to behaviour patterns established during the teenage years or to exposures to health threatening environments in childhood.

I learned about ways to turn evidence into action when working as an environment minister and then Prime Minister 15 years ago. The evidence must be clearly presented in ways that make sense to policy-makers. Our Commission on Environment and Development did this, spelling out the risks to our environment, and the consequences of neglecting them. Then we had to make sure that they themselves communicated the evidence and acted on it. That called for several years of consensus building – by the leaders themselves. That is what happened at the Rio summit in 1992.

Over the last few weeks I have reviewed the evidence on risks to health caused by indoor smoke pollution, environmental tobacco smoke, lead in gasoline, and unclean water. All these hazards endanger the health of children. *The world health report* will show us the human cost. Millions are disabled, and hundreds of thousands die needlessly. We can prevent all these deaths. I have seen how ministers of health and environment want to tackle the risks, save lives and promote child development.

So, when I attend the World Summit for Sustainable Development in Johannesburg in September, I shall launch a new initiative to promote **healthy environments for children**. It will bring a range of national and international actors together, and provide back-up for evidence-based action at the community level.

I shall also reinvigorate WHO's work on **diet, food safety and human nutrition** – linking basic research with efforts to tackle specific nutrient deficiencies in populations and the promotion of good health

through optimal diets – particularly in countries undergoing rapid nutritional transition. We have come a long way in developing new guidelines for healthy eating. When these are complete I shall invite the key players in the food industry to work with WHO in addressing the rising incidence of obesity, diabetes and vascular diseases in developing countries.

We have an immediate, safe and reliable remedy for some of the major health risks linked to unhealthy consumption. It is free. It works for rich and poor, for men and women, for the young and the old.

It is physical activity. At least 30 minutes each day.

This is why I chose "**Move for Health**" as the theme for this year's World Health Day. I spent it in Brazil, witnessing an impressive mass movement for "movement". It is an example many countries can learn from. The gains, in terms of the number of chronic diseases prevented, will be huge.

We know that most people will choose to adopt healthier behaviours – especially when they receive accurate information from authorities they trust, and when they are supported through sensible laws, good health promotion programmes and vigorous public debate. We have seen in the global movement for tobacco control that transparency and disclosure are the keys to success. Promoting trustworthiness is the key. This requires long-term vision and step-by-step action, over the years. Some countries – such as South Africa, Brazil and Thailand – can proudly point to reductions in tobacco consumption.

WHO has been intimately involved in the tobacco-free movement. We have created the environment within which governments are negotiating a framework convention for tobacco control. We are committed to seeing the process through. Success will bring benefits to millions of people: they will be healthier and live longer. We have seen many countries strengthen their national tobacco control policies: but many are still not doing enough. I urge all Member

States to redouble their efforts before our deadline of a completed convention at this Health Assembly next year. For the sake of future generations we cannot afford complacency.

On alcohol, we are much further behind. New data to be released in *The world health report* later this year, show that the burden of alcohol on mortality and morbidity has significantly increased since last reported in 1990.

Alcohol, like tobacco and other risk factors, is widely marketed – particularly to young people.

This does undermine health. Turn on the TV, open a newspaper or magazine, visit a store or market. In just about any country you will see that children and youth are the targets of the new technologies of persuasion. Getting loyalty to brand names is the key to influencing consumer behaviour – from the time children start to walk. Children currently influence 45% of household purchases in the United States of America and 65% in urban China.

Brand name promotions – whether for tobacco, alcohol or fast foods – are designed to take advantage of people's subconscious. They use messages which influence behaviour through their emotional appeal.

These marketing approaches matter for public health. They influence our own – and in particular our children's – patterns of behaviour. Given that they are designed to succeed, they have serious consequences for those at whom they are targeted. We need to work on healthy messages that promote healthy lifestyles and healthy products. There is certainly a need for guidance: in some cases, like tobacco advertising and alcohol advertising aimed at the young, what we need is control.

WHO will play its part.

We provide an umbrella of authoritative positions under which many others can act for health. This includes speaking out against tobacco use and confronting all forms of and discrimination in relation to mental disorders, leprosy or other stigmatizing conditions.

Our umbrella includes calling for policies to improve access to essential health care for all; urging pharmaceutical companies to reform their pricing structures and to invest more in drugs to treat AIDS, malaria and other infectious diseases; urging a fair and innovative use of new knowledge in the field of genomics so that developing countries benefit on an equal footing with industrialized countries.

That is why our own advocacy must always be rooted in our evidence base; in our bank of scientific knowledge. In the past, few paid attention to our work to develop recommendations. Now advocates for health – whether outside or within government – see their importance. There is widespread interest in our recent recommendations for the treatment of people affected by AIDS in resource-poor settings. This has been reported as a breakthrough in the effort to reach the six million people who need it.

The need for good evidence is reflected in the continuous vigilance that must protect the quality of the food people eat, permit the early detection of infectious diseases and help the world detect and respond to dangerous pathogens – particularly those resistant to modern medicines. The evidence should also be used to make healthy food the choice that is easy – and attractive.

Collecting and presenting such evidence are core tasks for WHO. We will expand this work.

Let me turn to the challenges of health systems. I know from my own experience as a politician that if we do not have the ability to measure how systems perform, we cannot implement policies properly, and meet the requirements expected of us when in government. Without the data we cannot adjust the systems and improve results. Establishing systematic methods for assessing health systems' performance has been

one of my key concerns over the past four years. The work was pioneered in 2000 and has now been subject to rigorous review. I salute the staff who are working on this within WHO, and the thousands of people within countries who are putting together the evidence base for it to be revised and taken forward.

Demands on health systems are ever increasing. Care for acute conditions, such as malaria and injuries, as well as pregnant women, delivering and caring for newborns – is essential.

Much more attention is also being paid to accessible care for longer-term conditions. Tuberculosis treatment. Care for people with HIV. Therapy for those with noncommunicable illnesses – including mental illness, epilepsy, cardiovascular disease, cancer and disabilities.

Wherever I go I see – first hand – the difficulties being faced. Resources for health are always scarce. Dedicated health workers are always achieving miracles, frequently with minimal pay. Often they succeed by going outside the traditional structures; through joint efforts with nongovernmental organizations and private entities.

But health ministers are always subject to criticism. That is why I want us to provide them with better methods for examining health system coverage and quality, based on the new world health survey.

Health systems need to make the best use of available funds. So I have established a new initiative to provide guidance on **health care financing** in different settings.

Health systems also need people with expertise. I have also established an initiative to improve **human resources in national health systems**. This has many facets: one is the damage to the health systems which serve poor communities by the relentless recruitment of skilled nurses – and other health personnel – to places where the pay is better. The initiative will also examine options for developing stewardship and technical skills within the health professions.

Mr President,

When we speak of a health system, we imply a functioning organization overseen by a competent health ministry. Countries in crises usually have health systems too, but often they have broken down.

People caught up in conflicts and crises need humanitarian help. But they also need the basic infrastructure of life – essential water supplies, sanitation, health care, food and personal security.

Women, children and men suffer terribly as a result of their being caught up in other people's conflicts. It is cruel – and unjust – when they are deliberately targeted; when they are deprived of what is essential for their survival.

Intentional attacks against innocent civilians, as they go about their daily lives, can never be justified, no matter what the political or military context. I condemn such attacks, wherever they occur. Imagine the anxiety of a mother as she searches for loved ones in the ruins of what used to be her village. Imagine a father's anxiety as he puts his child on the school bus and wonders whether he will ever see her again.

Within any conflict, there are fundamental elements of a people's existence, including the ability to maintain its health, that must be respected. The respect for the neutrality of health staff needs to be upheld by all sides at all times. I want to stress – clearly, to all: restrictions should never be imposed on the movements of medical staff, patients, medicines, ambulances and other goods. Military operations should never target the infrastructure necessary for water and electricity supplies, or waste disposal.

The current crisis in the Palestinian territories shows us the impact of what happens if the health system – and the rest of the infrastructure needed for life – breaks down as a result of conflict. The Assembly will be debating this and will be anxious to know our analysis of the health situation.

WHO has managed to get some medical supplies into the Palestinian territories, and we are currently working to get more across from Jordan where it is now pre-positioned. But that is not enough. The health system in the territories must start functioning again, as soon as possible.

Let me add the voice of public health in support of all who are urging all parties in the current conflict to move towards peace and away from confrontation. Israel and the Palestinian territories are now zones where people suffer mental and physical ill-health as a result of military conflict. The spiral must be turned.

During the coming years WHO will give added emphasis to taking **exceptional action for health** in emergency and crisis situations, throughout the world. We will assemble information on health situations and responses, work in synergy with all concerned partners, and join them in improving access to essential health commodities, equipment and personnel. At all times we will help coordinate an effective response by all involved. This, Madam Minister, is the role we seek to perform in Afghanistan.

Mr President,

In this hall, in 1998, I said that only a broad alliance can manage the critical task of bringing the 1.2 billion people who live on less than a dollar a day out of poverty. I said WHO must be the health component of that alliance – impatient and ready to fight for the health needs of poor people. We should lead when required, and seek to make a difference.

Now, four years later, I feel WHO has fully taken on that role. We are a growing force in the global effort to improve people's lives. We are reaching towards the millions who have been excluded from this century's health revolution.

We have helped to focus international attention on what this really involves – in terms of political commitments and new resources.

WHO set up the Commission on Macroeconomics and Health to get world class practitioners and scholars to analyse the degree to which people's ill-health impacts on human and economic development. Jeff Sachs, the Commission's Chair, will be with us this week.

Their analyses have aroused much interest and debate among people who – until now – have not been focused on international health. Now they want action to reduce this drain on world development.

The position we are in today is approaching what we envisaged when we first spoke of the need for a "Massive Effort", three years ago.

We have seen considerable movement. Summits setting goals for AIDS action, to Roll Back Malaria, to Stop TB, to improve child health. Partnerships to tackle AIDS, malaria and tuberculosis, improve access to medicines, tackle epilepsy and unsafe motherhood. Also to vaccinate children, develop new medicines, prevent chronic diseases, reduce malnutrition, tackle influenza and eliminate leprosy and filariasis. There are new funding mechanisms – such as the Vaccine Fund, the TB Fund, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

We have introduced an integral approach towards reducing the suffering from HIV/AIDS, malaria and tuberculosis through programmes that combine prevention, diagnostics, treatment and care. We are better able, now, to fight for more resources to tackle these devastating conditions. We have moved a long way towards making essential medicines accessible to a much larger number than we could have envisaged even only three years ago. But it is not enough. We need continued reduction in prices of medicines and other commodities, and expansion of quality services to the millions in need. We must scale up our effort even if the struggle seems beset with political and institutional minefields.

The Global Alliance for Vaccines and Immunization is a great innovation. It has shown what can be done. In several countries, vaccine coverage figures have already started to rise – by as much as 8% in some cases. I salute the people who work tirelessly to make

children's immunization a reality: whether they maintain the cold chain, keep vaccine-carrying vehicles running, encourage children to come for their jabs, mobilize financial resources, keep partnerships going, and handle the paperwork that enables the money to move. If all the 74 countries that have engaged with GAVI meet the targets they have set (and I believe many of them will) they will have saved two million lives annually. Every life saved is a real victory – a triumph for us all. Communities, governments, activists, donors and private entities all share the credit.

We must press on.

We must further increase the funding for tackling the illnesses of poverty. The "absorption capacity" of countries far outstrips donor capacity.

We must increase the number of people who can access treatments, like antiretrovirals, at the same time as we scale up prevention programmes. This means rolling out diagnostics and treatment schemes in a way that broadens access while being equitable, fair and realistic.

We must improve our ability to measure the impact of interventions on poor people's health. We need to know how we are progressing towards our goals. We must know what is working and fine tune our programmes.

We must also do all we can to increase access to essential medicines and health technologies. Participants in last years' WTO meeting in Doha supported the differential pricing of essential medicines, and encouraged flexible interpretation of TRIPS with a view to enhancing access to essential medicines. Further work will be undertaken this year: I know that several ministers of health have asked for WHO to help with this process.

New funds, antiretroviral care, measuring impact and better access to essential medicines are all challenges for Member States and for WHO.

So we will improve our capacity to work with countries, to help them interface both with the new funds and with other global initiatives. We will strengthen our backing for the Roll Back Malaria, Stop TB and AIDS partnerships, particularly within countries. We will support national and global initiatives to improve maternal and children's health, and reduce the impact of mental illness, injury, sleeping sickness and other health conditions on poor societies. At all times we will pay attention to the ways in which people's gender influence their health. Gender concerns must be infused in all our efforts.

In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, the private sector and Foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference. And the evidence shows we are. Whether we like it or not, we are dependent on the partners, the resources and the energy necessary for at least a 30-fold scale up in effort – to bridge the gap and achieve health for all.

It is because we are reaching out, as I said when I started in 1998 – that we are all succeeding, on so many fronts. We will continue to reach out, for one reason only. We will continue to engage more partners, build stronger movements and move beyond the health sector, for one reason only. Why? To pursue health for all, achieving real impacts among the world's poorest people.

I should add that in every joint venture we seek to define what each partner can bring to the relationship. We identify where potential conflicts of interest may limit certain types of interaction. We aim to play to each others' comparative advantages. All of this has required WHO to strengthen its work on ensuring transparency in the affiliations of all special interests, on ethics and on our internal oversight mechanisms.

What matters most, though, is the extent to which the people of the world's poor nations achieve better health. For WHO a crucial question is always "How can we best help the achievement of sustained and equitable health gains in countries?".

We must subject everything we do to the "people and country" test. Will it make a difference? How much? What else could achieve a better result? That means being self-critical. Taking account of the enormous demands on national institutions and capacities. The constraints they face – notably limited human and financial resources.

There is strong support for scaling up WHO's focus on countries – from inside and outside WHO. Through the **country focus initiative** we are intensifying action while doing our best to ensure the development of capacities within countries as well as within WHO country teams.

Mr President,

It has been a long 12 months since we last met in this hall. Over the course of these 12 months, the context for our work has changed.

As world leaders have struggled to chart a course towards a more stable, secure and peaceful world, they have agreed the importance of reducing poverty, suffering and inequity.

They see, now, how instability and inequity in one place, or affecting one community, threatens the whole world. They see how global action against health risks in one country can help protect all people in all countries; and that efforts to tackle stigma and denial have to work at home at the same time as they are promoted abroad. We have far to go to respond to these imperatives.

The health-for-all concept, the Millennium Development Goals, World Health Assembly resolutions, our corporate strategy and now the report of the CMH, the Monterrey Consensus, the outcome of the Madrid ageing summit and the UNGASS declarations on children (last

week) and AIDS (last year) are there to guide us. These road maps remind us that we are fighting against poverty and inequity, that the world's goals are ambitious, that there is a huge shortage of available resources, and that all of us committed to change must work together. Nothing can be sustained unless the people of poor nations want it, and their leaders act on this desire when they make decisions about how resources are to be used.

In Johannesburg, this coming September, I hope to see different national leaders working with civil society in concerted efforts to invest in people for their sustained development. This is the only viable route to the long-term future of our planet. It means continuing with our massive effort to fight the health conditions which most affect poor people, with ever stronger alliances and partnerships, and a relentless focus on long-term results.

Mr President,

We have a full agenda ahead of us.

Forging real change is never easy. You have to confront established ways of thinking and working. But if you are convinced, as I am, that the change is essential for our shared purpose, then there is no opportunity to yield to short-term pressures because this would be the more comfortable way to go. I have never seen real change happen easily. Never in history was equity achieved without a battle.

We must continue to build the momentum to fight the diseases of poverty.

We must build new alliances and new initiatives to address the risks to health that threaten the essential requirements for a healthy life.

Thank you.

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