World Health Organization

SIXTY-SECOND WORLD HEALTH ASSEMBLY **A62/3**
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Address by Dr Margaret Chan, Director-General to the Sixty-second World Health Assembly

Mr President, honourable ministers, excellencies, distinguished delegates, Dr Mahler, ladies and gentlemen,

Over the past three decades, the world has, on average, been growing richer. People have, on average, been enjoying longer and healthier lives.

But these encouraging trends hide a brutal reality. Today, differences in income levels, in opportunities, and in health status, within and between countries, are greater than at any time in recent history.

Our world is dangerously out of balance, and most especially so in matters of health. The current economic downturn will diminish wealth and health, but the impact will be greatest in the developing world.

Human society has always been characterized by inequities. History has long had its robber-barons and its Robin Hoods. The difference today is that these inequities, especially in access to health care, have become so deadly.

The world can be grateful that leaders from 189 countries endorsed the Millennium Declaration and its Goals as a shared responsibility. These Goals are a profoundly important way to introduce greater fairness in this world.

Populations all around the world can be grateful that health officials are recommitting themselves to primary health care. This is the surest route to greater equity in access to health care.

Public health can be grateful for backing from the Commission on Social Determinants of Health. I agree entirely with the findings. The great gaps in health outcomes are not random. Much of the blame for the essentially unfair way our world works rests at the policy level.

Time and time again, health is a peripheral issue when the policies that shape this world are set. When health policies clash with prospects for economic gain, economic interests trump health concerns time and time again. Time and time again, health bears the brunt of short-sighted, narrowly focused policies made in other sectors.

Equity in health matters. It matters in life-and-death ways. The HIV/AIDS epidemic taught us this, in a most visible and measurable way.

We see just how much equity matters when crises arise.

Ladies and gentlemen,

The world is facing multiple crises, on multiple fronts.

Last year, our imperfect world delivered, in short order, a fuel crisis, a food crisis, and a financial crisis. It also delivered compelling evidence that the impact of climate change has been seriously underestimated.

These crises come at a time of radically increased interdependence among nations, their financial markets, economies, and trade systems. All of these crises are global, and all will hit developing countries and vulnerable populations the hardest. All threaten to leave this world even more dangerously out of balance.

All will show the consequences of decades of failure to invest in health systems, decades of failure to consider the importance of equity, and decades of blind faith that mere economic growth is the be-all, end-all, cure-for-all.

It is not.

The consequences of flawed policies show no mercy and make no exceptions on the basis of fair play. As we have seen, the financial crisis has been highly contagious, moving rapidly from one country to another, and from one sector of the economy to many others.

Even countries that managed their economies well, did not purchase toxic assets, and did not take excessive financial risks are suffering the consequences. Likewise, the countries that contributed least to greenhouse gas emissions will be the first and hardest hit by climate change.

And now we have another great global contagion on our doorstep: the prospect of the first influenza pandemic of this century.

Ladies and gentlemen,

For five long years, outbreaks of highly pathogenic H5N1 avian influenza in poultry, and sporadic frequently fatal cases in humans, have conditioned the world to expect an influenza pandemic, and a highly lethal one. As a result of these long years of conditioning, the world is better prepared, and very scared.

As we now know, a new influenza virus with great pandemic potential, the new influenza A(H1N1) strain, has emerged from another source on another side of the world.

Unlike the avian virus, the new H1N1 virus spreads very easily from person to person, spreads rapidly within a country once it establishes itself, and is spreading rapidly to new countries. We expect this pattern to continue.

Unlike the avian virus, H1N1 presently causes mainly mild illness, with few deaths, outside the outbreak in Mexico. We hope this pattern continues.

New diseases are, by definition, poorly understood when they emerge, and this is most especially true when the causative agent is an influenza virus.

Influenza viruses are the ultimate moving target. Their behaviour is notoriously unpredictable. The behaviour of pandemics is as unpredictable as the viruses that cause them. No one can say how the present situation will evolve.

The emergence of the H1N1 virus creates great pressure on governments, ministries of health, and WHO to make the right decisions and take the right actions at a time of great scientific uncertainty.

On 29 April, I raised the level of pandemic influenza alert from phase 4 to phase 5. We remain in phase 5 today.

This virus may have given us a grace period, but we do not know how long this grace period will last. No one can say whether this is just the calm before the storm.

Presence of the virus has now been confirmed in several countries in the Southern Hemisphere, where epidemics of seasonal influenza will soon be picking up. We have every reason to be concerned about interactions of the new H1N1 virus with other viruses that are currently circulating in humans.

Moreover, we must never forget that the H5N1 avian influenza virus is now firmly established in poultry in several countries. No one can say how this avian virus will behave when pressured by large numbers of people infected with the new H1N1 virus.

Ladies and gentlemen,

The move to phase 5 activated a number of stepped up preparedness measures. Public health services, laboratories, WHO staff, and industry are working around the clock.

A defining characteristic of a pandemic is the almost universal vulnerability of the world's population to infection. Not all people become infected, but nearly all people are at risk.

Manufacturing capacity for antiviral drugs and influenza vaccines is finite and insufficient for a world with 6.8 billion inhabitants. It is absolutely essential that countries do not squander these precious resources through poorly targeted measures.

As you heard this morning, we are trying to get some answers to a number of questions that will strengthen risk assessment and allow me to issue more precise advice to governments. Ideally, we will have sufficient knowledge soon to advise countries on high-risk groups and recommend that efforts and resources be targeted to these groups.

I have listened very carefully to your comments this morning. As the chief technical officer of this Organization, I will follow your instructions carefully, particularly concerning criteria for a move to phase 6, in discharging my duties and responsibilities to Member States.

While many questions do not have firm answers right now, I can assure you on one point. When WHO receives information of life-saving importance, such as the heightened risk of complications in pregnant women, we alert the international community immediately.

To date, most outbreaks have occurred in countries with good detection and reporting capacities. Let me take this opportunity to thank the governments of these countries for the diligence

of their surveillance, their transparency in reporting, and their generosity in sharing information and viruses.

An influenza pandemic is an extreme expression of the need for solidarity before a shared threat. We are fortunate that the outbreaks are causing mainly mild cases of illness in these early days.

I strongly urge the international community to use this grace period wisely. I strongly urge you to look closely at anything and everything we can do, collectively, to protect developing countries from, once again, bearing the brunt of a global contagion.

I have reached out to the manufacturers of antiviral drugs and vaccines. I have reached out to Member States, donor countries, United Nations agencies, civil society organizations, nongovernmental organizations, and foundations.

I have stressed to them the absolute need to extend preparedness and mitigation measures to the developing world. The United Nations Secretary-General is joining me in these efforts, which are tireless.

Ladies and gentlemen,

As I said, equity in health matters in life-and-death ways. It matters most especially in times of crisis.

The world of today is more vulnerable to the adverse effects of an influenza pandemic than it was in 1968, when the last pandemic of the previous century began.

The speed and volume of international travel have increased to an astonishing degree. As we are seeing right now with H1N1, any city with an international airport is at risk of an imported case. The radically increased interdependence of countries amplifies the potential for economic disruption.

Apart from an absolute moral imperative, trends such as out-sourcing and just-in-time production compel the international community to make sure that no part of the world suffers disproportionately. We have to care about equity. We have to care about fair play.

These vulnerabilities, to imported cases, to disrupted economies and businesses, affect all countries. Unfortunately, other vulnerabilities are overwhelmingly concentrated in the developing world.

On current evidence, most cases of severe and fatal infections with the H1N1 virus, outside the outbreak in Mexico, are occurring in people with underlying chronic conditions. In recent years, the burden of chronic diseases has increased dramatically, and shifted dramatically, from rich countries to poorer ones.

Today, around 85% of the burden of chronic diseases is concentrated in low- and middle-income countries. The implications are obvious. The developing world has, by far, the largest pool of people at risk for severe and fatal H1N1 infections.

A striking feature of some of the current outbreaks is the presence of diarrhoea or vomiting in as many as 25% of cases. This is unusual.

If virus shedding is detected in faecal matter, this would introduce an additional route of transmission. The significance could be especially great in areas with inadequate sanitation, including crowded urban shantytowns.

The next pandemic will be the first to occur since the emergence of HIV/AIDS and the resurgence of tuberculosis, also in its drug-resistant forms. Today's world has millions of people whose lives depend on a regular supply of drugs and regular access to health services.

Most of these people live in countries where health systems are already overburdened, understaffed, and poorly funded. The financial crisis is expected to increase that burden further, as more people forego private care and turn to publicly-financed services.

What will happen if sudden surges in the number of people requiring care for influenza push already fragile health services over the brink? What will happen if the world sees the end of an influenza pandemic, only to find itself confronted, say, with an epidemic of extensively drug-resistant tuberculosis?

We have good reason to believe that pregnant women are at heightened risk of severe or fatal infections with the new virus. We have to ask the question. Will spread of the H1N1 virus increase the already totally unacceptable levels of maternal mortality, which are so closely linked to weak health systems?

Ladies and gentlemen,

In the midst of all these uncertainties, one thing is sure. When an infectious agent causes a global public health emergency, health is not a peripheral issue. It moves straight to centre stage.

The world is concerned about the prospect of an influenza pandemic, and rightly so. This Health Assembly has been shortened for a good reason. Health officials are now too important to be away from their home countries for more than a few days.

Much is in our hands. How we manage this situation can be an investment case for public health.

The world will be watching, and one big question is certain to arise. Are the world's public health services fit-for-purpose under the challenging conditions of this 21st century? Of course not. And I think the consequences will be quickly, highly, and tragically visible. Now comes the second question. Will something finally be done?

At the same time, we cannot, we dare not, let concerns about a pandemic overshadow or interrupt other vital health programmes. In fact, many of the issues you will be addressing this week, or have addressed in recent sessions, concern exactly the capacities that will be needed during a pandemic, or any other public health emergency of international concern.

The health sector cannot be blamed for lack of foresight. We have long known what is needed.

An effective public health response depends on strong health systems that are inclusive, offering universal coverage right down to the community level. It depends on adequate numbers of appropriately trained, motivated, and compensated staff.

It depends on fair access to affordable medical products and other interventions. All of these items are on your agenda. I urge you, in particular, to complete work under the item on public health, innovation and intellectual property. We are so very close.

The International Health Regulations, also on your agenda, give the health sector an advantage that financial managers, at the start of last year's crisis, did not have when faulty policies precipitated a global economic downturn. The International Health Regulations provide a coordinated mechanism of early alert, and an orderly system for risk management that is driven by science, and not by vested interests.

I must remind you. We need to finish the job of polio eradication, as guided by the ongoing independent evaluation. I must also remind you that this job is already providing solid benefits as we reach for the goal of ridding the world of a devastating disease.

Right now, the vast surveillance networks and infrastructure in place for polio eradication are being used to step up surveillance for cases of H1N1 infection, especially in sub-Saharan Africa and the Asian sub-continent.

The proposed programme budget is also on your agenda. WHO is prepared to lead the response to a global public health emergency. Our services, in several areas, are strained, but we are coping. We need to be assured that we can continue to function well, especially if the emergency escalates.

Ladies and gentlemen,

I have a final comment to make.

Influenza viruses have the great advantage of surprise on their side. But viruses are not smart. We are.

Preparedness levels, and the technical and scientific know-how that supports them, have advanced enormously since 1968. We have the revised International Health Regulations, and we have tested and robust mechanisms like the Global Outbreak Alert and Response Network.

As I said, an influenza pandemic is an extreme expression of the need for global solidarity. We are all in this together. And we will all get through this, together.

Thank you.

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