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Transcript

The Rise of Global Health in International Affairs

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Dr Margaret Chan:

Colleagues in public health, ladies and gentlemen. In addressing the place of global health in international affairs, I will be speaking about success, shocks, surprises, and moral vindication.

The 21st century began well for public health. When the governments of 189 countries signed the Millennium Declaration in 2000, and committed themselves to reaching its goals, they launched the most ambitious attack on human misery in history. The contribution of health to the overarching goal of poverty reduction was firmly acknowledged, as was the need to address the root causes of ill health that arise in other sectors.

World leaders were optimistic, visionary, and determined to see their visions realized. A host of global health initiatives sprung up, with many designed to deliver life-saving interventions on a massive scale. New financing instruments were created, and clever ways were found to secure new money for purchasing medicines and vaccines. Presidents and prime ministers launched international programmes for diseases rarely seen within their own borders. Official development aid for health more than tripled.

Unmet needs for new drugs and vaccines drove the creation of a new breed of strategic R&D partnerships that have already licensed impressive innovations. Not surprisingly, this desire to cooperate internationally for better health, these innovations, these dramatic increases in resources, had an impact. The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200 000 in late 2002 to nearly 7 million today. The number of under-five deaths dropped to its lowest level in more than six decades.

The number of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, the steadily deteriorating malaria situation turned around. Countries following WHO-recommended strategies are seeing drops of 50% and higher in malaria deaths.

Yet, for much of the decade, the number of maternal deaths stayed stubbornly high. The explanation is not hard to find. Reaching the goal for reducing maternal mortality depends absolutely on strong and accessible health services. The strengthening of health systems was not, initially, a core purpose of most single-disease global health initiatives. But it is now.

As the drive to reach the goals taught us, commodities, like pills, vaccines, and bednets, and the cash to buy them will not have an impact in the absence of delivery systems that reach the poor. When the overarching objective is poverty reduction, if you miss the poor, you miss the point. In my personal view, one of the biggest bonuses of all this progress came in the form of a frank realization, in the large single-disease initiatives, in the Global Fund, in the GAVI Alliance, that goals cannot be reached and progress cannot be sustained in the absence of well-functioning health systems.

I believe this renewed focus on health systems is one reason why 2010 estimates finally showed a significant worldwide drop in maternal mortality, with the greatest declines, of around 60%, reported in Eastern Asia and Northern Africa. Like others, WHO welcomed last week's news of dramatic price slashes for vaccines sold by the pharmaceutical industry to the developing world. This represents a sea change in pharmaceutical policies. As one chief executive stated, the pharmaceutical industry can no longer view itself as detached from the well-being of society.

Not all the news is good. Of course, many countries will not reach the MDGs, especially in sub-Saharan Africa. But striking progress over the past decade tells us two things. First, investment in health development is working. And second, despite the many crises and obstacles thrown our way, the high place of health on the development agenda has held steady. The momentum to improve health outcomes has persevered. But so much for the success of public health when left to its own devices.

Ladies and gentlemen. The year 2008 will likely go down in history as the tipping point that demonstrated the perils of living in a world of radically increased interdependence. That year experienced a fuel crisis, a food crisis, and above all, a severe financial crisis. That year also demonstrated that these crises are entirely different from those experienced in previous centuries. They are not just temporary dips and blips in the up-and-down cycle of human history. Their origins are so deeply embedded in the international systems that govern today's interdependent world that we must begin to accept them as recurring, if not permanent features of life in the 21st century.

These days, the consequences of an adverse event in one part of the world are highly contagious and profoundly unfair. In terms of impact, the financial crisis has behaved, roughly, like the economic equivalent of a drive-by shooting. The innocent bystanders, the countries that managed their economies well, have also been hit hard. In a similar way, the countries that

contributed least to greenhouse gas emissions are being the first and hardest hit by climate change.

Two months ago, the World Bank and the International Monetary Fund cited skyrocketing food and fuel prices as the most serious immediate threat to developing countries, and warned that we could lose an entire generation of the poor. At WHO, we have been advised by outside experts to accept financial austerity as the new reality. We have done so, and this has added urgency to the sweeping administrative, managerial, and technical reforms being introduced at WHO.

Under the conditions of this century, the health and economic costs of chronic diseases have created an impending disaster. The burden of these diseases has shifted from affluent societies to the developing world, where nearly 80% of mortality is now concentrated. Most health systems in the developing world are designed to manage brief episodes of illness from infectious diseases. They are entirely unprepared to cope with the demands and costs of chronic, sometimes life-long care.

Prevention is by far the better option. Unfortunately, the forces that drive the rise of chronic diseases, including demographic ageing, rapid urbanization, and the globalization of unhealthy lifestyles, lie beyond the direct control of the health sector. It is my sincere wish that the September high-level meeting on non-communicable diseases, being held at the UN, will produce broad-based plans for urgent action.

To combat the rise of these diseases, policies in other sectors, like food, agriculture, and trade, must change. Using the WHO Framework Convention on Tobacco Control, the world must get tougher in resisting the increasingly aggressive tactics of Big Tobacco.

Ladies and gentlemen. We are just halfway through this year, but 2011 has already delivered an unprecedented cascade of calamities, catastrophes, and humanitarian crises. We are seeing waves and waves of social unrest in the Middle East and in parts of Africa. Haiti and Pakistan are still suffering from the mega-disasters of the previous year. In March, Japan was hit with the triple tragedies of a magnitude 9 earthquake, a massive tsunami, and a related accident at a nuclear power plant. Some countries are now questioning the safety of nuclear power and rethinking their energy policies for the future.

In May, an outbreak of a rare strain of E. coli began in northern Germany. The strain had been detected in isolated human cases before but had never been

associated with an outbreak. To date, cases have been detected in 15 countries. Almost all patients had a recent travel history to northern Germany, many have required intensive care, and many have died. This event demonstrates how rapidly a disease can spread in our highly mobile world. It shows how difficult it can be to pinpoint the source when investigations are complicated by the intricacies of world food trade. And it tells us how much outbreaks can cost economies, with EU officials estimating weekly losses to vegetable farmers of more than US\$ 610 million.

Ladies and gentlemen. I mentioned moral vindication earlier. Our world is dangerously out of balance. The gaps in health outcomes, within and between countries, are greater now than at any time in recent history. The difference in life expectancy between the richest and poorest countries exceeds 40 years. Annual government expenditures on health range from as little as US\$ 1 per person to nearly US\$ 7 000.

A world that is greatly out of balance is neither stable nor secure. Perhaps the biggest lesson from all these recent events concerns the impact of social inequalities on national and international security. In their analyses of the recent waves of social unrest, top experts from around the world cite vast inequalities, within and between countries, in opportunities, especially for youth, in income levels, and in access to social services, as the root cause of unrest and protests.

Some cite the crumbling of public health services, after years of utter neglect, so that the best care goes to the elite and the poor pay unregulated, exaggerated prices for even the most routine care. In one speech, editorial, news report, or article after another, we hear that greater social equality must become the new economic and political imperative for a safer, more secure world.

This is nothing new for public health. We have been making this same point since the Declaration of Alma-Ata. The MDGs are all about ensuring that those who suffer most or benefit least get help from those who benefit most. This is the essence of social justice and solidarity. Again we see how fragile our advanced, sophisticated, high-tech, intertwined, modern world has become as the climate slowly warms, some 44 million pre-schoolers are obese or overweight, and social fabrics in so many places begin to unravel.

Public health has been on the right moral and ethical track for ages. It is good to see the world's politicians and economists wake up and open their eyes to

the moral imperatives that have always driven the best in public health, and always will.

Thank you.

Rt Hon Andrew Lansley MP:

Thank you David for that introduction and thank you Margaret for your speech, and it's a great pleasure to have you here in London and speaking not only here but also it was a great pleasure to have you with my colleagues at the Department of Health earlier today. We're delighted that you were able to spare time and thank you for that too.

Can I just say, two of the government's highest priorities here at home are firstly to return the country to the path of economic prosperity and secondly to give people, especially the poorest and most vulnerable in society, access to excellent healthcare with outcomes that are consistently amongst the very best in the world. Those two priorities are also present when we look beyond our own borders. We want to do everything within our power to bring sustainable growth to all the countries of the world and to the poorest in particular and we want that growth to bring with it improving health outcomes that will in themselves underpin future prosperity.

Why are these priorities so important? Why are we interested in the health and prosperity of those who don't live here and who don't pay taxes here? They're important because we understand that today more than ever before our national interest cannot be defined simply by what happens within our own borders, if indeed it ever could, because the strength of our economy, the health of our society, the success of our nation depends on the strength of our partners around the world because we understand the fundamental importance to our long-term national interest of making the lives of others wherever they may be better than they are now and one of the main ways of achieving this is through improving health.

The health challenges we face in Britain – an ageing population, increasing costs of healthcare, a rising tide of lifestyle related diseases – these are not unique to us as Margaret so eloquently said; they are shared and international concerns. Across the globe we share a common destiny: borders are more open, travel is faster, more frequent and more affordable; normally, our economies are more integrated than at any time in human history. This interdependence means that to a greater degree than previously imaginable we share in each other's prosperity and indeed hundreds of millions of people

who have been lifted from poverty in China in recent decades can indeed testify to that.

But we also share the risks of failure: the risk of climate change where the effects are felt by all irrespective of borders, the risks of diseases and infections and indeed as H1N1 pandemic demonstrated, or as Margaret said in relation to the recent E coli outbreak, it can spread very quickly from country to country, or indeed the risks of collapsed and failed states bringing terror and conflict to the world.

Acting alone in any of these respects is not an option. Acting together, acting in common purpose, that is the only way forward.

Of course especially in times of economic difficulty, as Margaret said of financial austerity, we do all of us need to look to our own economic and trade interests. Without a strong economy there is little we can do in any arena. I do want British companies, British healthcare organisations, to succeed abroad bringing more jobs and more prosperity to our people. We have seen some examples. [Inaudible] hospital has a new facility in Dubai. Imperial College Hospital operates a diabetes clinic in Abu Dhabi. They are pioneers seeking new opportunities on a global basis for the NHS and indeed by doing so providing new revenue to fund better care for NHS patients. I want more than this. And some Trusts with well developed international reputations such as Great Ormond Street Hospital already treat many international patients here in England; revenue again that is then invested back into the National Health Service to provide ever better care for NHS patients here in Britain.

And the UK has long been a global hub for research and clinical expertise. The life sciences are of particular importance to our economy now and for the future. We want to build that base that we have had here for many years in the future encouraging global leaders like GSK to build on their success, creating new jobs and indeed many new treatments, always attracting new investment, always pushing the boundaries of medical science for the benefit of all, giving UK companies and NHS organisations that have so much to offer the world every opportunity to do so and of course with \$3 trillion invested in healthcare each year around the world it pays to be a major player.

But above and beyond self-interest there is enlightened self-interest. I am deeply proud of the fact that Britain has forged a reputation as one of the leading voices and principle donors in international development. This is perhaps most obviously apparent in our commitment to lifting our development spending to 0.7% of gross national income, a commitment made by the last government at Gleneagles in 2005 and one that will be realised by

this government in 2013. The international community can depend on the United Kingdom to keep its promises on development spending and to use its influence to encourage others to do the same, and we know what that will enable us to do: training midwives to help make childbirth the joyful experience it should be instead of the potential death sentence it too often still is; working to eradicate the scourge of polio and guinea worm disease; providing safe fresh drinking water which can transform lives not only for an almost instantaneous improvement in their health but also by freeing girls, because it is invariably they who work so hard to collect it, to go to school or work, improving their lives and those of their families still further; and of course vaccinating children against diseases like severe diarrhoea, that for the sake of a few pounds would otherwise kill them.

This has been a good month for progress in vaccinating children. Earlier this month GSK announced that it would make its rotavirus vaccine available to GAVI for two-thirds of the price at which it is currently available and of course at today's GAVI Replenishment Conference I was delighted that the Prime Minister was able to announce an additional commitment of £814 million, an additional commitment, money that between now and 2015 will help vaccinate over 80 million children and save 1.4 million lives: that's one child's life saved every 2 minutes.

We, government and industry, understand that in the long-term their interests, the interests of those people whom we help, are indeed our interests because their problems left unchecked and ignored will sooner or later become ours whether we like it or not, for when people are poor, desperate and without hope, chaos can be close at hand. States that are today fragile can, without outside support, soon fail and the risk of failed states are huge, unleashing fear and hatred that can bring terrorism or conflict, unchecked immigration or crime to our doorsteps.

David Cameron said only last month at the G8 in Paris: If we had spent a fraction of what we are paying now in Afghanistan on military equipment into that country as aid and development when it had a chance perhaps of finding its own future, would that have not been a better decision? He's right. No country can escape the logic of global interdependence, accepting the bountiful prose while somehow avoiding the inevitable cons, no matter how much we might want to.

So the question is, if we are indeed all in this together what should we do about it? Britain's answer is to make global health an explicit aim of our foreign and economic policy. At home we are working to ensure that all

relevant government departments work together, sharing information, developing common goals and working to a shared strategy. Abroad we need to work ever more closely with other governments and with international organisations like the World Health Organization and across civil society, making and exploiting the connections between us, making the most of the talent, expertise and passion that exists in abundance out there in the world and putting that work to the benefit of humanity.

Two years ago the H1N1 pandemic affected just about every country on the planet. The global response was swift, calm and impressive. I would like to pay particular tribute to Margaret for how she and her colleagues at the WHO handled that particular crisis, a crisis that throughout was characterised by a high degree of international cooperation, openness and trust, an approach I was pleased to see that was vindicated in a recent review of the WHO's actions.

We of course were also lucky. That particular flu strain proved in the event to be relatively mild. Of course we may not be as lucky next time. That is why all of us, countries together, must work together to develop adequate warning systems, to develop quickly and produce and distribute effective treatments and to agree protocols of how the business of the world economy can be sustained during times of crisis.

But we must also be clear as to the political and financial realities that donor countries face. Everyone is under pressure at the moment – under pressure to put aside their development commitments to contribute less than they had promised, under pressure to turn their backs on free trade to try to protect jobs at home by raising barriers to trade, under pressure to think of the national interests in the narrowest of terms. We must and we will resist those pressures.

So here in Britain we will not make the world's poor pay the price for the debt crisis by abandoning our commitment to the 0.7 percent objective. We will not seek the false shelter of protectionism. We will not close our eyes to the realities of a modern integrated and globalized world. Instead we are determined to prove to our citizens that the money they spend is making a genuine difference. That is why we updated the original health is global strategy to an outcomes framework for global health.

Here in England we are modernizing the National Health Service. One of the most important elements of that modernization is measuring how effective the NHS is in terms of the health outcomes it delivers for patients, so instead of saying that so many operations must take place, we want to measure for

example the survival rates for those operations – to measure, to publish and to improve. That way not only can we in government but clinicians and most important of all patients see just how good services are and if there is a problem clinicians then will be challenged to sort it out. Such an approach in this country for cardiac surgery has halved death rates in England over the last 5 years; as at home, likewise abroad.

The 'health is global outcome' framework brings tangible measurable outcomes to bear on our efforts to improve global health, focussing on some of the greatest challenges to global health across key areas of for example global health security, health and development and trade for better health. On food security, on access to affordable immunisation and treatment, on adapting to the effects of climate change on the health of the very poorest communities and strengthening local health services to improve lives, reduce preventable deaths and improve prospects for peace and security.

In this way working together across departments we can focus our resources not only on what matters most, we will be able to see far more clearly whether or not what we are doing, whether the billions we are spending, is having the desired effect. If it's not, we can adapt and change what we are doing. Taken together, the realisation that our interests reach far beyond both our own borders and our narrow immediate economic interests and the clarity of purpose that the global health outcome framework brings with it means the traditional approach to international relations is evolving.

Global health is now central to effective foreign policy. You cannot separate health from security, not when so much of our security means preventing or dealing with the aftermath of natural disasters or civil conflicts or of pandemics. You cannot separate health from economics, not when a new pandemic could bring the global economy to an abrupt standstill or when positively life sciences and health industries have so much to contribute to global growth and trade. And you can never separate health from our desire for social justice, for all people, from all countries, of all incomes, to share the dignity of good health.

The World Health Organization will be central in tackling the challenges we face. I would like to applaud the determination and leadership that Director-General Margaret Chan has displayed in helping the organization adapt to the changing nature of these challenges. I hope that all countries will join the United Kingdom in integrating the global health agenda into all aspects of their foreign and economic policies, to continue to work together and with

organizations such as the WHO to meet the Millennium Development Goals for when we work together, everyone benefits. Thank you very much.

Question One:

Dr Chan, in the past few months I've seen you debate with Vladimir Putin about the future of non-communicable diseases, engage Prime Minister Harper about women and children's health and even from afar dance with President Kikwete late into the night in Tanzania.

Global health is the hottest date in town and WHO and considerably due to your leadership over the past few years deserves that place for the vast technical guidance that WHO gives the countries, the first historic NCD Summit later this year. And yet there's a paradox. We have WHO in this leadership position. We have unprecedented investments in global health and yet, as you rightly pointed out, WHO is going through a painful reform process which some of us interpret as a retreat from multilateralism.

How is it that we have this fashionable movement for global health supported by many countries and yet WHO and the UN system generally is suffering considerable strain, some might even say crisis, that multilateralism is not being supported as much as it should be? How does that fit with the role of global health in international affairs?

Dr Margaret Chan:

Richard, your question is always difficult but this is an extremely important question. I think we need to ask the question why we get to this stage.

The UN by virtue of the UN is a very exclusive club. It is a member state only organization, be it in UN General Assembly, in WHO and others. The UN needs to change with the world. Nowadays nobody can succeed in global health without engaging the civil society, without engaging the academics, the scientists, without engaging the industry, the PVP, and that's why in WHO one of the suggestions I am proposing for the consideration of my member states is you need to create space for the voiceless and the faceless where they can make a contribution and the reason why countries do not want to give money to multilateral organizations is because they cannot bring into WHO the *Lancet* and other private sectors, so we need to change.

Without changing that, and we are an inclusive organization where all voices are heard, but the ultimate decision-making power still rests with the country I

don't think we are going to change that. It's not that people don't value multilateralism – yes they do, because they are issues that cannot be solved on a bilateral basis or in small groups of countries. It does require global solidarity to address global issues and to find solutions for global problems.

I am quite optimistic if my member states in WHO support the opening of space for partners to come in then governments do not need to go the backdoor way to create partnerships. I'm not saying partnerships are not good? I must make this very clear. GAVI is important, Global Fund is important... [inaudible] One of the reasons why countries go to the backdoor and create this is because they don't see that mechanism allows others to come in.

There is another thing, also the UN needs to reflect: the division between countries, the north and the south, the east and the west. But I'm more hopeful now. I'm in the Cold War stage. You're either left or right, right? It's so easy to choose but nowadays it's very complicated. Countries form alliances, which depends on mutual interest. They come together based on the issue. So it is important. We need to keep an open mind.

And I see Patty here. When I see Patty I'm very nervous. She's a good friend. We are very personal about breastfeeding, we are, but the important thing is, the way forward is, every organization, every government, every civil society and the industry, we must [inaudible] and deliver on our promises and commitment and that is the foundation to build trust. You don't have to trust the private sector today. If they don't [inaudible] we chuck those out; we just work with the enlightened ones.

Rt Hon Andrew Lansley MP

Well could I just add two points if I may very briefly. Firstly, as I'm sure you know, we in the British government, our intention in increasing our support for international development aid was at the same time to expose it to challenge in terms of the benefits that were being derived and the effectiveness with which those resources were being used and that did include through the Multilateral Aid Review some pretty challenging questions being asked of the multilateral organizations through which we work.

As Margaret and I have discussed, and as indeed I told the World Health Assembly just last month, as far as we are concerned the programme of reform that Margaret is pursuing inside the World Health Organization is one best calculated to deliver those kind of improvements which we do think are

necessary in the effectiveness with which resources are used, so I do wish her very well and we give her our strong support in what she's setting out to do.

The second thing I'd say is that I don't think one should underestimate the potential benefit through organizations with the authority of the World Health Organization of moving beyond working together on challenging infections, responding to emergencies, to thinking about this tide of non-communicable diseases.

It isn't that the World Health Organization can take responsibility for the whole of health systems in any sense but all of us I think are trying to be clear about how we can deliver those better and improving health economies. It's something we've contributed. Margaret was referring to the wider determinants of health. It's something I think in this country we've contributed a lot of thinking through Michael Marmot's work and I hope in this country the way in which we take it up but I know from the conversations we've had, multilaterally as it were, that getting to those strategies are going to be terribly important.

But then in the countries where it is most difficult to combat that rising tide of non-communicable disease what the WHO can and will be doing in terms of strengthening health delivery to respond to infections, to promote vaccination, to respond to health emergencies, is absolutely the same task as improving health systems in order to respond to non-communicable disease as well. We can see it happening around the world.

So as we share those thoughts about how we deliver better health economy and better health effectiveness in the future, I think actually the WHO in some of the least developed and poorest nations are already in the right place to be able to translate some of those thoughts.

Dr Margaret Chan

You know I can't agree with you more because you need to have a robust health system in order to deal with the multiple demands. The tendency to work in silos is very strong. It's important that we resist this.

I was discussing with my friend from WHO, Ian Smith. I said is there such a word called *silomania* because people just protect our turf but the time has come to look at what is important for the people.

This year I delivered my speech at the Assembly. I used the title Remember the People. Often we think we are representing the people. Civil society thinks that they are representing the people. Governments think that they are representing the people. Of course they are but then they also need to go through a process and to ask them really is what we decided is what do they want and this is a big challenge.

That's why I said let's go back to basics, have a good primary healthcare system, a system that has the capacity and the capability to deal with multiple crises. It's easier said than done but it can be done, look at Rwanda – unbelievable what they have done in the last 5-10 years.

Question Two:

Dr Chan, thank you very much for your comments and I was especially delighted to hear that you did make reference to demographic ageing as being one of the underpinning factors to the rise of NCDs, delighted because sadly, despite all the evidence that's been building that knowledge that we have, even the UN [inaudible] its own statistics that demographic ageing is happening globally worldwide, that this is actually going to be affecting developing countries the most, they had the least amount of time to respond to this, and demographic ageing is the invisible side of global health planning and indeed international development and it even is coming through in the planning for the NCD High-Level Meeting itself, so the preparatory documents for example go to great extent to emphasise the 30 percent of deaths of people under the age of 60 were ignoring 70 percent over.

My question though is about trying to understand how is the WHO going to ensure that the health outcomes for older people as well as younger people are achieved through the NCD High-Level Meeting and, indeed, from the Secretary of State, I would be very interested in understanding what the UK government is going to do to take the experience and knowledge that we've gained here in the UK and to try to achieve those same outcomes.

Dr Margaret Chan:

Thank you for that excellent question because NCD is very close to our heart especially the topic you talk about, demographic ageing, being as I qualify for that – well, I look pretty young but I'm not.

In fact WHO, the next World Health Day which is next April 7, April 7 is our birthday, and every year we use our birthday to highlight one very important

topic that is important in the sense of being neglected or that if you do not pay attention to it you pay through your nose eventually. So ageing is one such issue and ageing has a very close relationship with NCD. Now notwithstanding the fact that it hurts us to see that more and more young people – and when I say young, is below 60 – are becoming affected by either hypertension or diabetes or cancer, so how do we look at the A-Z in the prevention and promotion of non-communicable diseases.

The good things are four risk factors, if we do them well we can prevent a lot of those diseases; no smoking, modest drinking and then good exercise and balanced diet.

But modest drinking I'd better be careful; I got trapped once. A girlfriend of mine called me one day and said: Margaret, did you tell my husband one glass of red wine a day is good for health? I said: Yes, I did say that. But she said: You never checked his glass; the size of his glass is one bottle of white wine. I made that mistake so I need to quantify the amount.

If you do address those four risk factors a lot can be achieved contrary to the belief, there is a strong movement in some sectors in some countries, calling for the establishment of a global fund for non-communicable diseases. To be honest, I don't agree with that because countries within their existing resources there's much that can be done and also it is government responsibility. Use the whole of government approach, the whole of society approach to have good nutrition, breastfeeding, exclusive breastfeeding for two years – I say this because Patty is here – but there's good reason for good nutrition.

When we are looking at close to 45 million pre-schoolers, obese and overweight, it's daunting. Many of them will have diabetes and diabetes, once you have it, you cannot shake it off and can you imagine that burden on the family budget, on the society, on the government? One country that hurts me a lot, a small country, a minister came and saw me and told me her country is No. 3 in the world in terms of the number of diabetics and her country ranks No. 1 in terms of amputation arising from diabetes.

These are things that we can do and WHO is working very hard with partners and with scientists to look at the A-Z, what are some of the things that is individual responsibility; we can't always blame the government, what should the government be doing and what the scientists can be doing and the industry as well.

So prevention and promotion you can only do so much but what about the people who are already having hypertension, having diabetes? We need to

make sure that medicines are affordable and they should be high quality, generic, affordable and many of the medicines that are good for hypertension and diabetes and off-patent so it's not logical to say categorically that patent is standing in the way.

Of course I'm very passionate about making the right balance to preserve the foundation for R&D – that has to be kept – and at the same be creative and come up with different business models where different society sectors can have access to medicine. Without that we are not living in a good world.

Rt Hon Andrew Lansley MP:

I was very struck that at the World Health Assembly when our colleague, the Health Minister from China, if I paraphrase correctly said: We know in China we will get old before we get rich. So to have greater focus on understanding what disability-free life expectancy is going to best achieve is absolutely essential and so the Chinese government at the World Health Assembly, I think they and we shared absolutely a commitment to trying to tackle non-communicable diseases.

I think from my point of view there's a lot to say but I'll just say two things that from our point of view I think will be important. The first is that we have I think an unparalleled opportunity in this country, through research in linking datasets in this country, we have through the National Health Service and its data systems a tremendous opportunity to link data about a diverse population many of whom come to this country, adopted an urban lifestyle and we are seeing the impact of diabetes for example and I'm conscious of that for example in the South Asian community in the country. We can learn, we can pilot a great deal by way of the ways in which people respond to that and we can offer a great deal of that research to the rest of the world.

The second thing is I think we have to be right at the leading edge of understanding how we achieve prevention. So things like the health check programme, as I said to the World Health Assembly, I hope that's something that as the data comes through, and we are looking beyond cardiovascular disease and issues like diabetes and so on, identifying the early onset of non-communicable diseases it's terrifically important we need to tackle them but we should never for a minute fail to recognise where we don't achieve enough. We don't achieve enough in terms of early diagnosis very often for things like dementia or for cancer and we need to tackle that too.

But I think we can also be proud, simply in this country, of the fact that in our health system we are absolutely committed – I reinforced it just a few weeks ago – to no age discrimination in access to healthcare and that I think is something which I hope we will be able to say to others around the world, we can give people that sense of security as they get older that they will have access to a high quality healthcare system.