

Text of Dr. Sania Nishtar's speech at the opening session of the Interactive Hearing, as part of the preparatory process towards the third High Level Meeting of the General Assembly on NCDs.

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Your Excellency, Miroslav Lajčák, President of the GA
Excellencies,
Ladies and Gentlemen

NCDs are the world's leading killers—and the numbers behind the NCD tragedy are stark, but it is the reality behind the numbers, which is even starker

Last week, I met a family, where the grandfather was struggling with heart failure; the grandmother lived with consequences of untreated diabetes—amputated foot and near blindness; the breadwinner had high blood pressure and his wife, suffered from lung disease due to decades of cooking indoors. 40% of the family's income was spent on treating largely preventable diseases; and because of the opportunity cost, their children were mal-nourished, and the girls had fallen out of school.

The footprint of NCDs on people's lives is everywhere and it is ravaging them.

Countries are crying out desperately for help. This is evidenced by data from WHO's Country Cooperation Strategies in more than 150 countries—and therefore, the high-level commission on NCDs has recommended to WHO that it prioritizes NCDs, given its enormous leverage to impact change. Across the developing world, adoption of high-income lifestyles combined with epigenetic influences has escalated NCDs exponentially—and its imprint is seen in hospitals, homes and societies.

In high income countries, where geographic and financial access to services for NCDs is not a major barrier, the ravages of lack of treatment may not be that

visible—but rising obesity is crippling a generation and healthcare costs have become threatening.

Progress has been simply and grossly inadequate to tackle NCDs, especially in terms of implementing the recommendations of the 2011 Political Declaration, despite the normative spadework done by WHO.

It is important to get the NCD agenda on track—and within this context, I would like to outline three points

First, NCDs need to be woven in healthcare, in Universal health coverage and renewed commitments towards Alma Ata. We could end up undermining the economic viability of UHC if plans failed to address the world’s leading killer. As a commission we will be signaling priorities to achieve the scale up that countries need to reach SDG 3.4 in this regard.

We also need to “negotiate” policy space for NCDs within the existing success engines of global health. For example, GAVI could adopt life course vaccination and the Global Fund and PEPFAR could allow leveraging of their systems, to jumpstart nascent NCD programs

But this will not happen without a global push and we must understand why not.

Since the days of tropical medicine, the mix of three ingredients have contributed to global health successes: institutional focus, strategy, and adequate funding. This is also why the 2001 political declaration on HIV and AIDS sparked global momentum, but nothing comparable ensued when UNGA united politically behind NCDs for the second time in 2011.

We need signaling of support for NCDs from development partners who wield enormous influence in setting agendas in the developing world and **catalytic resources**—which is why our Commission has called for the establishment of a MDTF to spur and supplement domestic investment; and we hope to make clear its envisaged details in the forthcoming months.

Secondly, the NCD agenda, and indeed the SDG agenda means governments will have to think long term and organize themselves differently.

NCDs need to be plugged into long-term national development initiatives, into SDG implementation road-maps, in social protection policies, into resilience plans, into national metrics and reporting and accountability frameworks.

There are various Governments approaches that need to come into play—regulation, taxation, subsidies, disincentives and incentives, investments and trade measures; these are outside of the control of ministers of health and often opposes the agendas of their cabinet colleagues, which is why the commission has squarely stated that heads of state and government must take the lead.

Governments also need to unbundle the term of MS action to decipher how this factors into domestic policy—this creates imperatives for new instruments to forge convergence within government, incentives for collaborative division of labor, and metrics for whole of government performance assessment....more broadly, an overarching change so that governments choose to prioritize long term sustainability over short term gratification—which is why the commission has called for full-cost accounting of the total societal burden of NCDs—and for the same reason, we have also called for the integration of NCDs into the human capital ranking which are likely to dictate countries' borrowing costs as soon as 2025.

My third point is about NCDs and societal transformation

That transformation is happening anyway—and we need to ask ourselves as a public health community what are we doing to shape the objectives we are responsible for, such as equity?

In the streets of New York, green bars, wellness gyms, and restaurants that label calories are increasing—but is the same trend being driven commercially in the obesity capitals of the developing countries?

Most technology innovations shaping the future of healthcare today are NCDs-centric such as hospital reengineering, home diagnostics, the internet of things, wearables, mobile wellness apps. As a public health community, are we geared up for programmatic scale, for norm setting, for building regulatory capacity?

Applications of Blockchain, artificial intelligence, robotics, and 3D printing are largely developing around NCDs—but are we creating incentives for public objectives where the market is failing?

Today, most cutting-edge developments in gene editing, precision medicine, biotechnology, and immunotherapy are hardcore NCDs, but as a community are we working to address the financial access barriers that will definitely deepen?

The private sector is aligning incentives to announce the end of cigarettes; this week artificial plant-based meat was served on an airline.

Changes that can impact NCDs at a societal level are happening anyway—as a community, we need to gear up to playing our part in relation to exercising oversight, regulation, overcoming the financial access barriers and strengthening the evidence base.

Attacking lifestyle choices, corporate interests, vilifying others or creating an oversimplistic enemy narrative is not going to help.

We need to learn to develop the public health skills of this millennium to address the wider determinants of health and shape institutional and individual behaviors—which is why the commission has recommended that we tap the expertise of marketing experts and behavioral economists and that is why we have called for establishment of a health fora for investors and other stakeholders.

Our commission has laid stress on accountability so that we can collectively be held responsible for bridging the largest chasm in public health ever. A chasm between knowledge of the burden of disease and evidence of what works on one hand and absence of commensurate action on the other.

Amongst other things, we need a platform to register commitments and an independent mechanism to track progress against commitments.

We have had enough of inaction and now it is time to deliver.

On behalf of my fellow commissioners present in this room, His Excellency Festus Gontebanye Mogae, Sir George Alleyne, Professor Ilona Kickbush and Katie Dain, I wish to thank you Mr. President for your commitment to address NCDs and the United Nations for hosting the high-level meeting, which we hope will be the point where we turn the corner on NCDs.

I thank you.

