Prime Minister Gro Harlem Brundtland
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**INFLUENCING ENVIRONMENTAL FACTORS IN CARDIOVASCULAR DISEASE PREVENTION - A GLOBAL VIEW**

Welcome to Oslo, Welcome to Norway. We are so pleased and also proud to see you all here tonight - one thousand seven hundred specialists, and some of their spouses, that is unique.

When John Kennedy gathered a group of Nobel Prize laureates in the White House, he said that there had not been so much talent in the building since Thomas Jefferson dined there alone.

I am proud to say that never has there been so much talent gathered in this building, and I doubt if there ever will be.

Given my own background from the field of medicine and public health, I regard it as a privilege to address you as colleagues. I have sometimes been asked what it is like to move from the medical profession into politics. My answer is simple: Medicine and politics are closely related. In my life and experience it has been one continuous line.

Doctors and medical scientists have a lot in common with politicians.

- We are all concerned with diagnosis, with finding the reasons for a particular problem.
- We are all concerned with finding the remedies, how to solve present and future problems.
- And we are all concerned with how we can anticipate and prevent problems so that the need to react and cure will be reduced.

Having been an environmental minister myself, and an environmentalist all my life, I have seen how this same basic attitude applies to a wide range of issues of public and private concern. The best remedy is almost always to find out why a problem occurs, anticipate where and how it may occur, and get to work on the sources of the problem based on knowledge and sound analysis.

This basic attitude, I know, is shared among you here. Your commitment to preventing cardiovascular diseases have brought you to Oslo. Your are part of a wider global community of responsible people which has assumed a life task of solving social problems.

It is the same kind of commitment that instilled so much sense of responsibility into the World Commission on Environment and Development, which the UN Secretary-General asked me to lead back in 1983. Anticipation and prevention is better that

reacting and curing afterwards. This applies to global affairs, to regional affairs and to local affairs.

A long-term, intra-sectoral, cross-boundary, North-South, East-West view of health in general speaks of great achievement and revolutionary improvement. Life expectancy is increasing, infant mortality is declining, communicable diseases are being brought under better control, immunization programmes are becoming more effective.

The benefits of social and medical progress, however, are unevenly distributed among people and countries. Parasitic diseases such as malaria are still a major problem in the tropics. Inadequate water supplies and poor sanitation are direct causes of widespread, debilitating diseases such as diarrhoeas and various worm infestations which take such a toll of lives in the Third World.

Almost 2 billion people lack access to clean water and almost 1.5 billion lack adequate sanitation. Poverty, malnutrition, lack of education and insufficient access to basic health services are also among the major reasons why millions lead a life which cannot be reconciled with human dignity, exposing many to the risk of disease and premature death.

**UNEVEN GEOGRAPHIC DISTRIBUTION**

In this global picture, a view on cardiovascular disease mortality reveals a strikingly uneven geographic distribution. The highest figures are found in Central and Eastern Europe, with other industrialized countries in the middle, and the People's Republic of China on the bottom of the list. While, fortunately, the trend are pointing downward in the United States, Australia and other industrialized countries - including Norway, a disturbing upward trend has been noted in Eastern Europe.

We are lacking information about the trends in the Third World, but we suspect that the figures are rising, as shown for some Latin American countries and for certain groups in India.

We must ask what these differing trends tell us. Are there environmental and external factors that can be attacked?

When we worked on the World Commission, we saw it as an overriding objective to advice the developing countries about the risks of repeating the mistakes that the industrialized world had made with regard to pollution on the road to greater prosperity.

If developing countries should go through such polluting stages in development, as we did earlier in this century, then environmental destruction would be certain and human diseases would expand.

Statistics were presented showing that countries with a GDP per capita of around 5000 US dollars experienced the gravest pollution in densely populated areas.

Similarly, it is important that the road to greater prosperity in developing countries evade the stages of development in which our populations have exposed themselves to too much unhealthy food, tobacco, fats and lack of exercise which so clearly are at the root cause of coronary heart diseases.

**UNEVEN SOCIAL DISTRIBUTION**

The uneven social distribution of heart diseases is equally striking. The most recurrent form of heart disease in many developing countries is rheumatic heart disease. Although it is caused by a group A streptococcal infection, it is also a demonstration of how an etiological agent and environmental factors work together to bring about disease. Its connection with poverty, poor housing and overcrowding, is irrefutable.

This disease can be prevented, in a programme where measures to combat poverty go hand in hand with systematic treatment of upper respiratory tract group A streptococci infections.

Such a successful combination of political action against poverty and active medical intervention is not new, but we constantly need to remind ourselves of how important and effective it can be.

It was more than 100 years ago that a bright leading star, Rudolf von Virchow first pointed out that a simple mechanical explanation of why a disease occurs had to be wrong. Although he was the founder of cellular pathology and recognized bacteria as etiological agents, he concluded that the causes of the really serious epidemics were primarily social.

Up to a few decades ago, coronary heart disease was primarily an affliction of the more well-off classes. However, it did not take long before the richer people adapted their living habits to new scientific knowledge, while a broad majority of the working class began to shift towards a more unhealthy lifestyle.

Today, heart diseases take their main toll in the poorer segments of the society. This is now true for the industrialized countries, and, unless corrective action is taken, will also create increasing concern in developing countries.

Thus, socio-economic and environmental trends will be an important premise for all of you. You are well equipped to meet this challenge. You belong to a professional group who - more than many others - realize that cardiovascular disease can be prevented. The vast majority of cases are not brought about by nature, but by environmental factors - in the widest

sense - including our way of life.

Changes in our way of life will not come about as result of a top down process only. We need to expand knowledge, to make knowledge more equally accessible, and to introduce measures covering a broad field of policy areas. We will have to rely on the gift of information technology for spreading knowledge and for developing those common perspectives and those common attitudes which the problems require.

In order to make far reaching decisions governments depend upon a population that will support even the most difficult decisions. Only then can truly effective change come about.

We must build community purpose, instill social responsibility and assert the larger vision only people can have of a safer, healthier, more future for all.

We need broad-based public health strategies for health promotion activities with special emphasis on prevention and we need to expand and share knowledge and get much more people engaged in the public health issues of our time.

We must establish a proper working relationship between various sectors of our societies and between the various professions and government.

All these are vital components which work together in a preventive programme, and which all will be dealt with here in Oslo, at one conference, under one roof.

**THE POTENTIAL OF PREVENTION**

It is clear that preventive cardiology is also a clinical challenge, and that it includes tracing, treatment and counselling of high-risk persons. These facets illustrate the need for close contact between clinical medicine, the art of health promotion and basic science.

Nevertheless, we will not succeed unless we focus greater attention on the root causes of the problem and make radical changes in the human environment. In the field of pollution control, we refer to "no regret" measures. "No regret"-measures are things that are sensible to do regardless of the yardstick by which their effect is measured.

More than 20 years ago, while the mortality rate from ischemic heart disease was still rising in Norway, our leading epidemiologist Knut Westlund, expressed his views on the possibility of preventing this disease. He said:

> "If we arrive at the conclusion that a disease has increased over a relatively short period, it has to be attributed to a change in the environment, and it must be possible to bring about a decrease again by means which

> are in principle simple. And if a disease virtually did not exist 50 years ago, it must be possible to point out means for its eradication. It is another matter if these means are considered so unpleasant that society prefers to retain the high incidence, and rather to go for detection and attempts to treat sick persons".

Knut Westlund, who said this, was my own professor in our short course medical statistics which I found a fascinating subject, - one of the inspiring reasons for me to go to the Harvard School of Public Health to study epidemiology and preventive medicine shortly after.

His observations are of course supported by solid evidence. However, there are often powerful special interest groups working to promote unhealthy practices and habits. They often have resources which by far surpasses those of institutions dealing with preventive health.

It is deploring example, to say the least, that in 1988, the cost of tobacco advertising in the United States and the European Community were 12 times higher than the total regular budget of the World Health Organization.

**NUTRITION**

As we all know and experience, people do not always choose the optimal diet for good health. Industry also produces products which conflict with the optimal demands and needs of the public.

The predominant pattern in the industrialized countries after World War II is that the health of the best situated classes has improved, and that differences between groups have increased rather than diminished. It is so obvious that we must promote more equal health opportunities in a population and disseminate knowledge about risks and opportunities for adding years to life and life to years.

Not only must we provide education and information about healthy diets, but we must also develop labelling, taxation and policies which enable all segments of society to choose healthy food. Even the well-to-do are exposed to misinformation which prevents them from taking appropriate action in the interest of their health.

North America and Europe were the first regions in modern times where meat and fat intake increased and cereal consumption dropped, thereby laying the foundation for this century's epidemic of atherosclerotic disorders.

These regions also showed us that dietary habits are not as stable as we tend to believe. Today changes are taking place rapidly all over the world. In China the annual per capita consumption of foods of animal origin increased from 26.5 kilograms in 1957 to 47.7 kilograms in 1984.

In China it is realized that economic reforms influence food consumption, and the government has announced that food and nutrition policy will be a major concern in the coming years.

The production of safe, sufficient and healthy food is a national task where conflicts are bound to arise - conflicts in which economic interests too often take precedence over possible health consequences. Scientific research is needed to have a solid base for nutritional political action or population-based campaigns. It is always possible to generate controversy to justify inaction. Doubts and mistrust will quickly be exploited by those who stand to gain. The market is easily lured towards not so heart-friendly habits.

But despite the difficulties, there are indeed also positive trends. In Norway, for example, we eat 5 kilo less of fat each year compared with the situation 20 years ago. In the same period, deaths caused by cardiac infarction went down by 50 per cent among men and 54 per cent among women in the age group 40 - 49 years. In the age group 50 - 59, the reductions were 41 per cent and 26 per cent respectively.

**TOBACCO**

Let me turn to tobacco. The economic interests that exploit human weakness are even more obvious as far as the tobacco industry is concerned. Although the knowledge about the unhealthy effects of tobacco smoking has been available for more than a generation, legislation that can stem the tide of the tobacco epidemic is of relatively recent date. Economic interests have been placed before health concerns, and the problems are "dumped on" clinical medicine.

I am old enough to have grown up <u>before</u> the knowledge was there. But I decided, 10 years old, that I would never smoke - and for two basic reasons: One, - the smell was terrible in our living room when we had visitors, and two, - I was often asked to go down and buy the packets that I personally detested, - so, unknowingly, I was spared - by irritation and intuition - A smell that bad could not be good!

It is now time to acknowledge what a World Health Organization Expert Committee put forward already 15 years ago:

> "The common view of all those seriously concerned is that no worthwhile progress can be achieved unless governments are prepared to put the interests of public health before those of tobacco enterprise."

Most outrageous is the fact that the tobacco industry, to serve its own interests in developing countries, is taking on the role of a benefactor which encourages the growth of tobacco crops, but at the same time advertises a Western lifestyle with cigarettes as the major symbol. It must be a global concern that a scarce resource such as arable land is

used in the production of the single most important known cause of chronic disease.

**PREVENTION IMPLIES POLITICAL ACTION**

No controversy is involved when governments want to increase research and health education activities, nor when they want to establish systematic preventive programmes for high risk groups. These are positive endeavours which are applauded by all political groups and by the people themselves.

Controversies arise when restrictive and legislative measures are proposed and introduced which interfere with people's daily life and intervene with economic interests.

If we are to succeed, if we really care, we must utilize also these tools, which can be so highly effective.

**EXAMPLES OF POLITICAL MEASURES**

We can use price mechanisms in cardiovascular disease prevention, such as subsidies and taxation, to increase the intake of non-atherogenic food and to reduce tobacco consumption.

A few weeks ago, the Norwegian Government presented a white paper on "Challenges in health promotion and primary prevention". Nutrition and health was one of the major topics. In addition to surveillance and educational measures, we regard price policies to be an important element in the future action for healthy food habits in Norway.

We can and should put an end to all sales promotion of tobacco. It should not be too much to ask governments to abolish such marketing activities altogether.

Eighteen years ago, Norway introduced a total ban on tobacco advertising. It was a hard political fight.

We adopted legislation introducing smoke-free environments in public places and work premises in 1988. Also that was a hard fight. This kind of political effort is absolutely necessary, in this area as in others.

We have preserve large areas of untouched nature, secured public access to recreational areas and stimulated exercise, such as walking, skiing, jogging and other leisure time pursuits - together with family and friends. More physical activity in our spare time could help us to enjoy life more, to experience that a healthy lifestyle brings quality of life, adds life to years and years to life.

I am certain that this Conference will provide us with new knowledge, inspiration and courage to continue our struggle against cardiovascular diseases and their consequences.

I hereby take great pleasure in declaring this Conference for opened.