Remarks by Dr. Gro Harlem Brundtland

Dinner preceding the 4th Annual Peter M. Wege Lecture
October 28, 2004 – 8:00 pm
Michigan League – Koessler Room
The University of Michigan

This year, after 40 years, my husband and I have been back for a three-month period, at Harvard University, Kennedy School of Government. Harvard School of Public Health is my alma mater. The revisiting with academic and community life here in the US has been both interesting and inspiring. Coming here to the University of Michigan surely adds new momentum. I am glad to observe that you focus on a broad, interdisciplinary approach. The challenges of sustainable development certainly need it!

My year at Harvard was a major experience in my life.

I was 25 and the youngest in the class. That gave me wonderful opportunities, learning from others, people with experience who had chosen to focus on Public Health. I had fellow students from all over the world.

Last September, the Secretary General of the UN, Kofi Annan, made an urgent call to the nations of the world, in an address to the General Assembly. Having seen the shared vision at the Millennium Summit 3 years ago, a vision of global solidarity and collective security, he reminded delegates that recent events have called that consensus into question. He announced that he would establish a high level panel to analyze the present and future challenges to peace and security, to consider the contribution which collective action can make in addressing them, and to recommend ways of strengthening international collaboration and the United Nations. I am honored to be part of that crucial process, and will focus much of my attention to the challenges of social injustice, disease, lack of development and poverty. We now need to

refocus our attention to the achievement of the Millennium development goals, the common struggle to protect our environment, and the struggle for human rights, democracy and good governance.

Let me share with you some of my own experience, which has led me to concentrate on the links between people and the environment, between health and development, and the crucial observation that there is no common future unless we invest in people, in all people, in their future health and well-being. Without it, there will be no hope of sustainable development, prosperity and peace.

As I go back to my childhood years, I am aware that my international commitment stemmed from early exposure to strong values and beliefs about social justice, about the inherent rights of every individual and about the responsibility we all have to try to make a difference. These values about human dignity, about equality between men and women, about a fair and just society have always in my own mind had an international perspective. They could not only apply to your own neighborhood, your own country, or your own region of the world.

My year at Harvard reconfirmed and deepened my international commitment; I was exposed to different cultures and religions.

My choice of project at the School of Public Health was based on my experience in Norway. I was concerned about the falling rates of breastfeeding in my own country, and I wanted to look at it in a global perspective.

Rates had been falling around the world, leading to increased infant mortality in many developing countries. A perspective that really struck me, that of rich country influence on poorer ones, was clearly exemplified by the falling rates in Puerto Rico. TV advertising from the US that linked baby milk formula with successful mothers and careers was part of a very disturbing picture.

Later, as a young medical officer in the Ministry of Health, the promotion of breastfeeding became one of my issues.

Today Norway is one of the countries with the highest levels of breastfeeding in the world. It took time; it took effort. In Norway, but even more across the world. It was essential that WHO and UNICEF developed the international code of marketing of breast milk substitutes, regulating advertising, and inspiring breast feeding as well as baby friendly hospitals.

As the World Health Assembly in 1981 decided on the code, by a 118 to 1 vote, I was Prime Minister and had closely followed and pushed the developments that took place in Geneva. The one country that voted against argued that the WHO, by protecting the needs and rights of women and infants was interfering in global trade.

I am happy to say that in 2003 that kind of argument in the end did not prevail, over and above the goals of public health in a globalized world. The historic framework convention on tobacco control and the first ever negotiated treaty in the field of health, passed unanimously in the World Health Assembly. A gift to the world, a gift to future generations. A milestone both for Global Health and for Sustainable Development.

At 35, when I had my life turned around, and overnight found myself a member of the Government, and Minister of the Environment, I realized I now had a unique chance to make

much more of a difference. I argued, not only for the environment, but for women's equal rights, paid pregnancy leave and women's role in society. In Norway and globally.

In 1977, I was called at midnight from a wedding dinner and informed that there was a blow-out of a well at the Ekofisk field in the North Sea. As an environment minister, I was less shocked about such an accident than many of my colleagues. I knew the oil drilling in the North Sea was pioneering work. I had been arguing that risks were real and that oil spill equipment must be put in place.

Luckily, after an intense week with little time for sleep and food, the well was capped, and the spill turned out to do less environmental damage than we had feared.

The Ekofisk blow-out was a turning point for the Norwegian people as well as for its politicians. For many, this was the first time they fully realized that environmental questions were not a peripheral issue for conservationists, but a policy area right at the center of the country's economic development. Investment in the environment was an integral part of investment for the nation's future.

As a young environment minister, I realised that you cannot make real changes in society unless the economic dimension of an issue is fully understood. This is what took the environment from being a cause for the convinced and marginal green to becoming an issue for real societal attention by major players. It was necessary for the scientific facts to come in. The true costs of environmental degradation were analysed and spelled out in figures. The political importance of environment changes became an issue for voters. Then, gradually, governments and parliaments started to establish incentives to change behavioural patterns among industry and consumers.

Indeed, with an increasingly strong and robust economic argument, it was possible to make sense both of government investment in the environment, and commercial investment in the development of cleaner technologies. Finance ministers and heads of state were made to understand the developmental consequences of environmental policies. We moved from a situation of market failure to one in which the market was made to serve global interests: sustainable development has gradually come to be seen as a global public good.

Recently, we have been witnessing similar processes with the issues of health.

The moral case has been made for years, and - by and large - has been ignored. Until recently, an overwhelming majority of finance officials and economists believed that health is relatively unimportant both as a development goal and as a strategy for reducing poverty. Health spending was seen as consumption of scarce resources rather than investment in our common future.

For global health, the HIV/AIDS pandemic seems to be eye-opener that the Ekofisk accident was to environmental issues among Norwegians. The debate over the moral, economic, social and security consequences of this catastrophe now unfolding around the world, has forced health onto the agenda in a way we have not seen before.

Historically, disease in other places was seen as an impediment to exploration, and a challenge to winning a war. Cholera and other diseases killed at least three times more soldiers in the Crimean War than the actual conflict. Malaria, measles, mumps, smallpox and typhoid felled

more combatants than did bullets in the American civil war. And the Panama Canal went over-schedule because of “tropical” diseases – then unknown, untreatable and often fatal.

Today on that front, there are very few unknowns. In an interconnected and interdependent world, bacteria and viruses travel almost as fast as email messages and money flows. There are no health sanctuaries. No impregnable walls between the world that is healthy, well fed, and well off, and another world, which is, sick, malnourished and impoverished. Globalization has shrunk distances, broken down old barriers, and linked people together.

Now, there are solutions for those diseases, which plagued the explorers, soldiers and colonialists of historical times. We know how to prevent and treat malaria. There are vaccines for yellow fever. There are treatments for TB. The striking feature is, while we diligently take anti-malarials and top up our vaccinations when we travel to developing countries - the people living there, those threatened most by these diseases - don’t have this access. 3,000 children in Africa die each day from malaria. They die of vaccine preventable diseases – like measles, by the hundreds of thousands. And, people are dying, by the millions every year, of HIV/AIDS.

They are mothers and fathers, teachers, and nurses and other health professionals, civil servants, miners, and soldiers. They are leaving a huge social and professional gap – an imminent threat to countries struggling to develop. They are leaving orphans, penniless grandmothers caring for their children’s children, family members and communities frightened, hurt, stigmatized. Health systems stretched well beyond their often-frail capacities. We will see the effects of this unfolding tragedy for decades to come.

The short, sharp impact of conflict more quickly brings to light the inevitable links between health and security. The obvious – the war wounded, soldiers and civilians. The medium-term impacts– people uprooted, displaced to camps with little sanitation or health services, schools disrupted, and food insecurity.

And last year, the shortest, sharpest shock of all – an outbreak which captured imaginations, often more column inches than the war in Iraq, and always more headlines than Aids, TB or malaria. Severe Acute Respiratory Syndrome put the world on high alert, and drove unprecedented cooperation to stop a disease, which had an immediate and negative impact on markets, on tourism, on trade. And, on hospitals, even in the most well developed countries with the most advanced health systems.

One person infected, staying at an international hotel, put the world at risk. And unlike other diseases which we can prevent or treat, SARS was undiagnosable, untreatable, and, for one of every six people, fatal.

The way the world responded to SARS was global public health at its best. Scientists put aside their differences and drives to be the first, and came together, to share sequencing and study results. Doctors from around the world came together in virtual conferences, to share advice on how best to treat patients. Public health authorities from opposite sides of the globe flew to Geneva, to share their experiences with SARS, their success and failures with 192 member states at the World Health Assembly. And as a result, in just four short months, we had identified a new disease and contained a global outbreak, which could have become a global catastrophe.

The short sharp shock made us all stand up and pay attention. Due to the speed of science and using the best evidence, we quickly knew that SARS could infect, anyone, anywhere.

Governments were committed. Resources made available. People made aware. Health workers given tools for action. Information shared across borders. In short, there was global mobilization to fight a global threat. The result – we probably won't find ourselves 10 years down the road with SARS also endemic in the countries, which can least afford it – devastating lives and economies. Because we acted.

In today's connected societies, there was no choice. It was impossible to hide SARS in a world with the Internet and email. Impossible to pretend it didn't exist, or that it was already contained. The consequences of doing so were mistrust in government, and in economies

A world where a billion people are deprived, insecure and vulnerable is an unsafe world. The separation between domestic and international health problems is losing its usefulness as people and goods travel across continents. More than two million people cross international borders every single day, about a tenth of humanity each year. And of these, more than a million people travel from developing to industrialized countries each week.

We also know that, in poor countries where people feel powerless, and watch as much of the world gets richer, they can bundle hatred and channel it in the most devastating ways. The giant construction site where the World Trade Center used to be will always remind us of a world of conflict, a world divided. It exposes a new awareness of our vulnerability.

Improving people's lives makes the bottom line. The way that we as an international community, work to address current crisis and prevent future ones, will determine whether we succeed or fail in our shared effort to advance global development, security and peace.

Our global interdependence, and our need to reach out across cultures and borders, really should be a main focus when the world's richest nation decides on its own future, and to a great degree on the future of the world.

Thank you.