

EDITORIALS



Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health

The United Nations General Assembly in September 2021 will bring countries together at a critical time for marshalling collective action to tackle the global environmental crisis. They will meet again at the biodiversity summit in Kunming, China, and at the climate conference (COP26) in Glasgow, United Kingdom. Ahead of these pivotal meetings, we — the editors of health journals worldwide — call for urgent action to keep average global temperature increases below 1.5° C, halt the destruction of nature, and protect health.

Health is already being harmed by global temperature increases and the destruction of the natural world, a state of affairs health professionals have been bringing attention to for decades.¹ The science is unequivocal: a global increase of 1.5° C above the pre-industrial average and the continued loss of biodiversity risk catastrophic harm to health that will be impossible to reverse.^{2,3} Despite the world's necessary preoccupation with Covid-19, we cannot wait for the pandemic to pass to rapidly reduce emissions.

Reflecting the severity of the moment, this editorial appears in health journals across the world. We are united in recognizing that only fundamental and equitable changes to societies will reverse our current trajectory.

The risks to health of increases above 1.5° C are now well established.² Indeed, no temperature rise is “safe.” In the past 20 years, heat-related mortality among people over 65 years of age has increased by more than 50%.⁴ Higher temperatures have brought increased dehydration and renal function loss, dermatological malignancies, tropical infections, adverse mental health outcomes, pregnancy complications, allergies, and cardiovascular and pulmonary morbidity and mortality.^{5,6} Harms disproportionately affect the most vulnerable, including children, older popu-

lations, ethnic minorities, poorer communities, and those with underlying health problems.^{2,4}

Global heating is also contributing to the decline in global yield potential for major crops, which has fallen by 1.8 to 5.6% since 1981; this decline, together with the effects of extreme weather and soil depletion, is hampering efforts to reduce undernutrition.⁴ Thriving ecosystems are essential to human health, and the widespread destruction of nature, including habitats and species, is eroding water and food security and increasing the chance of pandemics.^{3,7,8}

The consequences of the environmental crisis fall disproportionately on those countries and communities that have contributed least to the problem and are least able to mitigate the harms. Yet no country, no matter how wealthy, can shield itself from these impacts. Allowing the consequences to fall disproportionately on the most vulnerable will breed more conflict, food insecurity, forced displacement, and zoonotic disease — with severe implications for all countries and communities. As with the Covid-19 pandemic, we are globally as strong as our weakest member.

Rises above 1.5° C increase the chance of reaching tipping points in natural systems that could lock the world into an acutely unstable state. This would critically impair our ability to mitigate harms and to prevent catastrophic, runaway environmental change.^{9,10}

GLOBAL TARGETS ARE NOT ENOUGH

Encouragingly, many governments, financial institutions, and businesses are setting targets to reach net-zero emissions, including targets for 2030. The cost of renewable energy is dropping rapidly. Many countries are aiming to protect at least 30% of the world's land and oceans by 2030.¹¹

These promises are not enough. Targets are easy to set and hard to achieve. They are yet to be matched with credible short- and longer-term plans to accelerate cleaner technologies and transform societies. Emissions reduction plans do not adequately incorporate health considerations.¹² Concern is growing that temperature rises above 1.5° C are beginning to be seen as inevitable, or even acceptable, to powerful members of the global community.¹³ Relatedly, current strategies for reducing emissions to net zero by the middle of the century implausibly assume that the world will acquire great capabilities to remove greenhouse gases from the atmosphere.^{14,15}

This insufficient action means that temperature increases are likely to be well in excess of 2° C,¹⁶ a catastrophic outcome for health and environmental stability. Critically, the destruction of nature does not have parity of esteem with the climate element of the crisis, and every single global target to restore biodiversity loss by 2020 was missed.¹⁷ This is an overall environmental crisis.¹⁸

Health professionals are united with environmental scientists, businesses, and many others in rejecting that this outcome is inevitable. More can and must be done now — in Glasgow and Kunming — and in the immediate years that follow. We join health professionals worldwide who have already supported calls for rapid action.^{1,19}

Equity must be at the center of the global response. Contributing a fair share to the global effort means that reduction commitments must account for the cumulative, historical contribution each country has made to emissions, as well as its current emissions and capacity to respond. Wealthier countries will have to cut emissions more quickly, making reductions by 2030 beyond those currently proposed^{20,21} and reaching net-zero emissions before 2050. Similar targets and emergency action are needed for biodiversity loss and the wider destruction of the natural world.

To achieve these targets, governments must make fundamental changes to how our societies and economies are organized and how we live. The current strategy of encouraging markets to swap dirty for cleaner technologies is not enough. Governments must intervene to support the redesign of transport systems, cities, production and distribution of food, markets for financial investments, health systems, and much more. Global coordination is needed to ensure that the rush for cleaner technologies does not come at

the cost of more environmental destruction and human exploitation.

Many governments met the threat of the Covid-19 pandemic with unprecedented funding. The environmental crisis demands a similar emergency response. Huge investment will be needed, beyond what is being considered or delivered anywhere in the world. But such investments will produce huge positive health and economic outcomes. These include high-quality jobs, reduced air pollution, increased physical activity, and improved housing and diet. Better air quality alone would realize health benefits that easily offset the global costs of emissions reductions.²²

These measures will also improve the social and economic determinants of health, the poor state of which may have made populations more vulnerable to the Covid-19 pandemic.²³ But the changes cannot be achieved through a return to damaging austerity policies or the continuation of the large inequalities of wealth and power within and between countries.

COOPERATION HINGES ON WEALTHY
NATIONS DOING MORE

In particular, countries that have disproportionately created the environmental crisis must do more to support low- and middle-income countries to build cleaner, healthier, and more resilient societies. High-income countries must meet and go beyond their outstanding commitment to provide \$100 billion a year, making up for any shortfall in 2020 and increasing contributions to and beyond 2025. Funding must be equally split between mitigation and adaptation, including improving the resilience of health systems.

Financing should be through grants rather than loans, building local capabilities and truly empowering communities, and should come alongside forgiving large debts, which constrain the agency of so many low-income countries. Additional funding must be marshalled to compensate for inevitable loss and damage caused by the consequences of the environmental crisis.

As health professionals, we must do all we can to aid the transition to a sustainable, fairer, resilient, and healthier world. Alongside acting to reduce the harm from the environmental crisis, we should proactively contribute to global prevention of further damage and to action on the root causes of the crisis. We must hold global leaders to account and continue to educate others

about the health risks of the crisis. We must join in the work to achieve environmentally sustainable health systems before 2040, recognizing that this will mean changing clinical practice. Health institutions have already divested more than \$42 billion of assets from fossil fuels; others should join them.⁴

The greatest threat to global public health is the continued failure of world leaders to keep the global temperature rise below 1.5° C and to restore nature. Urgent, society-wide changes must be made and will lead to a fairer and healthier world. We, as editors of health journals, call for governments and other leaders to act, marking 2021 as the year that the world finally changes course.

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Disclosure forms provided by the authors are available with the full text of this editorial at NEJM.org.

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Can Salt Substitution Save At-Risk Persons from Stroke?

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For decades, opinions about the degree to which sodium intake affects the blood pressure level and the risk of adverse effects such as stroke have been varied, even partisan.¹ Much relevant data have shown an association between high dietary sodium intake — and also low dietary potassium intake — and increased blood pressure levels, as well as higher risks of cardiovascular disease, stroke, and death.² In addition, multiple studies have reported that reducing dietary sodium intake while increasing potassium intake lowers blood pressure levels and decreases morbidity. Although many debate the extent of these effects,³ there is no doubt that salt intake in most parts of the world generally exceeds that needed for homeostasis.

Sodium intake in the form of sodium chloride does not affect everyone similarly.^{3,4} Most normotensive persons have a minimal change in mean arterial pressure when they ingest a high-salt diet, whereas many persons with elevated blood pressure have a measurable increase in the blood pressure, by approximately 4 mm Hg according to one study.⁵ Furthermore, persons with hypertension who are categorized as “salt sensitive” may respond to high salt intake with an increase in the blood pressure of 10 mm Hg or more.⁵ How such blood-pressure responses relate to the renal handling of salt and water and the responsiveness of the renin–angiotensin–aldosterone system is key. Recent data indicate that the availability of sodium in the body varies, because much is stored in bone and in the interstitium.⁶ However, identifying salt-sensitive persons is beyond clinical care in “real life” for large populations, and effecting major dietary change is difficult.

An appealing way to change both sodium and potassium intake concomitantly may be through the use of so-called salt substitutes, which are available as single products in which potassium chloride is substituted for a proportion of pure sodium chloride.^{7,8} Although a smaller, individually randomized trial of several months’ duration in India showed that a salt substitute could be effective,⁸ very-large-scale randomized trials that examine the effect of salt substitutes in at-risk persons at home in their communities have been elusive. The Salt Substitute and Stroke Study (SSaSS), the results of which are now reported in the *Journal*,⁹ may have provided some answers. The SSaSS, a trial involving 20,995 persons from 600 villages in rural China, aimed “to define the overall balance of benefits and risks of salt substitute as compared with regular salt on stroke, cardiovascular events, death, and clinical hyperkalemia.” The trial compared the effect of regular salt (100% sodium chloride) with a salt substitute (75% sodium chloride and 25% potassium chloride by mass) in a high-risk population with respect to hard outcomes of stroke, cardiovascular disease, and death. Vital status was purportedly determined for all the participants.

The participants in the SSaSS were at high risk — 72.6% had a history of stroke, the mean age was 65.4 years, and 88.4% reported having received a diagnosis of hypertension. In a cluster-randomization design, the villages were randomly assigned in a 1:1 ratio to the intervention group, in which the participants used the salt substitute, or to the control group, in which the participants continued to use regular salt. The primary trial outcome was stroke, and the secondary outcomes were major adverse cardiovas-