Action on noncommunicable diseases: balancing priorities for prevention and care

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After long being neglected, the global problem of noncommunicable diseases (NCDs) has received increasing attention, culminating in a United Nations high-level meeting on NCDs in New York in September 2011.[1] The growing global NCD crisis is now killing 36 million people each year and needs urgent and comprehensive action.[2] Attention is mainly focused on cardiovascular disease, diabetes, cancers and chronic respiratory diseases, but debate remains about the relative importance of prevention and care.

One of the lessons learnt from pioneering United Nations summits on HIV held in 2006 and in June this year is the importance of agreeing on priority actions for both prevention and care.[3] A focus on prevention alone disregards the needs of current and future patients, and may diminish the impact of prevention policies as people are reluctant to test for a disease for which there is no prospect of effective treatment. A balance must be found between the upstream, multisectoral policies for NCD prevention for the benefit of future generations, and the downstream, health-sector interventions for ensuring that people currently with NCDs obtain quality care. Where does the balance stand at present?

The focus of discussions on priority actions within the health sector has so far mainly been on the multisectoral policies for prevention of NCDs – policies that lie beyond the health sector and mainly require government action, such as tobacco and alcohol control, ensuring environmental safety, and promotion of agricultural and food industry reforms.[4,5] While necessary to reduce the future disease burden, prevention interventions will do little for the growing number of people who have already developed NCDs, and who are essentially being used to justify investments that will come too late to help them. As the global community gears up towards actions and investments aimed at limiting the number of future NCD patients, an important and unique responsibility for health advocates is to ensure that people with NCDs receive quality care today.

The inverse care law applies to the global problem of NCDs: with 80% of NCD deaths occurring in low- and middle-income countries, those most in need of care have least access. Health systems in developing countries have often been oriented towards tackling communicable disease and the approach to NCDs there is often unstructured, lacks systematic follow-up and monitoring of chronic clinical care, and provides little information about morbidity or mortality, a crucial element for effective health planning.[6]

Investing in improved primary care – the main entry point to health services for most people in resource-limited settings – has the potential to overcome some of these problems.[7] The crucial role of primary care in the global response to NCDs was highlighted by the Director-General of the World Health Organization, Margaret Chan, in her recent closing speech at the World Health Assembly in May 2011: "We need population-wide preventive measures for NCDs, developed with other sectors, but we also need to help individual people. We need to detect early, treat, manage complications and often provide prolonged or even life-long care. It is my strong view that primary health care is truly the only efficient and effective way to do so."[8]

Primary care has played a successful role in developing countries in delivering interventions for communicable diseases such as HIV, tuberculosis and malaria. Building on this success, a primary-care strategy has been proposed for NCDs with three key elements: (i) identifying and addressing modifiable risk factors; (ii) screening for common NCDs; and (iii) diagnosis, treatment, follow-up and, when necessary, referral of patients with common NCDs using standard protocols.[9] The strategy provides a structured, programmatic approach integrated into existing health services and has the potential to deliver quality primary care for people with NCDs. Given the enduring crisis in human resources, task shifting, community engagement and the enrolment of expert patients are all likely to be critical – a lesson learnt from the HIV experience.[10] Research is needed to validate the package of diagnostic and therapeutic tools required for quality primary care and to adapt models of delivery to particular settings and epidemiological situations. Finally, an essential lesson from the scale-up of HIV treatment is that a concerted international effort is required to bring down the cost of essential diagnostics and drugs, since many essential drugs for NCDs are unaffordable and consequently unavailable in many resource-limited settings.[11]

Especially in the current climate of economic crisis, hard-headed policymakers and decision-makers need effective persuasion when deciding on resource allocation. In articulating the arguments for investment in disease prevention and management, the case has to be made in terms of promoting health as a human right and as a means of contributing to poverty reduction and economic stability. The economic case was made successfully in the past for tuberculosis[12] and more recently for HIV,[13] and now needs to be developed for investment in a two-pronged approach to the global problem of NCDs: the upstream multisectoral actions for prevention, and the complementary downstream health sector actions for care. The United Nations high-level meeting must balance the priorities for multisectoral and health sector actions so that it will be recorded as a turning point for NCDs. ■

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