Wonca's NCD submission to UN :Too narrow a focus can obstruct our vision

This document is shortened - for a complete referenced version of this document please contact the Wonca Secretariat.

Cancer, cardiovascular disease, chronic respiratory disease, and diabetes are the focus of the NCD Summit. While not the only NCD, these four diseases dominate mortality due to NCD, share several important risk factors, and have an increasingly adverse impact on human health. These four chronic conditions reflect the complex interplay of numerous genetic, biological, behavioural, social, economic, and political factors. Prevention and control of these NCD will require an ecological approach that accounts for as many factors as possible.

Objective 1: Specific contribution of Civil Society in NCD prevention and control.

The protean nature and enormity of NCD make it essential that all levels of society participate in their prevention and control. Civil Society can provide leadership and activists, stimulate research, influence clinical services, raise funds, and educate professionals, patients, and the public. All of these important tasks can enhance the capacity of governments and others to better succeed in a shared effort to prevent and control NCD.

Objective 2: Lessons learned from previous efforts.

Other complex health issues, such as HIV-AIDS, malaria, and tobacco control, provide important lessons on how to improve outcomes. Focused programs such as the Global Fund and PEPFAR have prolonged the lives of millions with HIV-AIDS, but without evidence that the overall health of the community was improved and without sufficient consideration of the many other issues that loom large for those with HIV-AIDS, such as depression, stigma, unemployment, and so on. Malaria eradication efforts built on narrow objectives such as mosquito control or medication prophylaxis succeeded for a time, until resistance emerged and broader approaches became necessary using multi-modal and ecological strategies. The most effective tobacco control programs have incorporated multiple interventions at all levels of society, including social marketing campaigns, government policies such as taxation, development of new products and engagement of clinicians to assist tobacco users, etc.

Objective 3: Specific outcomes recommended for the outcomes document.

Best is to focus on outcomes that people experience and care about (eg death, pain, disability, hospitalisation). Thus, mortality, morbidity, and burden of suffering are essential outcomes to be tracked. More challenging however, is deciding on specific measures of morbidity. It is tempting to use biometric measures or intermediate outcomes (eg blood pressure, lipid levels, glycated hemoglobin) as proxies for better or worse disease control. These measures preoccupy health professionals, but are not felt or experienced by people. The value, stability, and appropriateness of specific numerical targets for these measures are not as dependable as we hoped and should be used cautiously. Choosing the wrong number can be dangerous for individuals, confusing for everyone, and diminish the public's trust.

Wonca's recommendations on NCDs

1. Think health, not disease.

Too few resources are devoted to research of and services for disease prevention. Remaining fixated on an illness paradigm makes it difficult to develop effective strategies for prevention.

2. Support primary care and mental/ behavioural health.

Most of the diagnosis and clinical care of the four NCD occur in the primary care setting. There must be sufficient numbers of qualified primary care and mental/ behavioural health professionals who have enough resources before there will be a substantial and enduring improvement in the disease burden of NCD.

3. Think integration, not fragmentation.

Many people with NCD have more than one chronic condition. People do not think of themselves as a collection of diseases in pursuit of a fragmented array of services. They prefer and deserve to be viewed as whole persons with interconnected concerns. The literature shows that people do best when their health care is centreed in a trusting relationship with a primary care clinician who provides the most comprehensive services possible and coordinates other needed services.

4. Support better science.

While most care occurs in primary care, most of the research and clinical guidance on these NCD are drawn from sub-specialty disciplines in academic health centres. Many policy makers think it is simply a matter of translating the expert knowledge from the academic health centre to the primary care setting. It is just the opposite. Much of the science coming out of academic health centres is not accurate or not relevant for those receiving or providing most of the care. If we want more evidence-based practice, then we must have more practice-based evidence. Research should be supported that advances complexity science, develops measures for continuity and comprehensiveness of care, and addresses social determinants of health.

5. Invest resources wisely***.***

The 15 by 2015 campaign urges funders of vertical programs for specific conditions to commit 15% of those funds for clinical care or research to horizontal programs such as primary care services or health services research. The only thing worse than insufficient funding for NCD is funding that is wasted in pursuit of inadequate or unwise strategies.

Complex problems demand comprehensive strategies. The risk of this initiative is not that we will try to do too much, but that we will try to do too little.

Respectfully submitted,

Richard G. Roberts, MD, JD