

Stronger guidance needed on lifelong care for chronic diseases

Badara Samb and colleagues (Nov 20, p 1785)¹ provide a good overview of the prevention and management of chronic diseases and the problems and potential interventions in different components of the health system. However, they fall short of putting forward a package of interventions that countries can take up to strengthen systems and to respond comprehensively to the chronic disease epidemic in the way *The Lancet's* Series on maternal survival boldly put forward the intrapartum care strategy.² Elaboration of a possible service-delivery platform for people who require lifelong care in low-income and middle-income countries is lacking.

Ala Alwan and colleagues³ report that India and the Philippines have developed and operationalised integrated national non-communicable disease (NCD) plans. Yet our experience in these countries suggests otherwise. In our view, the interventions that are on the ground are not only rare, but tend to be efforts to promote a healthy lifestyle or intermittent, episodic curative care plans. The screening, management, and retention of people in lifelong care remain very limited.

Is this lack of guidance a reflection of a paucity of experiences in delivering lifelong care in settings such as ours, which are characterised by a mixed provision of services by the public and private sectors? If so, we might need to look beyond NCDs for potential models.⁴ Yet, there might also be nascent efforts that deserve a second look. Comprehensive primary health-care initiatives in Nepal, China, and Mongolia⁵ include primary prevention efforts, screening, and retention of people with diabetes and hypertension in chronic care. Research efforts need

to focus on these few experiences to draw lessons and general principles for organising care for NCDs, given that health systems in many low-income and middle-income countries are currently not able to provide comprehensive care.

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Health and societal effects of alcohol

It was heartening to read of the forthcoming UN high-level meeting on chronic non-communicable diseases and the excellent strategic analysis by Robert Geneau and colleagues (Nov 13, p 1689),¹ which addressed the links between chronic disease and poverty and the reasons for inaction.

As Geneau and colleagues' Series paper states, alcohol (a fast-growing risk factor in the populous, dispro-

portionately young countries with growing economies) is a contributor to important chronic diseases including cardiovascular disease, cancer, and tuberculosis. It therefore qualifies for attention in this forum because of its contribution to premature mortality, the basis on which Geneau and colleagues suggest that resource allocation should be made. However, alcohol differs somewhat from other risk factors mentioned in the Series in that its contribution to the global burden of disease and injury is, in large part, via its effect on morbidity (injury from violence and motor vehicle crashes, alcohol dependence, and depression). Much of the effect is in young people, and disability-adjusted life-years are equivalent to those of tobacco globally.

Added to these effects are those on productivity in the working population. The societal response goes beyond the health sector to the police and justice systems and this also has an effect on development potential at the societal level. Because of these effects, heavy alcohol use (which makes up a substantial proportion of the alcohol market^{2,3}) makes an important contribution to impaired development and poverty.

There has been inadequate attention at the global level and a corresponding lack of resource applied to remediation.⁴ Those of us engaged in research and advocacy to promote effective alcohol policy, free from commercial interest, look forward to the opportunity to join in the forthcoming debate.

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