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I am an investigator in the ASCOT study.⁵

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MDGs: chronic diseases are not on the agenda

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2005 marks the fifth anniversary of the adoption of the UN's Millennium Declaration, signed by 189 countries and translated into eight Millennium Development Goals (MDGs) to be accomplished by the year 2015. The medical and public-health communities should rejoice that these eight goals include three specifically focused on health. There is a growing recognition worldwide that the time has come to fulfil the long-standing pledge to make health services available for all.¹ The three explicit health goals elaborated in 2000 were: to reduce child mortality by two-thirds relative to 1990; to improve maternal health, including reducing maternal mortality by three-quarters relative to 1990; and to prevent the spread of HIV/AIDS, malaria, and other diseases. But, in 2000, and again during a ten-taskforce review in 2005, cardiovascular disease (CVD) and other chronic diseases are not mentioned. This omission can, and must, be rectified.

Those involved in CVD prevention and control are ready to contribute to poverty reduction in low-income and middle-income countries, a most urgent goal of the Millennium Declaration. We are ready to join in the consultative process required to achieve real progress in health at both population and individual levels. We believe CVD prevention and control is critical to that effort. We want to join the MDG process at international and national levels, as do many colleagues in chronic diseases. More importantly, we have professionals, civil-society organisations, and partner international agencies in these low-income and middle-income countries ready to

commit time and energy. Our help is needed to achieve better health for adults and children alike, and to reduce poverty by the target of 2015.

There are four compelling arguments for including CVD and other chronic diseases in the MDG process. First, the global burden of disease data clearly reveals the predominance of CVD and other chronic diseases in low-income and middle-income countries. Second, cardiovascular disease strikes younger working-age people in these countries at higher rates, clearly affecting economic growth while increasingly threatening children through the combined impacts of tobacco and obesity. Third, health systems cannot be built vertically, disease by disease, but working together on CVD and other chronic diseases, health personnel can add strength to weak systems. Fourth, there are cost-effective policy, programme, and treatment initiatives in CVD and other

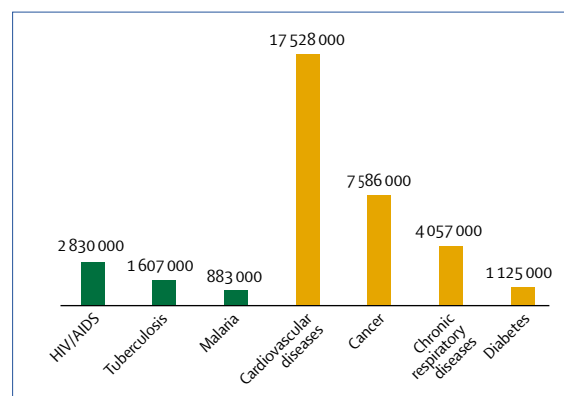


Figure 1: Projected global deaths by cause,⁶ all ages, 2005

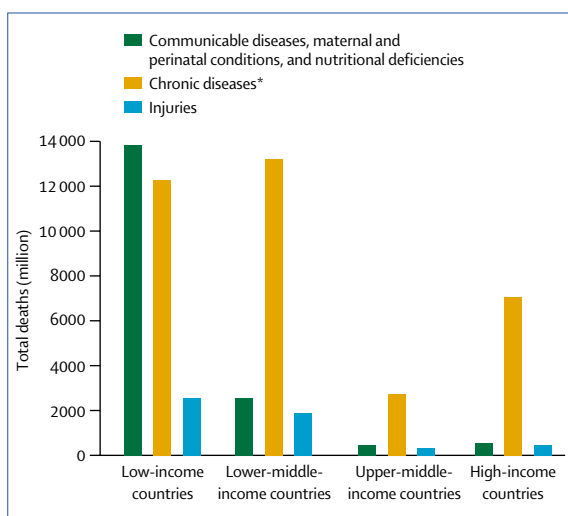


Figure 2: Projected deaths by major cause and World Bank income group,⁶ all ages, 2005

*Chronic diseases include cardiovascular diseases, cancers, chronic respiratory disorders, diabetes, neuropsychiatric and sense-organ disorders, musculoskeletal and oral disorders, digestive diseases, genitourinary diseases, congenital abnormalities, and skin diseases.

chronic diseases that could have a major effect on poverty and general health. The four-part series on chronic diseases that accompanies this Comment provides additional evidence in support of these arguments.²⁻⁵

For the global burden of disease, it is estimated that 35 million people will die in 2005 from heart disease, stroke, cancer, and other chronic disease (figure 1).⁶ Only a fifth of these deaths will be in high-income countries, while 80% will occur in low-income and middle-income countries.² Thus, when the MDGs imply that infectious diseases are the leading cause of death in all low-income and middle-income countries, this is not correct (figure 2). Chronic diseases (heart disease, stroke, cancer, diabetes, and chronic respiratory diseases) are the leading cause of death in every region of the world except for the lowest-income countries, including sub-Saharan Africa, and even there they are on the rise.

The lack of health systems, treatment, and prevention strategies make the probability of death from chronic diseases higher in sub-Saharan African than in established market economies. In South Africa, even with the overwhelming presence of HIV/AIDS as the leading cause of death, CVD ranks third in terms of women's disease burden.⁷

In a message of support to the new WHO report on *Preventing Chronic Diseases: a vital investment*, President Olusegun Obasanjo of Nigeria states: "We cannot afford

to say 'we must tackle the other diseases first—HIV/AIDS, malaria, tuberculosis—then we will deal with chronic disease'. If we wait even 10 years we will find that the problem is even larger and more expensive to address."⁸

Further, the onset of CVD occurs in younger people, increasingly affecting those of working and productive age. In South Africa 41%, and in India 35%, of all CVD deaths occurred in those aged 35–64 years.⁹ To protect the health of future generations, all major negative health effects must be taken into consideration. Chronic disease increasingly threatens young people through the influence of tobacco and obesity. In the Indian component of the Global Youth Tobacco Survey (2000–04), 25% of the students aged 13–15 years reported that they had ever used tobacco, and current use was reported by 17%.⁴ In China, a fifth of children aged 7–17 years in big cities are overweight or obese.⁵

To build sustainable health systems in these countries requires the concerted effort of all concerned with health. It is illogical to think that a health system can be built disease by disease. Health professionals, particularly in primary-care clinics, must be polyvalent. There is a growing consensus that the major bottleneck to achieving the MDGs is health systems that are too fragile and fragmented. Health systems face barriers in the areas of human resources, financing, drugs, and the supply and use of information.¹⁰ Working together in cardiovascular and other chronic diseases, health personnel can only add strength to weak systems.

Finally, there are a range of cost-effective policy, national, and community level programmes and prevention initiatives for CVD and other chronic diseases that can affect poverty and general health. By addressing the risk factors, particularly tobacco consumption, abnormal lipids, hypertension, diabetes, abdominal obesity, psychosocial factors, fruit and vegetable consumption, and regular physical activity that account for an overwhelmingly large (over 90%) proportion of the risk, we can save lives.^{11,12}

Policy actions on tobacco, combined with policy and community actions on diet, physical activity, and health, can be among the most cost effective. Thus, addressing chronic disease can be done concurrently with infectious disease interventions.

Those of us involved in CVD prevention and control want to help alleviate poverty through better health. We want to join the MDG process as do many colleagues in

chronic diseases. The four articles today support that argument.²⁻⁵ Logic dictates that we must all do so.

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We declare that we have no conflict of interest.

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The neglected epidemic of chronic disease

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The reduction of chronic disease is not a Millennium Development Goal (MDG). While the political fashions have embraced some diseases—HIV/AIDS, malaria, and tuberculosis, in particular—many other common conditions remain marginal to the mainstream of global action on health. Chronic diseases are among these neglected conditions.

Chronic diseases represent a huge proportion of human illness. They include cardiovascular disease (30% of projected total worldwide deaths in 2005), cancer (13%), chronic respiratory diseases (7%), and diabetes (2%). Two risk factors underlying these conditions are key to any population-wide strategy of control—tobacco use and obesity. These risks and the diseases they engender are not the exclusive preserve of rich nations. Quite the contrary.¹ Chronic diseases are a larger problem in low-income settings. Research into chronic diseases in resource-poor nations remains embryonic. But what evidence there is^{2,3} shows just how critical it will be to intervene early in the epidemic's course. There is an unusual opportunity before us to act now to prevent the needless deaths of millions. Do we have the insight and resolve to respond?

With a new series of articles,⁴⁻⁷ for which we thank the superb efforts of Robert Beaglehole, *The Lancet* aims to fill a gap in the global dialogue about disease. It is a surprising and important gap, one that health workers

and policymakers can no longer afford to ignore. The call by Kathleen Strong and colleagues⁴ for the world to set a target to reduce deaths from chronic disease by 2% annually—to prevent 36 million deaths by 2015—deserves to be added to the existing eight MDGs.

Without concerted and coordinated political action, the gains achieved in reducing the burden of infectious disease will be washed away as a new wave of preventable illness engulfs those least able to protect themselves. Let this series be part of a new international commitment to deny that outcome.

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