



WORLD HEALTH ORGANIZATION

Chronic Disease in the Developing World

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Introduction and Summary of the Problem

The pervasive view among those in developed countries is that developing countries primarily suffer from infectious diseases – lethal microbes that spread quickly between people under largely unsanitary conditions in the context of poverty. HIV/AIDS, tuberculosis, and malaria are the “big three” diseases that often dominate transnational health policy discussions and the vast majority of global health funding from Western donors is dedicated to addressing these health needs within developing countries. However, despite a burgeoning political consciousness around these three infectious diseases, the aid afforded to developing countries is insufficient to meet health needs for these three diseases, let alone other illnesses. In the midst of a global financial crisis, it has become an increasingly uphill battle to pressure Western governments to disburse more aid to developing countries, creating a contraction in public health budgets around the world.

The United States is one of the largest global health donors in absolute terms, and as President Obama recently proposed to freeze discretionary funding for three years, new challenges confront chronic disease advocates. According to Rachel Nuget, “Chronic diseases were responsible for 50% of the disease burden in 23 high-burden developing countries in 2005 and will cost those countries \$84 billion by 2015 if nothing is done to slow their growth.” Treatment and prevention of chronic disease already was a low priority on the global public health agenda, and with limited funding it will likely hold even less political significance. New strategies and more energized advocacy must take place if the treatment and prevention of chronic disease is to get the attention it deserves.

Focus of the Debate

The debate between those who aim to focus on cheaper, cost-effective prevention efforts and those who are supporters of extending more expensive treatment has been a longstanding split within the field of public health. While preventative measures may decrease mortality and morbidity more widely than treatment, it is more difficult to sympathize with potential future patients compared to patients suffering from chronic disease in the present. Further complicating the debate is the nature of the way most chronic disease spreads. Unlike infectious diseases, which are communicable and can spread to many people if not treated, many chronic conditions like diabetes, heart disease, and cancer are non-communicable, meaning they do not spread through contact from person to person. Non-communicable chronic diseases often develop based on a person’s inherited genes and their lifestyle. Many advocates pressing for treatment for infectious disease have argued that *treatment is also prevention*, because treatment will prevent the further spread of the disease. This premise is not true for chronic disease, since the treatment of one individual will not reduce the incidence of chronic disease.

With the current financial and fiscal crisis among many wealthy donors, advocates for the treatment and prevention of chronic disease must choose a “social strategy” to alter the priority chronic disease is given within health systems. With inspiration from HIV/AIDS, they may argue that we ought to work to lower the price of chronic disease care while spending considerable portions of the budget on chronic

disease treatments. With inspiration from the smallpox campaign, they may decide that prevention is what should be focused on, using arguments of cost-effectiveness to make the most of health care resources. There may also be a third way in the middle of both extremes.

Recent Developments and Questions to Consider

To Treat or Not to Treat: Partners In Health

Partners In Health (PIH) is a non-profit corporation based in Boston, Massachusetts, whose mission is to provide a preferential option for the poor in health care. PIH provides comprehensive, high-quality health care, including treatment for HIV/AIDS and drug-resistant tuberculosis, and chronic disease in mainly rural, underserved settings. Through service delivery, training, research, and advocacy, PIH works globally to bring the benefits of modern science to those in most in need, and to serve as an antidote to despair. PIH currently has programs in Haiti, Peru, Guatemala, Mexico, Russia, Rwanda, Lesotho, Malawi, and Boston.

Having been one of the first organizations to treat HIV/AIDS in developing countries, PIH was integral in the struggle to put the treatment of HIV/AIDS onto the global agenda by proving that it was possible to treat complex medical conditions in resource-poor settings. Since providing free antiretroviral treatment to patients living with HIV/AIDS, PIH has tried to take the quality and comprehensiveness of the care they deliver to a new level – treating chronic, non-communicable diseases.

For instance, in rural Haiti, PIH regularly offers care to patients suffering from malignant forms of cancer. For instance, take a toddler named Evansly, who is suffering from Wilm's tumor, a malignant cancer formed on the kidney. PIH started the boy on chemotherapy in Haiti, an expensive but often effective treatment option and transferred the boy to the Massachusetts General Hospital to receive a complex treatment regimen at no charge to the boy's family, who was very poor. Evansly is now leading a healthy, cancer-free life.

PIH is a rare case among advocates for the increased prominence of chronic disease care in developing countries. Many have decided to push for preventative measures rather than an extension of curative services, which are deemed more "cost-effective" and perhaps have a greater chance of being funded by international donors. Many would argue that it is too costly to transport a Haitian boy to the United States for complex medical treatment and that the money would be better spent on providing cheap preventative medicines to many more people, which could save more lives. Others would argue that everyone deserves access to the fruits of medical and scientific technologies, especially when such technologies are effective at prolonging life. These advocates would question why the cost of treatment is so high and the resources dedicated to treatment so low. The decisions of PIH allow us to examine the divergent priorities of international advocates, and question the extent of our own commitments to improving public health.

Questions for Policymakers

Too often health policies and recommendations are made on the basis of the resources available rather than the scientific evidence of what is efficacious. The questions confronting policymakers are numerous, but key issues to think about involve recommendations that would be given to a developing country aiming to extend health services to its population. Should chronic disease care be included in a basic minimum care package? Ought there to be prevention programs and preventative medicines that should be taken? What is feasible given the current economic situation of many donor

countries?

Conclusion

Chronic disease kills millions upon millions of people every year, with the most number of deaths occurring in developing countries. Sadly, those in most need of care are least likely to be able to afford and access it. The World Health Organization is charged with deciding whether to marshal resources to prevent and treat chronic illness and how to best implement such health programs. This will require taking into account global political context and local complexities that must be addressed to practically achieve greater coverage of the world's poor for chronic disease. It is now up to you to come up with an efficient, realistic, and successful resolution to this pressing global crisis. Good luck!

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