Addressing the gaps in global policy and research for non-communicable diseases

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Non-communicable diseases (NCDs)—including cardiovascular disease, diabetes, asthma and chronic respiratory infections and cancers—are the leading causes of death worldwide. An estimated 36 million people die from such diseases each year, or roughly two out of three deaths globally; 80% of these fatalities occur in low- and middle-income countries. The statistics are stark, yet they hide the human toll of such disease burdens. Think of the attention and resources given to AIDS, TB and malaria over the past 20 years—and the dramatic progress we’ve seen in the fight against these infectious diseases. Yet TB and malaria killed between 1 and 2 million people worldwide in 2010. On World Cancer Day, it’s appropriate to remember that cancers killed 8 million people in 2010—a number one-third higher than in 1990. The picture is similar for other NCDs—one in four deaths globally from heart disease or stroke, 1.3 million deaths from diabetes. This is a global epidemic—at current rates, there will be a 17% increase in the NCD burden over the next decade. But this burden is not evenly distributed: Africa will see a growth of greater than 25%, and the absolute number of deaths will be greatest in the Western Pacific and Southeast Asia regions.³

Millions of these deaths are preventable, both through programs aimed at reducing high-risk behaviors (tobacco use, alcohol abuse, poor diet, lack of physical activity) and environments and also through improved treatment and service delivery for patients who need chronic care. Cost-effective interventions to reduce the burden of these diseases exist now and sustained action can prevent millions of premature deaths. There has been growing awareness in the global health community of NCDs as primary threats to individuals, communities, health-


system infrastructures and economic development. It is now acknowledged that NCDs contribute greatly to rising health care costs and the loss of economic productivity.

A range of programs and interventions has been considered and some innovative efforts are underway, but positive outcomes have often been difficult to secure because of global inequities in healthcare access, the globalization of risk factors—many of which originate outside the health sector—and the costs of implementing interventions. In low- and middle-income countries, where the disease burden is transitioning from communicable to non-communicable diseases, many populations are currently suffering a double burden. This conclusion was made clear in the recently published results of the Global Burden of Disease Study 2010 in *The Lancet* last December.\(^4\)

A global movement for action on NCDs has been gathering momentum in recent years. The UN General Assembly passed a resolution on the prevention and control of NCDs in 2010. The NCD Alliance, a coalition of civil society organizations now led by Cary Adams of UICC, was created that fall. A year later, in September 2011, the UN convened a High-Level Meeting that led to the adoption of a political declaration that laid out a clear plan for global surveillance, monitoring and health-system response to prevent and control NCDs. In May 2012, the WHO’s 65th World Health Assembly set the first voluntary global targets for a 25% reduction in premature mortality from NCDs by 2025. These were confirmed just last month by the WHO Executive Board and will be debated at the World Health Assembly in May.

There are clear roles for the private sector as well as the public sector and civil society to work together in answering this call to action. Yet given the global fiscal crisis of recent years, it is unrealistic to expect large pools of new resources from traditional donors. Policy makers need to decide how best to incorporate NCD responses into existing funding streams and programs. We need recommendations for action that are sustainable in the current political and economic landscape.

This was the context in which the Johns Hopkins Institute for Applied Economics, Global Health and the Study of Business Enterprise convened an NCD Working Group of leading scholars to analyze gaps in NCD research, policy and practice, to make actionable recommendations to close the gaps. The members of the NCD Working Group are: Sir George Alleyne (former director, PAHO), Robert Black (Bloomberg School of Public Health, Johns Hopkins University), Felicia Knaul (Harvard Global Equity Initiative), Margaret Kruk ( Mailman School of Public Health, Columbia University), Louis Galambos (Johns Hopkins University), Richard Laing (WHO), Soeren Mattke (RAND Corporation), Sania Nishtar (Heartfile Pakistan), Tom Quinn (Center for Global Health, Johns Hopkins University), Kenji Shibuya (Tokyo

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Building on the 2011 RAND Report on “Improving access to medicines for non-communicable diseases in the developing world,” they have focused on five areas where health systems need strengthening to address gaps in the provision of NCD care and treatment: structuring supply chains, accelerating regulatory harmonization, improving access to interventions, restructuring primary care, and promoting multisectoral action.⁵

The next speakers, Sir George Alleyne and Professor Margaret Kruk, will outline their findings and recommendations on multisectoral action and reconfiguring primary care, respectively. Let me briefly sketch the recommendations from the other papers.

Prashant Yadav and Lisa Smith of the University of Michigan conclude that to improve access to NCD medicines, we need to understand the structural obstacles in medicine supply chains and to rethink access from the manufacturer through to the patient. This will require detailed study of global and national supply chains to address fragmentation of supply, which leads to poor economies of scale, poor coverage and challenges in tracing products. Other potential solutions include establishing accredited healthcare retail networks to ensure availability of quality medicines at affordable prices and to encourage appropriate use, as well as wider use of differential pricing. Yadav and Smith suggest testing these ideas in a targeted way, with initiatives to address diseases with the highest burden in selected resource-limited settings.

Brian White-Guay (University of Montreal) reviews current challenges and future prospects for the global regulatory framework. There has been considerable work on regulatory harmonization for medicines in recent years, but the whole has yet to add up to more than the sum of the parts. Dr. White-Guay recommends developing a common end-stage vision for regulatory convergence, then defining the most urgent priorities to improve access to quality essential medicines and adopting clear indicators of results to measure progress. Opportunities include training and capacity-building efforts for national medicines regulatory authorities; exploration of regional harmonization programs (to bring new administrative procedures that can reduce inefficiency and waste); and the establishment of a network of quality control laboratories to limit the circulation of substandard or counterfeit medicines. Finally, more widespread deployment of IT solutions can facilitate communications and knowledge transfer among NMRAs and SRAs in such areas as manufacturing licenses, import authorizations and GMP certification.

In his paper, Soeren Mattke (RAND) addresses lessons learned from the response to the HIV epidemic in assessing how to improve the use of NCD interventions. He focuses on the

importance of public/private partnerships to leverage industry capabilities in support of improved NCD prevention, treatment and care at the local level. Pharmaceutical and other healthcare companies can help to improve care delivery systems, research on ways to improve adherence to treatment (which will improve long-term patient outcomes), and the development of sustainable business models to improve access to medicines. Specific solutions include helping LMICs to develop context-appropriate treatment guidelines, training materials for healthcare providers and patient education tools. Industry can also deploy its R&D expertise in the search for new medicines (such as polypills) to provide better solutions for NCD treatment in resource-limited settings, as well as experimenting with community-based approaches to improve care and treatment outcomes.

The policy briefs we are here to discuss today distill the findings of Working Group members from a series of research papers that will be published in coming months. The policy papers and briefs emphasize how industry can bring its expertise to bear on preventing and controlling NCDs in developing countries and emerging markets. Together they develop a pragmatic agenda for reducing the burden of NCDs and provide an initial roadmap for policy development and progress in the fight against these chronic conditions.  

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