Misplaced priorities

Paul Malik MD FRCPC

How selfish soever man may be supposed, there are evidently some principles in his nature, which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it.

Adam Smith from *Theory of Moral Sentiments* (1759)

Practitioners of cardiovascular medicine are constantly dealing with chronic diseases: atherosclerosis, hypertension, diabetes mellitus and heart failure, to name but a few. We consider these diseases of affluence or excess. It follows, then, that the role of the physicians who take care of these conditions is largely restricted to developed nations. By contrast, countries with low income are afflicted more so by diseases of poverty, including famine and infectious diseases. While this is the prevailing view among many western physicians, nothing could be further from the truth. Chronic disease is nondiscriminatory and respects no geographic borders.

In countries with low income, communicable diseases such as tuberculosis, HIV and malaria account for 12% of deaths, whereas cardiovascular disease accounts for 27%. However, the World Health Organization spends \$7.50/person/death for a communicable disease, but only \$0.50/person/death for a chronic disease. What accounts for this apparently misplaced priority? Fundraising by international aid agencies through sympathy is one reason, because in addition to opening wallets, it shapes public perception. A child from a developing nation with AIDS is a much more powerful image than a man with diabetes. History also plays a role. In the early 20th century, infectious diseases were a major cause of death in the western world, but these were successfully controlled through immunization, sanitation and antibiotics. Such unparalleled success makes it an attractive option for policy makers. Indeed, the curability of infectious diseases is in direct contrast to the ongoing treatment and control that chronic conditions require over many years, which makes it a more palatable option for limited aid dollars. There is a certain self-interest in controlling communicable diseases in developing nations. Limiting the spread of avian influenza and preventing the next influenza pandemic are major goals of western countries because of porous geographic borders and widespread immigration.

Targeting chronic disease in developing countries will require more than just treatments directed against the disease itself, but will involve tracking and treating established risk

factors. Obesity and diabetes are two potent examples. The past 20 years have seen a threefold increase in obesity rates in the developing world, largely due to physical inactivity and overconsumption of foods that are dense in energy (1). Another alarming statistic is the projected increase in diabetes rates. By 2030, Latin America and the Caribbean are projected to see a 148% increase in diabetes, with an overall prevalence of 33 million cases. Sub-Saharan Africa will see a 162% increase, to 18.6 million cases, and southeast Asia will see a 161% increase, to 58.1 million cases (2). Smoking is another notorious example. It is estimated that by 2030, 10 million people will die per year due to smoking-related causes. The vast majority of these – 70% – are expected to occur in developing countries. So there is a tendency to blame developing countries for diseases resulting from these apparently ‘modifiable’ risk factors, because they appear to be self-inflicted. Behaviours that lead to poor health are expressions of the freedom of choice, and it is hardly fair to hold western countries accountable for their effects. A moral dilemma occurs, however, when one considers that most smokers in developing countries are unaware of the risks. For example, according to the World Bank, 70% of smokers in China in 1997 believed that smoking did them “little or no harm”. Furthermore, with little regulation of advertising, marketing is directed toward children and adolescents, thus breeding a culture of addiction by the time they reach adulthood. Indeed, freedom of choice cannot be seen as informed choice, and it becomes difficult to blame individuals for such behaviours.

Perhaps it is the indolent nature of chronic disease that breeds complacency. A quick but painful and graphic death from untreated tuberculosis garners much more attention than poor glycemic control. Despite numerous obstacles, there are multiple cost-effective strategies to controlling chronic disease. These include tax increases on tobacco products, educating local caregivers and even harnessing international generic pharmaceutical manufacturers. However, before any of these can be implemented, the problem of chronic disease in low-income countries must be recognized.

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2. Wild S, Roglic G, Green A, Sicree R, King H. Global prevalence of diabetes: Estimates for the year 2000 and projections for 2030. *Diabetes Care* 2004;27:1047-53.

Selected sites

1. New England Journal of Medicine
<<http://content.nejm.org/cgi/content/full/356/3/209>>
2. World Health Organization
<www.who.int/chp/chronic_disease_report/en>
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3. Health Politics
<www.healthpolitics.org/archives.asp?previous=prog_55>
4. The World Bank Group
<www1.worldbank.org/tobacco/tcdc.asp>
<www1.worldbank.org/tobacco/tcdc/fact_sheets/FastFacts&Myths.pdf>

Staff Interventional Cardiologist, Queen's University, Kingston, Ontario

For comments or to suggest a Web site for discussion in a future column, write to pgmalik@hotmail.com