

Our focus is AIDS. But the real global crisis is heart disease.

by David J. Heller, WP Outlook Section, p.B3, March 20, 2016

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In 2015, the United States spent \$7.5 billion, more than three-quarters of its global health budget, to fight AIDS, tuberculosis and malaria. These, after all, are the “big three” infectious diseases, and they’ve ravaged developing-world populations. AIDS has killed more than 25 million people worldwide since 2000; in 2015, there were 214 million cases of malaria and almost 10 million tuberculosis diagnoses.

But thanks to an unlikely coalition — including George W. Bush, Bill Gates and Bono — the tide is turning. AIDS deaths peaked at 2 million in 2004 and have dropped 42 percent worldwide since. Deaths from malaria have declined by nearly half since 2000; the malaria death rate for children under 5 has decreased by more than two-thirds. Tuberculosis deaths have also declined by half since 1990. In short, the battle against these diseases is slowly being won.

Unfortunately, our laser focus on them has blinded us to the next big public health crisis. Increasingly, what kills people in Africa, Asia and South America is the same set of non-communicable diseases that beset our loved ones in the United States: **heart attacks, strokes, cancer, diabetes and obstructive lung diseases such as emphysema.**

None of these conditions are directly contagious, but they are spreading across the developing world just as quickly as AIDS and malaria did a generation ago. Right now, heart disease kills more people in poor countries than AIDS, malaria and tuberculosis combined. So does cancer. By 2020, experts say, chronic conditions will cause 7 out of every 10 deaths, up from 56 percent in 2000. And at least 40 percent of these deaths could be avoided with better medical care, including more frequent physicals, education campaigns and simple interventions.

Those are hard to provide. Health systems in developing regions are understaffed, underfunded and ill-structured to respond to this emerging threat. In much of the developing world, there are fewer than 10 physicians per 10,000 people, compared with 24 in the United States. (In some very poor countries, such as Liberia, there is only one doctor per every 100,000 residents.) The U.S. government spends about \$4,500 per person on health care annually; in the 100 poorest countries it’s less — in many cases, much less — than \$250.

Addressing these barriers will require financial support and creativity. But internationally, the funding has not caught up to the crisis. In part, that’s because curing these ailments lacks the urgency, glamour and political clout of saving people from an outbreak. It’s also harder to measure outcomes (essential for nonprofits looking to secure grant money).

This won’t do. The World Health Organization describes the non-communicable disease epidemic as a “disaster for health, for society and most of all for national economies,” causing billions of dollars in national income loss and pushing millions of people below the poverty line. We need to start paying attention.

In some ways, the rise of non-communicable diseases is an inevitable side effect of development. As countries advance, consumption of fatty foods increases and the rate of obesity goes up. Exercise declines. And more people live in cities, where they face carcinogenic pollution and cigarettes.

Fortunately, there are proven, cost-effective ways for the United States and the global development community to respond. And we don’t have to reinvent the wheel; we can leverage the infrastructure we’ve already put in place to take on diseases such as AIDS and malaria.

For example, over the past two decades, HIV treatment centers have sprung up across Africa, Asia and Latin America. Treating and preventing HIV at those clinics involves educating communities about healthy lifestyles, testing seemingly healthy people for a silent killer, offering medications to control a chronic condition and using blood tests to measure progress. This playbook is essentially identical to the way to fight high blood pressure, diabetes and other non-communicable diseases.

And it doesn't need to involve many physicians or even nurses — HIV clinics have used community health workers, often local volunteers who get on-the-job training, to perform many of these tasks. The Comprehensive Rural Health Project in India, for example, achieved health gains few thought possible by employing and training village women. Often illiterate and of low caste, they were initially shunned by their peers but eventually gained unprecedented access to vulnerable women, increasing rates of contraception use from less than 1 percent to more than half over 30 years.

We can do the same for non-communicable diseases. Health-care workers can be given simple tools to screen for ailments such as high blood pressure. They can assess patients' disease risks by taking their medical histories. And they can be trained to educate community members about preventive measures, such as eating well, exercising daily and cutting back on smoking.

In Uganda on a year-long NIH fellowship, I worked on SEARCH, an ambitious trial aiming to prove that we can halt the spread of HIV in Africa with universal screening and treatment. The SEARCH team worked with local leaders in 32 communities across Uganda and Kenya to test not just for HIV but for hypertension and diabetes as well. Through these campaigns, thousands of new cases of high blood pressure and diabetes were diagnosed. Patients were linked to follow-up care, often in rural villages where these conditions are often unheard of, yet staggeringly common.

In another study, the World Health Organization had similar success. The organization trained health-care workers in Nigeria

and China to test for heart disease and to counsel patients on healthier habits. In both places, primary-care clinics were able to effectively screen for heart attacks and strokes, check blood pressure and urine sugar (an indicator of diabetes) and offer basic medications. Patients who saw the trained clinicians reported lower blood pressure after 12 months than those in the control group. Only 2 percent of patients needed to be referred to a specialist.

But there were problems, too. Less than half of patients got their high blood pressure totally under control. And some of the preventative measures fell flat. In Nigeria, study participants said they smoked less and ate more vegetables because of guidance from their clinic officials. But in China, patients did not respond to these interventions. This underscores the need for research into ways to target specific countries and regions. Scaling up public health programs often requires adjusting the medications, training and messaging, for both logistical and cultural reasons.

Philanthropists and policymakers in the United States should support this work because, in addition to the benefits for U.S. trade and development interests, these programs generate lessons that are applicable domestically.

In Harlem, for example, an organization called City Health Works applied a South African strategy, using peer health educators to help locals with chronic diseases access their medications and follow doctors' diet advice. Community members were trained as "health coaches" and sent to visit their neighbors weekly for three months. These coaches had no formal medical training, but their community ties helped them reach out to vulnerable people doctors might not otherwise meet. The 10 health coaches helped divert 20 patients from the emergency room through these interventions; New York is considering expanding the program.

Non-communicable diseases are the health issue of our time, both in developing countries and in the United States. We have the infrastructure and the playbook we need to address these problems.