Among the regulators, Mullard does not mention the Haute Autorité de Santé (the French health-care watchdog) and its “transparency” committee. This committee assesses drugs for reimbursement and pricing. A draft report produced in 2006 on the reassessment of benfluorex included a prominent note that benfluorex was (a) a hidden anorexigen misused for slimming; (b) a derivate of the fenfluramine family, withdrawn for valvular disease; and (c) withdrawn in Spain for adverse effects. The final version of the report contained no such note.

Lastly, the role of the experts and of many medical colleges was not mentioned by Mullard. This might need a separate piece.

I was sacked by the Department of Health from my position as a senior tenured consultant in public health at Amiens University Hospital.

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Non-communicable diseases in southeast Asia

In describing features of a comprehensive response to the rise of chronic non-communicable diseases (NCDs) in southeast Asia, Antonio Dans and colleagues (Feb 19, p 680) highlight the need to strengthen primary health care as the way to ensure care for millions affected with chronic conditions. This point echoes that of recent reviews on NCDs. But beyond establishment of a comprehensive service at primary level, putting people living with chronic conditions at the centre of managing themselves must be considered.

Traditional service delivery platforms that put health teams at the heart of disease management might not be feasible given the nature of chronic conditions and current resources. Even with stronger prevention programmes, we can expect an ever-growing number of people to be affected with chronic disease in the next decades. Just between Indonesia and the Philippines, the most populous countries in the region, there will already be an estimated 29.2 million people with diabetes by 2030.

Organisation of lifelong care for chronic conditions must move towards greater self-management, whereby patients gain a mastery of their disease. The role of expert patients, and peer and community support groups, must be harnessed further. In Cambodia, a community-based diabetes support group provides not only information but also facilitates greater access to laboratory tests and essential medicines among its members. We must also seize the opportunities provided by the spread of mobile phones and smart devices to support patients in managing their own conditions and to reshape how they interact with health-care providers.

We need to radically rethink our concept of health care to address the rise of non-communicable disease. This shift implies very simple diagnostic and treatment protocols, fewer barriers to essential medicines, greater access to simple monitoring devices, and a move towards true empowerment of patients.

I declare that I have no conflicts of interest.

According to Antonio Dans, lack of workforce and infrastructure is one of the limitations to management of non-communicable diseases (NCDs) in southeast Asia. We agree that the health-care delivery system was designed mainly to manage acute infectious diseases in resource-limited southeast Asian countries. However, many of these countries have also established a system to manage HIV as a chronic disease, and such systems can be applied for the management of NCDs too.

In Burma, Cambodia, Thailand, and Vietnam, 312 566 HIV patients were on antiretroviral therapy (ART) in 2009: 68% of those in need. To promote a long-term continuum of care, these countries established pioneer chronic disease management systems. Services were integrated within public health-care facilities and linked to the communities. A key feature was the involvement of affected communities as co-service providers, whereby patients had a central role in promoting self-care, treatment adherence, and peer support. Further, a longitudinal patient follow-up system has been developed with registers and individual patients’ cards and files,
which is used to monitor and assess service performance and quality. For example, 84–88% of patients who started ART in 2008 remain in the 12-month follow-up in all four countries.4

In Cambodia, the care for HIV, diabetes, and hypertension has been integrated in two public hospitals.5 In Vietnam, cancer hospitals are adapting the HIV care systems, including home-based care for cancer patients.6 Rather than reinventing the wheel to manage NCDs, southeast Asian countries can adapt and apply learning from chronic care HIV systems.

The views expressed in this letter are those of the authors and do not necessarily represent the official views of their organisations. KCP has received remuneration from WHO and Family Health International to review the paper, “HIV service delivery in six Asia and the Pacific countries”, however, this correspondence is independent of the above-mentioned work. The other authors declare that they have no conflicts of interest.

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Authors’ reply

We support the adoption and expansion of strategies for self-management, including expert patients and peer and community support groups. Self-care, in fact, is part and parcel of a “whole of society” approach that we have advocated. Many models of self-management for chronic disease are likely to be present in southeast Asia, often well adapted to indigenous concepts of disease; however, these models are insufficiently documented and tested for their effectiveness in ensuring good patient outcomes in the long term and in other populations. Whatever the approach, self-care can be made effective with support from a strengthened primary care system.

We also agree that many lessons can be learned from HIV and tuberculosis management, which are increasingly being conceived of as chronic diseases. However, non-communicable disease (NCDs) are a mixed bag of conditions, so the care required can vary substantially. Furthermore, HIV and tuberculosis programmes have benefited from substantial investments in financial, technical, and political resources. This has not yet been the case for NCDs.7 We are hopeful that the upcoming high-level meeting on NCDs at the UN will lead to greater international commitment to address the challenge of NCDs.

We look forward to long-term outcomes of these important programmes that have been mentioned. We also keenly await results of attempts to scale up their implementation. For sure, there will be no magic bullets to solving NCDs, and each southeast Asian government must lead the way in shaping their own responses to the challenge.

AD has received a research grant from AstraZeneca and on diabetes for Merck Sharp and Dohme, on liraglutide for Novo Nordisk Pharma, and on diabetes for AstraZeneca and Bristol-Myers Squibb. He is the recipient of a research grant from Pfizer, and has received honoraria for lectures from Merck Schering-Plough, GlaxoSmithKline, and Abbott Manufacturing. RF receives honoraria for her work with the China Medical Board. NN, CV, and RB declare that they have no conflicts of interest.

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Prevention of elder abuse

Your Editorial on prevention of elder abuse is timely (March 12, p 876).1 However, any parallel with child abuse programmes should be approached with caution.

On the positive side, advocates for older people could learn much by studying the factors whereby child protection benefits from greater public awareness, superior funding, better education of health-care providers, a more organised response team and legal system, and a more robust research base. Some, but not all, of this represents a longer history in the health and social care arena. Older people would certainly benefit from the adoption of many of these features including the creation of a tzar advocate at the federal level, increased resources, public awareness, better education of health-care