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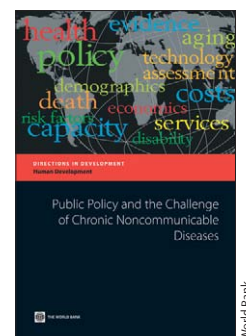
## Time for a global partnership on non-communicable diseases

The World Bank's report about public policy and non-communicable diseases<sup>1</sup> has the potential to cascade change in public-health priorities in developing countries. The Bank provides three times as much as the entire budget of WHO and has the potential to tie its recommendations for reform to fiscal resources. However, the Bank's focus on analytical and advisory services, and support for approaches through which it will include non-communicable diseases into lending operations, emphasises support for country-led efforts. The report does not focus on coordination of a global response, which is needed to harmonise technical support to countries, nor does it signal the Bank's role in any envisaged global arrangement to pool resources and technical expertise to improve access to products and services.

A global response to non-communicable diseases is urgently needed because macroeconomic growth and liberalisation of trade and communications, coupled with the spread of technology and global branding, is rapidly contributing to the transnational threat of such diseases. This point is especially relevant in developing countries, which are rapidly undergoing epidemiological shifts in disease patterns. However, global public-health partnerships that have formed so far have failed to focus their attention on non-communicable diseases.

In view of these considerations, there is a need for establishment of a global non-communicable disease partnership, with a multisectoral construct and a scope beyond the health sector. The relation of the risk of

non-communicable disease with agriculture and trade ties-in the role of the Food and Agricultural Organization, the World Trade Organization, and the UN Conference on Trade and Development. Partnerships with employers to develop preventive services in the workplace involve the International Labour Organization, whereas UNICEF and the UNFPA could be partners because of the life-course approach to non-communicable diseases. The partnership must also include international non-governmental organisations, such as the World Heart Federation and the International Union Against Cancer, which are working in non-communicable diseases, as well as industries whose products affect risk and outcomes in non-communicable diseases, albeit with ethical safeguards. However, irrespective of setup, the arrangement should build on the strength of current global efforts, such as: the Framework Convention for Tobacco Control, the Global Strategy on Diet and Physical Activity, and WHO's regional networks; civil society-led efforts such as the Global Prevention Alliance;<sup>2</sup> academia and commercial sector collaborations, such as the Oxford Health Alliance and the Bloomberg Initiative;<sup>3,4</sup> and corporate social-responsibility programmes, such as the Ovations Initiative.<sup>5</sup> The arrangement should also gain insights into countries where non-communicable diseases have been addressed holistically.<sup>6</sup> In the setting up of the global partnership, it seems plausible to make cancer prevention a priority because international collaboration here is best established within non-communicable diseases.



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As a starting point therefore, a global governance mechanism should be established and coordinated by a multilateral agency with a global-health mandate to set goals and targets that are acceptable worldwide, and to create a mechanism for synchronising stakeholders' efforts. Synchronisation can be achieved through the creation of multilateral agreements, institutional and programmatic relations, and partnerships to derive an agreement for stakeholders and their roles and obligations. Multisource funding also needs to be established; possible options include multilateral mechanisms for grants, private-sector funding, and most importantly the creation of a financing method that will enhance the partnership's ability to catalyse country allocations for non-communicable diseases—an approach to which country investment from WHO can bring substantial value. WHO would also be an important stakeholder by offering technical assistance to countries to promote sustainable and integrated public-health models that will strengthen the prevention of non-communicable diseases. Work should also begin to coordinate and harmonise civil society's response to the challenge of non-communicable diseases and to develop a common understanding of, messaging about, and strategies related to these diseases. Possible medium-term deliverables of this effort could include a framework for the partnership, a portfolio of agreements outlining

the roles of stakeholders, and the creation of the fund itself, with initial seed funding.

The establishment of this arrangement as a first step towards developing the global non-communicable disease partnership would counter some of the concerns about the current neglect of such diseases. However, the establishment of safeguards against ethical, methodological, accountability, sustainability, and governance issues will be essential. Lessons from earlier experiences with infectious disease partnerships can be instructive.<sup>7-9</sup>

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I declare that I have no conflict of interest.

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## Screening for diabetes and prediabetes

The Health Technology Assessment report by Norman Waugh and colleagues,<sup>1</sup> on screening for type 2 diabetes challenges the health sector, and primary care in particular, to be more proactive in the detection and treatment of both diabetes and prediabetes. The conclusions are firmer than those of the UK National Screening Committee after a previous review.<sup>2</sup> Waugh comes to this new view mainly as a result of the increasing prevalence of obesity and consequent type 2 diabetes, and the potential to reduce cardiovascular risk, especially with cheap generic statins. We welcome the attention given to prediabetes (impaired glucose tolerance and impaired fasting glucose).

We suspect that an absence of clear guidelines or acceptability for screening for diabetes has kept

prediabetes in the shadows. Impaired glucose tolerance increases the risk of cardiovascular disease by about 60%, and impaired fasting glucose does the same by around 30%.<sup>3,4</sup> Furthermore, for every person with diabetes, there are four with prediabetes.<sup>5</sup> Although almost half of those with prediabetes progress to diabetes, this process can be prevented or slowed by diet, exercise, and several drugs that are used to treat diabetes.<sup>6</sup> Waugh and colleagues' modelling predicts that screening for and treating impaired glucose tolerance would be cost effective, particularly when lifestyle interventions are used to treat identified cases.

Waugh and colleagues note that three of the National Screening Committee criteria are still not met. First, current management of diabetes is still less