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A human right to health approach for non-communicable diseases

We agree with Robert Beaglehole and colleagues (Oct 13, p 1283)[1] that a monitoring framework for non-communicable diseases (NCDs) needs well defined targets. But experience from the Millennium Development Goals taught us that isolating targets from their context does not work. As Einstein said, doing the same thing over and over again, and expecting different results, is insanity. No matter how you measure it.

NCDs are linked to the way we eat, the way we exercise, the way we live, and to the accessibility and organisation of care. Effective control of NCDs requires a comprehensive approach. Even more so at a time when "deep concern about the impact of the financial and economic crisis" pervades the UN.[2]

Therefore, NCD targets must explicitly address global and local social determinants. Corporate behaviour, including potentially damaging marketing practices, must be regulated. Equitable access to healthy food, care, and medicines needs public intervention supported by empowering processes in communities.[3]

We recommend the inclusion of broad process indicators that assess the effect of "crisis-coping policies",[4] that measure how governments ensure corporate compliance, that monitor policies to curb the influence of "Big Food" and "Big Beverage" on people's diets,[5] and that ensure access to quality care. These indicators will help to understand why targets are (or are not) met, and will contribute empowering strategies to governments and civil society.

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Dementia—a geriatric syndrome

In their perceptive dissection of the parallel tunnel visions of much dementia research (Oct 20, p 1441),[1] Carol Brayne and Daniel Davis highlight a troubling collective lapse of scientific curiosity accompanied by widespread adoption of what the late Petr Skrabanek termed "nonsensus consensus",[2] elegantly illustrated by Hieronymus Bosch five centuries previously.[3]

An additional approach to their helpful proposals to radically rethink this major public health problem is to view dementia as a geriatric syndrome, which in the first place should be prevented to the greatest extent possible by early intervention.[4] It is increasingly evident that clinical dementia in old age, even if often over-enthusiastically labelled as "Alzheimer's disease", is a geriatric syndrome with several causes including neurodegeneration, disorders of cerebral circulation, and many other factors. This diversity complicates the search for single-mode therapeutic approaches, but opens the door to innovative preventive[4] and therapeutic approaches.

The hallmark of successful therapeutic trials in geriatric syndromes is the marked superiority of multicomponent interventions over single-component ones.[5] Additionally, the geriatric medicine approach parallels that of Brayne and Davis in promoting clinical trials that include individuals of similar age, frailty, or fitness to those who will receive the treatment in practice.

To design multicomponent trials for dementia in predominantly older and more frail patients will clearly pose more of a challenge than single-component trials in younger and fitter patients, but it is not an insuperable task: it is also imbued with a strong moral and scientific imperative, strengthened by the observations of Brayne and Davis.

We are both members of the Executive Board of the European Union Geriatric Medicine Society.

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