The Ethics Of Chronic Diseases And Their Management

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In the 19th century, improvements in public health emerged. In the 20th century, acute disease either became preventable or cures were found. In the 21st century, the management of chronic disease becomes the test of ingenuity and imagination. [1]

Chronic diseases – cardiovascular diseases, cancer, chronic respiratory disease and diabetes are the leading global cause of death -60% of global deaths in 2008 were from non communicable diseases, of which 80% were in low and middle income countries [2]. Deaths are projected to increase but lack of progress on control is a major obstacle to achieving Millennium Development Goals (MDGs) [3]. Long term care for people with chronic diseases and disabilities is a major global challenge and particularly in developing countries like Nepal where current systems of care will not meet the demands. [3] A recent WHO study estimates that in many developing countries the need will increase by as much as 400% in the coming decades.[3]

Piot and Ebrahim have identified 3 myths of chronic disease which have contributed to their neglect [4] -

1) They are "diseases of affluence" where as risk factors are socially patterned with age standardized mortality rates almost twice as high in low income than in high income countries. Studies indicate that about 1 in 10 Nepalis, both poor and rich have diabetes with overall diabetes mellitus prevalence increased to 25.9% of all over 60s in 2009. [5]

2) They do not cause premature death where as 60% in low income countries occur in under 60 year olds.

3) There are no cost effective interventions where as tobacco control with salt restriction could stop 13.8 million premature deaths over 10 years in low and middle income countries costing US$0.50 per person per year. Treating high risk cardiovascular disease patients with aspirin, statins and two anti-hypertensives is also highly cost effective – about equivalent to above population measures.

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This should be seen as a justice issue for society and a fundamental ethical obligation of society to provide cost effective care protecting the weak and vulnerable.[3] Known at risk lifestyle factors e.g. smoking, unhealthy eating and physical inactivity are not only determined at an individual level but also societal factors can influence. Control of promotion of tobacco, regulation of levels of fats, sugars and salt in processed foods and strengthened health care systems enabling access to essential treatments of chronic diseases are issues to be tackled.[4] Urbanisation with its influence on lifestyle is an important risk factor – in Nepal the prevalence of diabetes is much greater in urban populations 14.1% versus 2.9%.[5]

There will need to be a fundamental paradigm shift in health care in a country like Nepal to meet the demands of chronic disease management.

WHO has identified 5 core competencies –

1. Patient centred care –understanding the patient's perspective
2. Partnering –with families and other health professionals with effective referral systems
3. Quality improvement –monitoring and evaluating quality
4. Information and communication technology – good records to be shared
5. Public health perspective –think about the whole population.

Specifically in Nepal, issues of bias in health care e.g. gender, urban/rural divide will need tackling. Most patients with a chronic disease must self-manage their condition to some extent and preparation for these responsibilities is needed.[6] Recipients of care and those providing it should have a voice in making decisions that affect them. Communication between acute care and long term care systems needs to be improved. Partnerships between patients and their families and healthcare givers need to be based on mutual respect and recognition of each's strengths. Long term care needs to be provided in ways that respects cultural values. The principle of autonomy may need to be moderated by family and societal needs. Effective use of scarce resources is essential and the welfare of other family members must be considered when decisions are made on use for family resources.[3]

However in the reality of scarce resources, basic obligation for care must first be recognized. A long-term care system is comprised of a comprehensive range of services, some based in the home, others based in the community, in health care institutions, and elsewhere. In an optimal and rational model, all of the services and structures that form a system will be designed to allow individuals to lead lives of dignity and, where possible, independence, without placing intolerable burdens on their families.[3]

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