Comment on WHO INDEPENDENT HIGH-LEVEL COMMISSION ON NON-COMMUNICABLE DISEASES. Version dated 1 May 2018

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I appreciate the opportunity given by the WHO NCD commission to comment of the NCD report. The document clearly includes actions for both social determinants and risk factor for NCDs and I would like to propose some variations on the following recommendations:

1. **Identify and implement a small set of priorities within the overall NCD and mental health agenda. Prioritization is the key to achieve the scale-up that countries need to reach the SDG 3.4 target.**

   **Comment:**
   The statement could be starting with the part b (Countries should also work towards) which establishes health promotion actions. In high income countries the decline of cardiovascular diseases has been attributed to both the population interventions towards to the control of cardiovascular risk factors and the individual interventions to manage people who have been affected by NCD and risk factors (1, 2). The population strategies are also in the line with the best-buy strategies (3).

b) **Countries should also work towards**

   **Comment:**
   The strategy of health promotion should include a key point promoting healthy habits such physical activity, smoking cessation, low salt intake, low sugar intake and higher fruits and vegetables consumption through formal and informal education. Health promotion for children and young people in schools has been an effective strategy to low NCD incidence (4, 5) and the impact of salt and sugar intake on NCD has been also demonstrated (6-11).
a) Countries should prioritize a few of the cost-effective interventions that have been endorsed by the World Health Assembly, based on sound data on morbidity and mortality and their main drivers.

These priorities should include:
- Treating every patient with hypertension and high-risk patients with statins and aspirin

**Comment**

I suggest revising this recommendation based on the current evidence. First, the use of statins should be based on the cardiovascular risk and the level of LDL cholesterol and/or total cholesterol because the preventive effect of statins depends on both variables (12). Therefore, for every patient with hypertension an assessment of his cardiovascular risk should be attained (13). Although the association between cholesterol levels and cardiovascular diseases has been demonstrated (14), additional evidence supported using statins for primary prevention, particularly for people under 50 years from low and middle income countries is needed (15) Similarly, the benefit of prescribing statins for older people has been questioned (16)

Secondly, the long term use of statins is a risk factor for Diabetes (17, 18). Although the diabetes related risk could be lower compare with the benefit, a massive use in people with hypertension at low and middle risk could be lead to an increase in diabetes prevalence particularly in countries like India or México (19, 20). Similarly, evidence supporting prescribing aspirin for primary prevention in people at low or middle cardiovascular risk is weak (21). The use of aspirin in people aged 55 years and over without atherosclerotic cardiovascular disease has been also associated with mortality risk due to bleeding.(22-24)

Thirdly, the recommendation also could detract health providers from promoting non-pharmacological interventions in hypertensive patients at low or middle cardiovascular risk. Weight loss, low sodium intake and doing physical activity should be the first intervention for hypertensive people. These interventions lead to similar blood pressure reductions those pharmacological interventions do for hypertensive patients. (25)
References