Para 2: needs to include more details of premature NCD mortality as specifically defined for SDG 3.4 (deaths due to cardiovascular disease, cancer, chronic respiratory disease or diabetes, in the age range 30 to 69 years inclusive (https://sustainabledevelopment.un.org/sdg3)). It may also be worth making clear here that many territories achieving SDG3.4 will not achieve an all-age reduction in NCD deaths because of population ageing and other factors – and doing so is not expected. Countries should not regard overall increases in NCD deaths, linked with life expectancy increases, as a failure.

Para 3 and para 12: universal health coverage (UHC) needs pulling out from among the many NCD-specific obstacles and strategies mentioned, and given a separate paragraph. Implementing UHC is a fundamental pre-requisite for progress on NCDs, diseases which by their nature need continuity of accessible care. NCD-specific elements of UHC frameworks (such as screening programmes, risk reduction strategies, preventive treatment, etc.) need to be carefully evaluated for efficacy and cost-effectiveness. Interestingly Sweden achieved a 25% reduction in premature NCD mortality (as per SDG 3.4 definition) over 15 years (1991 to 2006), not as a result of specific interventions but probably largely due to effective UHC (https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-015-0313-8)

An important part of UHC in relation to NCDs is resourcing civil registration and vital statistics (CRVS) systems so that individuals can be properly identified and followed longitudinally within health information systems – otherwise tracking progress towards SDG 3.4 becomes impossible.

Peter Byass

Professor of Global Health, Umeå University

Honorary Professor, Universities of Aberdeen and the Witwatersrand