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Twin epidemics of covid-19 and non-communicable disease

Worse than the sum of their parts

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The exclusive focus of political, regulatory, health service, and public health agencies on covid-19 has concealed another less visible epidemic. Non-communicable diseases (NCDs) such as obesity, diabetes, heart disease, stroke, cancer, chronic respiratory diseases, and mental health disorders cause many times more premature deaths and greater suffering than covid-19, year after year.

Like children playing Sunday football, we have all been chasing after the covid-19 ball but have left the goal wide open. The response to coronavirus has constrained the physical and mental freedoms of people with NCDs and severely disrupted access to essential services.[1] The management of the acute epidemic in isolation from the chronic epidemic is short sighted and will leave a legacy of great harm from the effect of lockdown and the serious disruption of health and care services for people with NCDs.

Synergism

These two epidemics are closely connected and act synergistically on morbidity and mortality: people with NCDs are more vulnerable to severe covid-19 and death[2]; covid-19 and NCDs share a common set of underlying risk factors, including deprivation, obesity, older age, and ethnicity.

Although communicable and non-communicable diseases seem very different, distinguished by transmissibility and chronicity, the dichotomy created by these categories is being challenged.[3] An alternative concept of socially transmitted conditions has been proposed[4] to reflect their shared social, environmental, and commercial[5 6] determinants and to stress "the anthropogenic and socially contagious nature of the diseases."[4]

The term socially transmitted conditions includes both communicable diseases such as covid-19 and NCDs such as diabetes. It signals clearly that these conditions are driven by upstream factors such as urban design, housing, poverty, the availability of tobacco, alcohol, and processed foods, and physical inactivity.

Public health policies to prevent disease and tackle the corporate and other social determinants of health have been frustratingly slow and chronically underfunded in the UK.[7] Consequently, the UK lags behind many other industrialised countries in reducing premature mortality from NCDs, a poor starting point for a pandemic as challenging as covid-19.

Prevention strategies and research have focused on downstream interventions that rely on influencing individual behaviours, an approach that widens health inequalities. Interventions should instead target whole systems such as health, education, local government, and communities to tackle the underlying social economic and environmental causes of ill health.[8]

Learning from covid-19

Aspects of national responses to covid-19 can be learnt from and adapted to help tackle the equally devastating and much more durable epidemic of NCDs. Firstly, a strong cohesive national policy is urgently required, developed across all government departments and underpinned by legislation where needed, mirroring the emergency legislation introduced to control covid-19.

Policy, legislation, and regulation should target the key structural factors underlying epidemics of both covid-19 and NCDs, including income inequality, insecure employment, poor education, inadequate housing, and the societal risks driven by industries such as tobacco, alcohol, and processed foods.[6 9] Sweeping changes, including legislation, were made in a matter of weeks to protect the public from covid-19. We need the same urgency to stop the premature morbidity and mortality caused by NCDs.

Secondly, local systems must be strengthened. Coordinated action is needed by local decision makers with responsibility for housing, schools, local employment, transport, and the environment—including strong community engagement. The covid-19 pandemic showed the power and agility of working through gold (strategic), silver (tactical), and bronze (operational) command structures to coordinate tailored local responses—from preparing hospitals through to supporting vulnerable citizens and developing community based recovery strategies. These well established emergency command structures should be deployed to control NCDs.

Thirdly, testing and tracking of covid-19 cases has a parallel in NCDs, where effective secondary prevention involves concerted action to identify and manage cases as early as possible. Rigorous, community based detection and follow-up of patients with hypertension, for example, reduce both morbidity and inequalities in stroke mortality.[10] Some argue for parity between measures to reduce local variation in NCDs and measures to control infectious disease.[11] Excess rates of some NCDs could be notifiable for example. Local and national public health agencies should develop a standardised incident response to clusters of premature NCDs, equivalent to that used for local outbreaks of infectious diseases.[11]

Action involving the whole health economy, and exploiting the wealth of surveillance data available

from primary care databases, hospital statistics, and public health intelligence in real time, should be at the heart of our response to variations in NCD outcomes.[12]

Throughout the covid-19 epidemic, the government has pledged to "save lives." The lives of people with NCDs are equally important. Reducing mortality from NCDs requires both primary prevention to tackle the underlying causes and secondary prevention to ensure early detection and effective management. Our local and national response to covid-19 has shown what is possible with common purpose and collective endeavour. Let us put the same vigour and commitment into tackling the other pandemic.

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