Blood-Pressure-Related Disease Is a Global Health Priority

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In global-health politics, cardiovascular disease is the elephant in the room—a massive problem that few want to acknowledge and even fewer want to tackle. In [a recent issue of] Lancet, Carlene Lawes and colleagues, on behalf of the International Society of Hypertension, estimate that blood-pressure-related diseases cause about half this burden, killing around 8 million people each year.¹ Low-income and middle-income countries shoulder about 80% of the cardiovascular-disease burden, half of which is in people of working age.

This situation was all predicted a decade ago by the Global Burden of Disease Project,² but none of the major health-development funds—including the Bill & Melinda Gates Foundation, the World Bank, the major regional development banks, and major bilateral donors—have made any substantive or sustained effort to address this issue. Similarly, none of the major international drug companies have offered material assistance in this global-health crisis, despite gargantuan profits from the sales of blood-pressure-lowering drugs in high-income countries. Hence, in the time that has passed since the Global Burden of Disease reports appeared, blood-pressure-related diseases have killed more than 50 million people, disabled many more, and taken billions of dollars from already fragile economies. So how big a problem does this have to become before anyone with resources takes meaningful action?

Reports from WHO³ and the World Bank⁴ provide some hope that real action may be imminent. Both reports highlight the importance of chronic disease as an obstacle to economic development as well as a barrier to improved national health-status. They recommend action to control the huge epidemics of cardiovascular diseases already affecting Asia and South America and threatening other regions, including Africa, where stroke is rapidly becoming a common cause of death and disability.⁵ The risk of stroke is quickly reduced by blood-pressure-lowering treatment⁶ and for high-risk individuals the absolute benefits of such treatment are large by any standard.⁷ Moreover, such benefits can be achieved with generic antihypertensive drugs costing as little as US$1 a year per person.⁸ Effective non-drug interventions can also be provided at low cost.⁹ However, there is still no single initiative on the whole African continent to implement blood-pressure-control strategies systematically on a population-wide scale, even to those at very high risk of death or disability. For many such individuals, the first relevant medical attention they receive is admission to hospital after stroke.

For most low-income and middle-income countries, the major obstacle to the control of blood-pressure-related diseases is the absence of appropriate primary health-care services. In many regions, primary-care services provide only episodic care with little record kept of previous visits. These services must be adapted to provide continuing care, not only for the management of blood-pressure-related diseases but also for the management of other serious chronic disorders, including HIV infection.¹⁰ How best to improve the quality of primary care in these regions is an open question. Undoubtedly, new approaches are needed, since the models that have evolved in high-income countries are neither affordable nor practical for the rest of the world, where non-medical health-care workers often provide the bulk of primary care services and most expenditure on health care is out of pocket. The formulation and assessment of new primary-care models of the management of chronic disease in resource-poor settings require investment in research into health-care delivery. Unfortunately, such research is not attractive to most international funding agencies, many of which still prefer to believe that the world’s leading health problems will be resolved by the development of new treatments based on technologies such as genomics, proteomics, or metabolomics. But for much of the world’s population, any new drugs, however effective, will have little relevance if there is no system in place to deliver treatment to those in need.

This failure of primary-care systems combined with a myopic view of disease targets among those who set international

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health priorities has contributed to the staggering inequality in access to blood-pressure-lowering treatments. Global expenditure on antihypertensive treatment is about $50 billion each year, more than 90% of which is spent in high-income countries, where the main debate about access concerns the provision of care to very-low-risk individuals. Middle-income and low-income regions have a five times greater burden of disease than do high-income regions, with access to less than 10% of the global treatment resource. Here the main access issue is whether care can be given to those at the highest risk of fatal or catastrophic events, because most of those for whom blood-pressure lowering is recommended receive no treatment whatsoever. In this regard, the antihypertensive care available for many people is much as it was in the first half of the twentieth century, before the development of diuretics and β blockers, when malignant hypertension was a common cause of hospital admission and death everywhere. This travesty cannot continue to be ignored by those most able to bring about change.